STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

January 13, 2017

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Shane E. Pendergrass
Chair
House Health and Government Operations Committee
241 House Office Building
Annapolis, MD 21401-1991

RE: 2016 Opioid Treatment Program Quality Improvement Work Plan – Final Report

Dear Chair Middleton and Chair Pendergrass:

At the request of Chair Hammen, the Department of Health and Mental Hygiene respectfully submits this final report on the Department's Opioid Treatment Program Work Plan, which was previously shared with the Senate Finance and House Health and Government Operations committees during the 2016 General Assembly Session.

This report covers meeting dates held from April 2016 through October 2016, and includes final recommendations approved by the Department on December 15, 2016.

Thank you for your consideration of this information. If you have any questions regarding the Department's Work Plan, please contact Webster Ye, Director of Governmental Affairs, at (410) 767-6480 or at Webster.Ye@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Members of the Senate Finance Committee
Members of the House Health & Government Operations Committee
Members of the Baltimore City Delegation
Barbara Bazron, Ph.D.
Webster Ye
Kathy Rebbert-Franklin, M.S.W.
Sarah Albert, MSAR# 11001

Behavioral Health Administration
Opioid Treatment Program Quality Improvement Initiative
Final Report
January 1, 2017

Introduction and Background

In early 2014, the Department of Health and Mental Hygiene (The Department) was contacted regarding the locations of opioid treatment programs in the central Baltimore City area. From this early engagement, the Department began meeting more frequently in 2015 with concerned community members and members of the General Assembly representing parts of Baltimore City to further discuss their concerns about opioid treatment programs. Following this, the Department provided a legislative briefing on February 2, 2016 before the House Health and Government Operations Committee. The Department identified strategies to improve the application process and quality of care of opioid treatment programs.

At the request of Delegate Hammen during the legislative briefing, the Department of Health and Mental Hygiene created an *Opioid Treatment Program Work Plan* (*OTPWP*), which outlines the Department's plan, and includes a timeline for implementing the plan. While the Department had been primarily conducting strategic planning activities with interested parties in Baltimore City, the results of the efforts related to the *OTPWP* will have a statewide impact. The Department provided a follow up legislative briefing on the progress achieved toward the goals and objectives of the *OPTWP* on November 2, 2016.

The Department's Behavioral Health Administration (BHA) created an Opioid Treatment Program (OTP) Quality Improvement Workgroup to assist in accomplishing specific goals and objectives of the *OTPWP*. Workgroup membership includes representation from BHA, the Local Addictions Authorities (LAA), Medical Care Programs (MA), Opioid Treatment Programs (OTPs), Community Representatives, and Consumer Advocates. The list of OTP Quality Improvement Workgroup members was provided as part of the July 1, 2016 report and is appended in this report as **Appendix A**.

The Stakeholder Workgroup met April 26, May 24, June 28, July 26, August 30, September 13 and September 27, October 18, and October 25, 2016. Not including occasional guests, a total of 43 people participated in one or more of the meetings, with a core group of 23 people participating in five or more meetings. Average attendance per meeting was 25, with a range of 20 to 35 persons attending per each of nine meetings.

Workgroup products include recommendations for managing potential impacts of programs in a community setting and overall quality of care standards. A description of the results of the workgroup's effort is provided below.

Opioid Treatment Program Work Plan (*OTPWP*) Goals, Objectives, Progress & Status

Goal #1: To create an integrated State and local process for approval of new programs and recertification of existing programs.

Objective A: In accordance with State and local network development role, the BHA will provide existing opioid treatment provider location and needs assessment data to the LAAs for the purpose of recruiting providers into areas of need.

Purpose: For LAAs to identify areas of need in their communities and inform potential OTPs of recommended locations.

Progress: BHA completed a statewide opioid disorder needs assessment that includes geo-maps of existing OTPs. The geo-maps and needs assessment data give a comprehensive state and jurisdictional analysis of needs and service provision at the zip code level. This information was given to local health officers and LAAs on November 18, 2016, and is included as **Attachment 1,** Opioid Treatment Programs in Maryland*: Needs Assessment Report.*

Status: Completed, November 2016

Objective B: Create mechanism to inform the LAAs about their role in recommending locations of new programs to potential OTPs based on areas of need.

Progress: BHA sent a letter of explanation to the LAAs on September 19, 2016, identifying their role in advising potential OTPs about locations in need of their services. A listing of various new roles associated with OTPs was included with the letter. A copy of this letter and the associated revised roles document were provided as attachments to the October 1, 2016 Quarterly Legislative Report.

Status: Completed, September 2016

Objective C: Inform potential new OTPs of the request that they meet with the LAA and discuss needs assessment data prior to selection of their location.

Progress: BHA sent a letter to OTPs on October 25, 2016 requesting that they consult with the LAA for location recommendations for new or additional sites prior to submitting application to the Office of Health Care Quality (OHCQ). A copy of this letter was provided as an attachment to the October 1, 2016 Quarterly Legislative Report. In addition, application instructions will be posted in January 2017 on BHA's website and will include information on meeting with the LAA prior to selecting a location for intended services.

Status: Completed, October 2016

Objective D: Determine best practices associated with managing potential impacts of programs in a community setting in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA) guidance.

Progress: BHA reviewed source documents: SAMHSA Federal Guidelines for Opioid Treatment Programs; SAMHSA Treatment Improvement Protocol 43 (TIP 43): Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs; The Baltimore Mayor's Heroin Treatment & Prevention Task Force Report, July 2015; sections of Commission on Accreditation of Rehabilitation Facilities (CARF International, 2016) and sections of The Joint Commission 2016 Standards for Behavioral Health Care in order to determine best practices for opioid treatment programs. Additional program specific materials and guidelines were received from workgroup members as requested.

Status: Completed, October 2016

Objective E: Based upon best practice information, determine criteria for new and existing programs related to managing potential impacts of programs in a community setting, in accordance with SAMHSA guidance.

Progress: The Opioid Treatment Provider Quality Improvement Workgroup created recommendations for managing potential impacts of programs in a community setting.

Workgroup recommendations included the following areas:

- Positive Community Relations/Liaising;
- Physical Facility Management and Sanitation;
- Patient Flow Management (Loitering) – Before and After Services;
- Program Design and Physical Space Considerations;
- Safety/Security;

- Diversion Control; and
- Problem Resolution.

A full set of recommendations is enclosed in this report as part of **Attachment 2**. These recommendations were sent to the Department for consideration on November 15, 2016; the Department approved them on December 15, 2016. See **Attachment 3** for final approved recommendations for implementation by BHA.

Status: Completed, December 2016

Goal #2: To improve the quality of care in opioid treatment programs.

Objective A: Enhance clinician competence to deliver high quality care by evaluating existing regulatory and other training requirements.

Progress: BHA has been working with the Board of Professional Counselors and Therapists (the Board) regarding the feasibility of requiring specific Continuing Education Units as part of the licensing or certification process for Alcohol & Drug Counselors. These continuing education trainings will result in a more qualified workforce and are part of a larger strategy to increase clinician competence. BHA developed a training proposal, including medication assisted treatment (MAT) training content, outline, requirements, and a timeline of deliverables for counselor training, which was presented to the full Board on October 21, 2016, and is still under consideration. The Board was receptive to the proposal. Should the Board agree, this requirement could be implemented as soon as October 2017.

Status: Pending Board of Professional Counselors and Therapists final approval.

Objective B: Implement actions needed to increase clinician competence.

Progress: The Central East Addiction Technology Training Center (the Danya Institute) has agreed to implement the medication assisted treatment counselor training when it is approved by the Board. Training will be provided both in-person and via webinar format. Future plans include use of a train-the-trainer model and provision of coursework via the BHA Office of Workforce Development.

Status: Pending Board of Professional Counselors Therapists final approval.

Objective C: Involve LAAs in audits and complaint investigations.

Progress: Currently identifying complaint investigation process.

Status: To be completed in January 2017.

Objective D: Clarify the authority and oversight role of LAAs to monitor the quality of care.

Progress: BHA has provided funding to the LAAs in anticipation of their involvement in complaint investigations, compliance activities, and system management. BHA and the LAAs have been meeting to refine protocols for these activities. BHA has been providing training and technical assistance to the LAAs on these additional roles and responsibilities.

Status: To be completed in January 2017.

Objective E: Develop quality of care standards.

- Promote use of Prescription Drug Monitoring Program (PDMP) and Chesapeake Regional Information System for our Patients (CRISP) in OTPs.
- Promote use of all FDA approved substance use disorder (SUD) medications in OTPs.
- Identify other areas of medical/clinical training needs and implement training.

Progress: The OTP Quality Improvement Workgroup created recommendations to address overall quality of care in the following areas:

- Staffing considerations;
- Use of PDMP in treatment planning and evaluation;
- Overdose response through promoting use of, and co-prescribing of, naloxone;
- Staff training;
- Hours of operation;
- Medical coverage;
- Coordination of care;
- Care provided based on outcome and individual response;
- Treatment for those with co-occurring mental health and/or somatic problems;
- Engagement;
- Management of concurrent misuse of other drugs; and
- Discharge considerations.

The Workgroup noted that the need for additional funding may be a consideration in the ability to implement any of these recommendations. See **Attachment 2** for full

workgroup product. These recommendations were sent to the Department for consideration on November 15, 2016; the Department approved them on December 15, 2016. See **Attachment 3** for the final approved recommendations for implementation by BHA.

Status: Completed, December 2016

Conclusions

The BHA *Opioid Treatment Program Work Plan (OTPWP)* has two goals. The first, to create an integrated state and local process for approval of new programs and recertification of existing programs, has been completed through the following objectives: 1) the development of the Opioid Treatment Program: *Needs Assessment Report*, which is an analysis of treatment needs and capacity to meet the need in each jurisdiction of the state (see **Attachment 1**); 2) provision of needs assessment information to the LAA in order for them to direct prospective providers to areas of unmet need in their jurisdictions; and 3) written instruction to OTPs requesting that they meet with the LAA to be informed of areas of need in the jurisdiction prior to selecting a new or additional site for services.

The intention of these three objectives is to ensure that LAAs have sufficient information to assist and recruit providers in matching their services with geographical areas of greatest need, and that OTPs are informed of this information prior to selecting new service sites. BHA will provide technical assistance to LAAs on the use of the needs assessment data, and their revised role regarding use of this data in assisting OTPs.

Activities designed to accomplish the second goal, to improve the quality of care of services in opioid treatment programs, are in progress. They include: 1) implementation of a MAT specific training for counselors to be approved by the Board of Professional Counselors and Therapists; and 2) implementation of a monitoring process for recommendations related to managing potential impacts of programs in a community setting and overall quality of care.

Recommendations were sent to the Department for consideration on November 15, 2016, and a final set were approved by the Department on December 15, 2016 (see **Attachment 3**).
A process is being established to incorporate designated recommendations into current requirements being monitored by BHA and the LAAs through their monitoring processes.
BHA will implement a dissemination plan to ensure all OTPs receive final requirements adopted by the Department, and will provide training to OTPs on specific areas identified as needed to increase competence.

This document constitutes the Final Report to the Senate Finance and House Health and Government Operations committees and the Baltimore City Delegation regarding the BHA *Opioid Treatment Program Work Plan.*

Attachment 1

November 18th, 2016 Introductory Letter to Stakeholders from BHA

Opioid Treatment Programs in Maryland
Needs Assessment Report
Supplemental Information and
Jurisdictional Summaries

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Behavioral Health Administration • Spring Grove Hospital Center • Dix Building
55 Wade Avenue • Catonsville, Maryland 21228
Larry Hogan, Governor – Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary
Barbara J. Bazron, Ph.D., Executive Director

November 18, 2016

Dear Stakeholders:

The Behavioral Health Administration has undertaken a system-wide substance use disorder needs assessment, designed to compare need for services to current service capacity. The needs assessment is being conducted in two phases. The first phase is focused on the needs of those with opioid use disorders and the need for medication-assisted treatment. The second phase will focus on the need for both residential and outpatient treatment, and supportive housing for individuals with substance use disorders.

Attached you will find the completed "Opioid Treatment Programs in Maryland: Needs Assessment Report" for your review. There are also two compendium documents that include additional, detailed information. These needs assessment findings will assist the BHA in future planning and will provide information to help local jurisdictions address priorities in the development and expansion of services.

If you have questions regarding the information contained within the attached documents, please contact Sue Jenkins at sue.jenkins@maryland.gov or 410-402-8625.

Sincerely,

Barbara J. Bazron, Ph.D.
Executive Director

Opioid Treatment Programs in Maryland

Needs Assessment Report

prepared by

University of Maryland Baltimore
Systems Evaluation Center

for the

Maryland Behavioral Health Administration

September 2016

Table of Contents

Introduction and Background

This report provides a collection of information regarding the current capacity of, and need for, Opioid Treatment Programs (OTPs) in Maryland's jurisdictions. This information is provided to help guide state and local officials in their planning and system development efforts to increase treatment capacity where it is most needed.

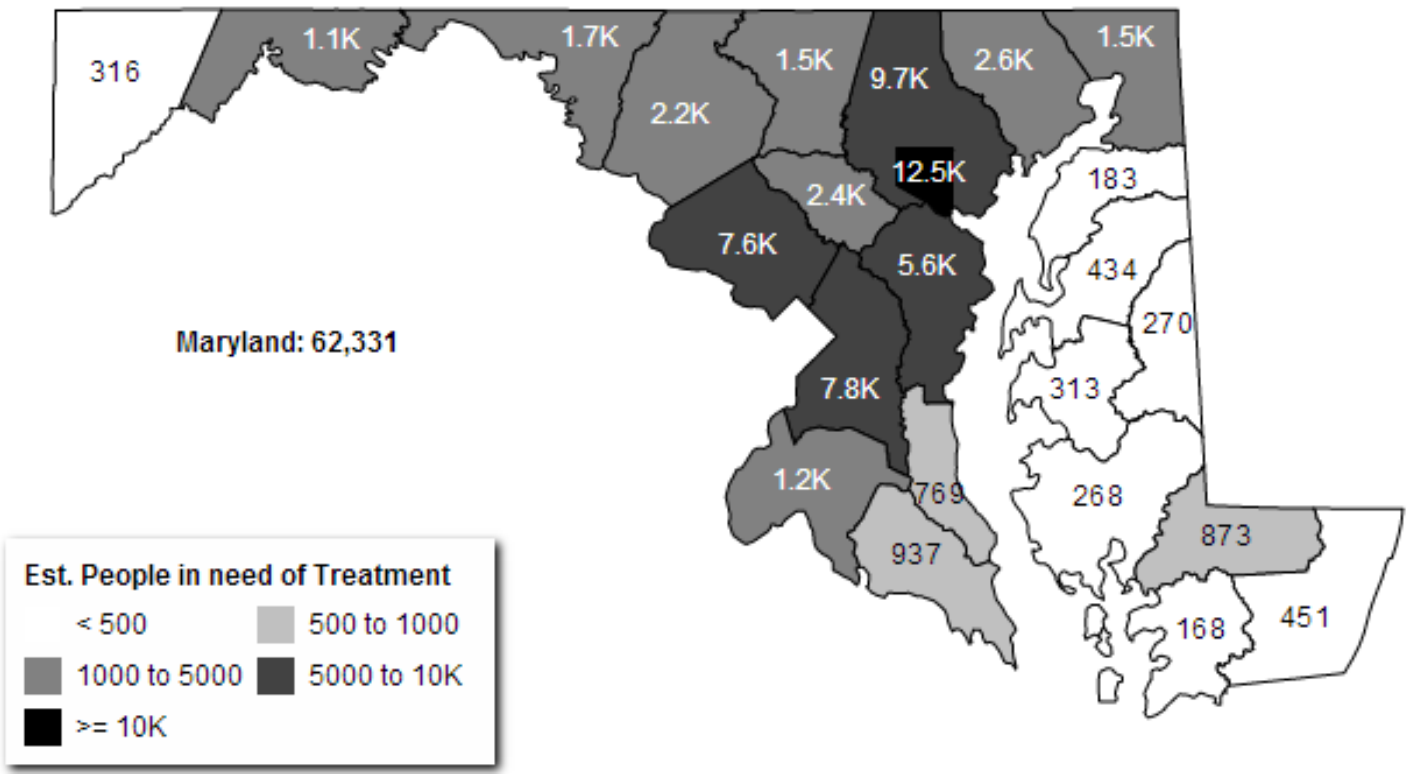
The "demand" for opioid use disorder (OUD) treatment – the number of people seeking treatment – is likely less than the estimated "need". Nationally, in 2014, the vast majority (~96%) of people classified as needing but not receiving treatment for an illicit drug or alcohol problem did not feel that they needed treatment (19.1 million out of ~19.9 million people) [1]. While medication-assisted treatment (MAT) does not work for all patients, and while non-medication treatments for opioid-related disorders are available, MAT has been shown to be an effective treatment for OUDs [2].

Summary

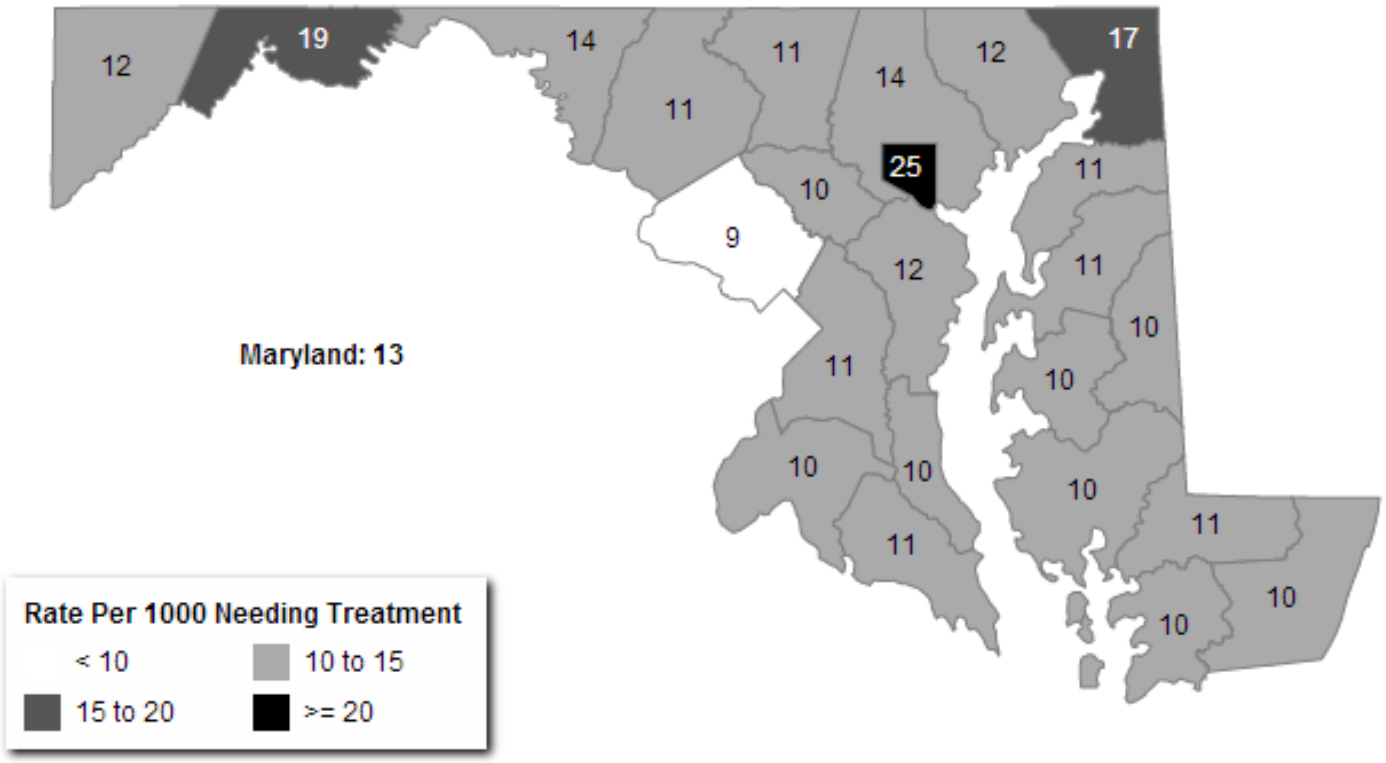
It is estimated that between 48,198 and 76,458 Marylanders age 12 or older are in need of treatment for a problem with opioid use. Based on the available OTP data there appears to be a large difference between the number of people needing treatment and those receiving treatment with methadone or buprenorphine.

Summary Maps

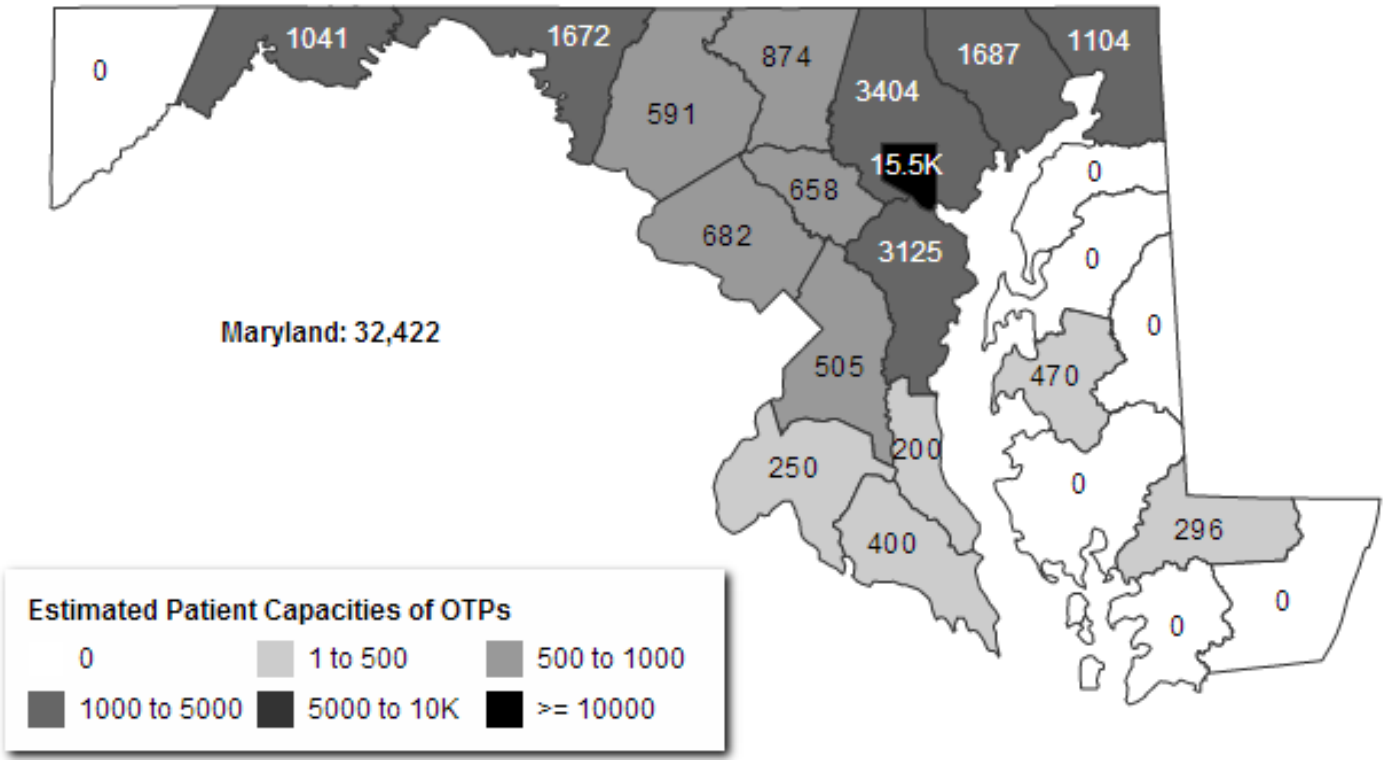
<u>Estimated Number of People in Need of Treatment for OUD (Age 12 or Older)</u>



Estimated Rate per 1000 Population in Need of Treatment for Opioid Disorder (Age 12 or Older)

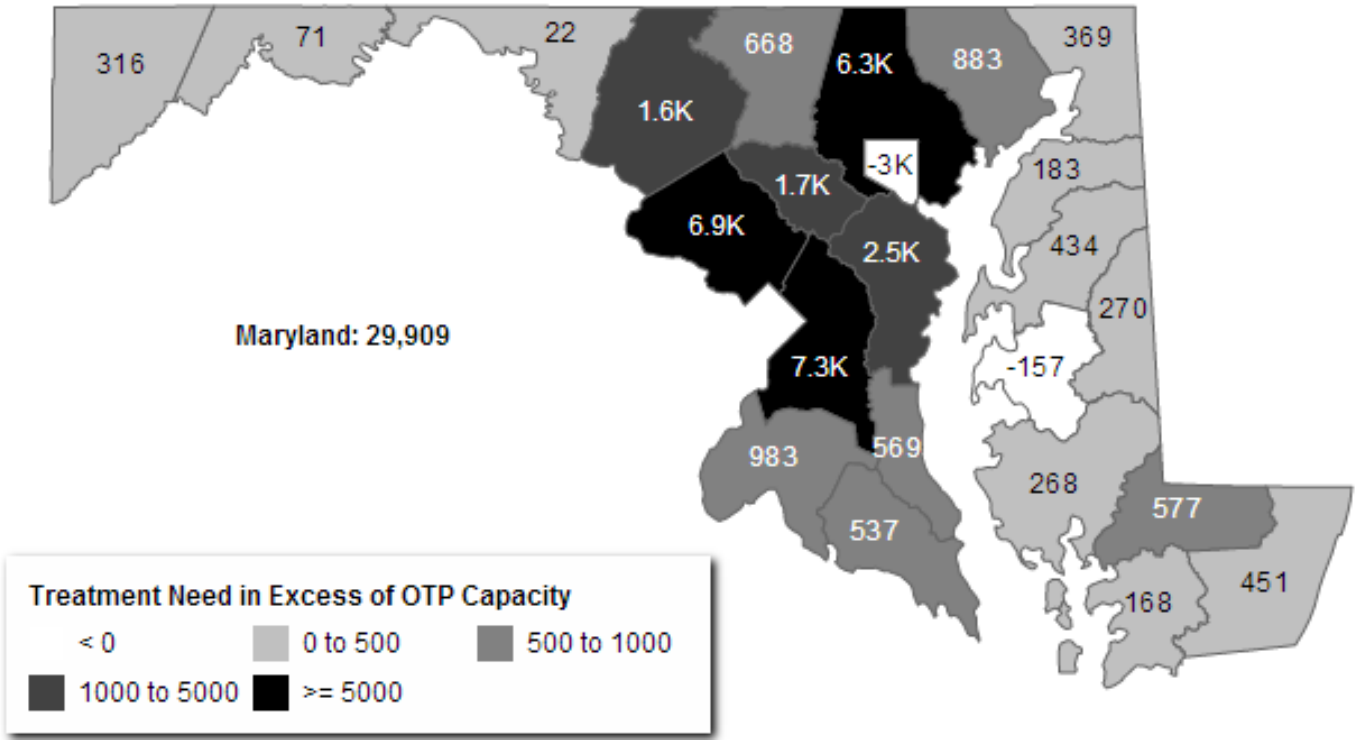


Estimated Patient Capacities of OTPs



Estimated Treatment Need Above Estimated OTP Capacity

(negative numbers indicate Capacity is above estimated need)



Estimated Need

In July of 2015, the City of Baltimore published a Task Force report that included estimating the need for heroin treatment in the City [3]. Within this report, the Task Force also recommended a methodology for estimating the need for treatment using multiple datasets, which is based on a recent publication that used this methodology in New York City [4]. In this section, a version of the methodology is applied across the jurisdictions and regions of Maryland using available data. The methodology involves combining multiple datasets, then providing a range of estimated numbers that are based on potential overlap between the datasets.

NSDUH Estimates

The first dataset is data from the National Survey on Drug Use and Health (NSDUH). This is an annual national survey conducted by the Substance Abuse and Mental Health Administration (SAMHSA) that asks people 12 and older about their drug use. SAMHSA releases this data to the public for use in research and planning. The table below provides estimates of the number of people abusing or dependent on opioids in Maryland counties and regions. 2010-2014 population estimates for age 12 years and older were taken from American Community Survey [5] data obtained from the Maryland Department of Planning. NSDUH data for estimates of drug or alcohol dependence were taken from SAMHSA [6]. The adjusted NSDUH estimate for dependence on or abuse of just opioids was calculated by multiplying the NSDUH percentages of any substance dependence or abuse by 0.1166 (11.66%), which is the national percentage of people with a heroin or prescription painkiller use disorder out of all people with any kind of substance use disorder [1].

Comparing NSDUH data from 2010-2012 to the data from 2012-2014, the percentage of Marylanders age 12 and older who were dependent on or abused drugs or alcohol in the past year has increased. This percentage has also increased in all of the Maryland's jurisdictions and regions for which estimates were calculated [6].

County/Region	Total Population, Age 12+	NSDUH Estimate of Substance Dependence and/or Abuse in the Past Year (2012-2014)	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids (2012-2014)	Estimated Number of People Age 12+ Dependent on or Abusing Opioids in the Past Year*
Anne Arundel	451,092	8.36%	0.97%	4,376
Baltimore City	509,100	10.72%	1.25%	6,364
Baltimore County	681,997	8.85%	1.03%	7,025
Montgomery	840,748	7.51%	0.88%	7,399
Prince George's	729,896	8.97%	1.05%	7,664
North Central Region	**389,704**	**7.49%**	**0.87%**	**3,390**
Carroll	139,765	7.49%	0.87%	1,216
Howard	249,939	7.49%	0.87%	2,174
Northeast Region	**410,093**	**7.92%**	**0.92%**	**3,772**
Caroline	26,816	7.92%	0.92%	247
Cecil	84,402	7.92%	0.92%	776
Harford	208,742	7.92%	0.92%	1,920
Kent	16,373	7.92%	0.92%	151
Queen Anne's	41,026	7.92%	0.92%	377
Talbot	32,734	7.92%	0.92%	301
South Region	**460,105**	**7.98%**	**0.93%**	**4,281**
Calvert	76,321	7.98%	0.93%	710
Charles	125,652	7.98%	0.93%	1,169
Dorchester	27,497	7.98%	0.93%	256
Somerset	16,446	7.98%	0.93%	153
St. Mary's	87,274	7.98%	0.93%	812
Wicomico	82,110	7.98%	0.93%	764
Worcester	44,805	7.98%	0.93%	417
West Region	**400,750**	**8.44%**	**0.98%**	**3,927**
Allegany	58,212	8.44%	0.98%	570
Frederick	198,081	8.44%	0.98%	1,941
Garrett	25,297	8.44%	0.98%	248
Washington	119,160	8.44%	0.98%	1,168
Maryland	**4,873,485**	**8.49%**	**0.99%**	**48,198**

**Regional and Statewide values are derived from adding up individual jurisdiction values, and may be slightly different from multiplying the Regional or Statewide population by their NSDUH Dependence / Abuse percentage for opioids due to rounding.*

Overdose Deaths

The second dataset used in the methodology is overdose deaths involving opioids. In Maryland in 2015, there were 1,089 unintentional overdose deaths involving opioids. The following table shows the number of heroin and prescription opioid-related overdoses for each county [7].

County/Region	Opioid-related deaths 2015
Anne Arundel	87
Baltimore City	365
Baltimore County	196
Montgomery	60
Prince George's	45
North Central Region	**61**
Carroll	36
Howard	25
Northeast Region	**83**
Caroline	2
Cecil	26
Harford	43
Kent	3
Queen Anne's	4
Talbot	5
South Region	**83**
Calvert	21
Charles	16
Dorchester	1
Somerset	4
St. Mary's	11
Wicomico	18
Worcester	12
West Region	**119**
Allegany	19
Frederick	38
Garrett	4
Washington	58

Claims Data

The third dataset is Medicaid claims data. Claims from OTPs were retrieved for FY 2015 for persons receiving either methadone or buprenorphine treatment. This unduplicated numbers of individuals receiving treatment is provided by jurisdiction and region below. It is important to note that the claims only represent persons receiving buprenorphine from an OTP; this is a known under-representation of the population treated with buprenorphine, as many persons receive buprenorphine outside of OTPs.

County/Region	Persons Receiving Methadone Medicaid Claims in FY2015	Persons Receiving Buprenorphine Medicaid Claims in FY2015	Total
Anne Arundel	2,353	21	2,374
Baltimore City	11,604	311	11,915
Baltimore County	4,902	224	5,126
Montgomery	281	2	283
Prince George's	208	3	211
North Central Region	**1,009**	**8**	**1,017**
Carroll	616	-	616
Howard	393	8	401
Northeast Region	**2,770**	**87**	**2,857**
Caroline	43	1	44
Cecil	1,354	14	1,368
Harford	1,185	72	1,257
Kent	60	-	60
Queen Anne's	110	-	110
Talbot	18	-	18
South Region	**726**	**25**	**751**
Calvert	96	1	97
Charles	111	1	112
Dorchester	22	-	22
Somerset	26	-	26
St. Mary's	216	22	238
Wicomico	200	-	200
Worcester	55	1	56
West Region	**2,190**	**437**	**2,627**
Allegany	765	299	1,064
Frederick	432	6	438
Garrett	61	70	131
Washington	932	62	994
Maryland	**26,043**	**1,118**	**27,161**

Estimates of OUD Need based on Combined Datasets

The final step in the methodology is to combine the 3 datasets. Since it is unknown if the same people may have been counted in each dataset, the methodology provides a range of estimates that assumes 100% overlap across datasets (Restrictive Estimate) and no overlap across datasets (Expansive Estimate). The average of these two estimates is then calculated as the Midpoint Estimate.

County/Region	Restrictive Estimate (NSDUH-only)	Expansive Estimate (NSDUH + Overdoses + Medicaid)	Midpoint Estimate of People in need of Treatment for Opioid Disorder*
Anne Arundel	4,376	6,837	5,606
Baltimore City	6,364	18,644	12,504
Baltimore County	7,025	12,347	9,686
Montgomery	7,399	7,742	7,571
Prince George's	7,664	7,920	7,792
North Central Region	**3,390**	**4,468**	**3,929**
Carroll	1,216	1,868	1,542
Howard	2,174	2,600	2,387
Northeast Region	**3,772**	**6,712**	**5,243**
Caroline	247	293	270
Cecil	776	2,170	1,473
Harford	1,920	3,220	2,570
Kent	151	214	183
Queen Anne's	377	491	434
Talbot	301	324	313
South Region	**4,281**	**5,115**	**4,699**
Calvert	710	828	769
Charles	1,169	1,297	1,233
Dorchester	256	279	268
Somerset	153	183	168
St. Mary's	812	1,061	937
Wicomico	764	982	873
Worcester	417	485	451
West Region	**3,927**	**6,673**	**5,301**
Allegany	570	1,653	1,112
Frederick	1,941	2,417	2,179
Garrett	248	383	316
Washington	1,168	2,220	1,694
Maryland	**48,198**	**76,458**	**62,331**

**Regional and Statewide values are derived from adding up individual jurisdiction values, and may be slightly different from the average of the Restrictive and Expansive Estimates due to rounding.*

Maryland OTP Census

In May of 2016, BHA provided a list of current and pending OTPs in Maryland. In June and July of 2016, phone calls were made to each OTP in Maryland (excluding those at correctional facilities and the Veterans Administration) to ask:

- How many patients are you currently treating with methadone?
- How many patients are you currently treating with buprenorphine?
- Given your current resources, facilities, and number of staff, what is the maximum number of patients you estimate you could treat with methadone?
- Given your current resources, facilities, and number of staff, what is the maximum number of patients you estimate you could treat with buprenorphine?

Calls were made to 71 OTPs, and data was obtained from all 71 of them (100% response rate). For a list of the OTPs, please see the Jurisdictional Summaries report.

Current Patient Census

The table below shows the patient census results.

Methadone Patients	Buprenorphine Patients
27,091	1,579

Again, it is important to note that many buprenorphine patients receive treatment outside of OTPs, so the above number is a known under-representation of buprenorphine patients being treated in Maryland.

Caveats: While it is important to note that people regularly enter and leave treatment at OTPs, the above data were collected at a single point in time to generate an overall state-wide estimate. Differences in the total number of treated patients listed in Medicaid claims compared to the phone call census may be attributable to one or more of the following reasons:

- Medicaid claims data does not include people receiving treatment but not receiving Medicaid.
- OTP census data may include non-Maryland residents.
- The data were collected at different times.

Maximum OTP Capacity

During the phone calls to each OTP in Maryland (excluding those at correctional facilities), each facility was asked to estimate their current maximum treatment capacity given their current facilities and staff.

Methadone Capacity	Buprenorphine Capacity	Total Combined Capacity
30,599	7,658	32,422

Caveats: Note that the methadone and buprenorphine numbers do not add up to the "total combined capacity". This is due to the fact that some programs that provide daily dosing of buprenorphine are also limited by the number of counselors available; in these cases, the capacity is "merged" across methadone and buprenorphine. Also note that in coming up with their estimates, all of the OTPs may not have accounted for

the recent change in counselor ratio rules for patients in treatment for 2 years who can take home 2 weeks of medication.

Regarding doctors who provide buprenorphine treatment, there are additional important limitations in trying to estimate their treatment capacity:

- Doctors providing buprenorphine treatment may change their capacity over time, moving from 30 to 100 to 275 patients over time.
- While there are hundreds of DATA-waivered doctors in Maryland who can prescribe buprenorphine [8], and an estimate can be made based on DEA records of the number of people they are legally allowed to treat, it is not certain that all doctors would be willing to treat up to their legal maximum number of patients.
- It is also not certain that all DATA-waivered doctors have remained in the state in which they received their waiver.
- It is likely that some DATA-waivered doctors don't treat at all, but are based in Maryland due to their occupations in government entities located in Maryland (SAMHSA, NIDA, etc.).

In the Summary Maps at the beginning of the report, capacities for jurisdictions are calculated by summing the capacities for all of the OTPs in that jurisdiction.

Future Work

While this report followed the New York City methodology used by the Baltimore Task Force, it is noted that all of the data used in that methodology were not available. Additional datasets that would be helpful include:

- PDMP data: The number of residents of each jurisdiction receiving buprenorphine
- Non-OTP Opioid Abuse/Dependence data: The number of residents in each jurisdiction receiving treatment for opioid abuse or dependence that does not include methadone nor buprenorphine
- Hospital data: The number of residents of each jurisdiction receiving inpatient and emergency room services and having at least one ICD code related to opioid misuse

Based on the methodology, addition of these datasets would likely increase the estimated number of persons needing treatment for opioid abuse or dependence.

References

1. United States Substance Abuse and Mental Health Services Administration. Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. September 10, 2015. http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf
2. United States Substance Abuse and Mental Health Services Administration. Medication-Assisted Treatment For Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol (TIP 43). 2005.
3. Baltimore Mayor's Heroin Treatment & Prevention Task Force Report, July 2015.
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Opioid Treatment Programs in Maryland

Supplemental Information

prepared by

University of Maryland Baltimore
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for the

Maryland Behavioral Health Administration

September 2016

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Introduction

This report provides additional and supplemental information regarding the need for Opioid Treatment Programs (OTPs) and Medication-Assisted Treatment (MAT) in Maryland. This document is meant to be a companion document to the main Opioid Treatment Programs in Maryland Needs Assessment Report, and references data from that report. It is strongly suggested that readers go through the main report before reviewing this report to better understand the data and its limitations.

Medicaid-eligible Population Estimates

While the main report listed treatment need using whole-population estimates, the table below estimates the need for treatment specifically in the Medicaid-eligible population. Medicaid-eligible population values were obtained from the Maryland Department of Health, and are for July of 2016 [1]. As data is only available for those who have applied and been deemed eligible, there is likely some percentage of those eligible for Medicaid who have not applied, and are thus not included in the estimate. As the Medicaid eligibility data was only available by jurisdiction for all age groups combined, the "Medicaid-eligible population, age 15+" was estimated by multiplying the all-ages Medicaid-eligible population for each jurisdiction by 0.5869 (58.69%), which is the percentage of Maryland's Medicaid-eligible population that is age 15 or older [1].

National Survey on Drug Use and Health (NSDUH) data for estimates of drug or alcohol dependence were taken from the Substance Abuse and Mental Health Services Administration (SAMHSA) website [2]. The adjusted NSDUH estimate for dependence on or abuse of just opioids was calculated by multiplying the NSDUH percentages of any substance dependence or abuse by 0.1166 (11.66%), which is the national percentage of people with a heroin or prescription painkiller use disorder out of all people with any kind of substance use disorder [3].

County/Region	Estimated Medicaid-eligible Population, Age 15+	NSDUH Estimate of Substance Dependence / Abuse in the Past Year (2012-2014)	NSDUH Estimate of Dependence / Abuse in the Past Year, adjusted for only Opioids*	Estimated Number of Medicaid-eligible People Age 15+ Dependent on or Abusing Opioids in the Past Year*
Anne Arundel	45,312	8.36%	0.97%	440
Baltimore City	130,243	10.72%	1.25%	1,628
Baltimore County	94,591	8.85%	1.03%	974
Montgomery	89,904	7.51%	0.88%	791
Prince George's	114,238	8.97%	1.05%	1,199
North Central Region	**32,640**	**7.49%**	**0.87%**	**284**
Carroll	11,257	7.49%	0.87%	98
Howard	21,383	7.49%	0.87%	186
Northeast Region	**51,405**	**7.92%**	**0.92%**	**474**
Caroline	5,868	7.92%	0.92%	54
Cecil	13,341	7.92%	0.92%	123
Harford	21,370	7.92%	0.92%	197
Kent	2,431	7.92%	0.92%	22

County/Region	Estimated Medicaid-eligible Population, Age 15+	NSDUH Estimate of Substance Dependence / Abuse in the Past Year (2012-2014)	NSDUH Estimate of Dependence / Abuse in the Past Year, adjusted for only Opioids*	Estimated Number of Medicaid-eligible People Age 15+ Dependent on or Abusing Opioids in the Past Year*
Queen Anne's	4,311	7.92%	0.92%	40
Talbot	4,084	7.92%	0.92%	38
South Region	**67,740**	**7.98%**	**0.93%**	**629**
Calvert	7,141	7.98%	0.93%	66
Charles	15,381	7.98%	0.93%	143
Dorchester	6,229	7.98%	0.93%	58
Somerset	4,232	7.98%	0.93%	39
St. Mary's	11,236	7.98%	0.93%	104
Wicomico	16,828	7.98%	0.93%	157
Worcester	6,693	7.98%	0.93%	62
West Region	**54,852**	**8.44%**	**0.98%**	**537**
Allegany	10,251	8.44%	0.98%	100
Frederick	19,388	8.44%	0.98%	190
Garrett	4,218	8.44%	0.98%	41
Washington	20,995	8.44%	0.98%	206
Maryland	**680,925**	**8.49%**	**0.99%**	**6,956**

**Regional and Statewide values are derived from adding up individual jurisdiction values, and may be slightly different from multiplying the Regional or Statewide population by the NSDUH Dependence / Abuse percentage for opioids due to rounding.*

ZIP Code Estimates

The U.S. Census Bureau provides population demographic data for 467 Maryland ZIP codes (based on 2010-2014 5-year estimates) [4]. Using the same NSDUH data that was used in the Medicaid-eligible Population Estimates, one can estimate the numbers of people in each ZIP code that are in need of treatment for opioid dependence or abuse. City and County names for the ZIP codes were taken from http://www.zipcodestogo.com/Maryland/.

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
20601	Waldorf	Charles	20,757	0.93%	193
20602	Waldorf	Charles	20,571	0.93%	191
20603	Waldorf	Charles	23,863	0.93%	222
20606	Abell	St. Mary's	368	0.93%	3

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
20607	Accokeek	Prince George's	7,774	1.05%	82
20608	Aquasco	Prince George's	657	1.05%	7
20609	Avenue	St Mary's	847	0.93%	8
20611	Bel Alton	Charles	863	0.93%	8
20612	Benedict	Charles	372	0.93%	3
20613	Brandywine	Prince George's	11,727	1.05%	123
20615	Broomes Island	Calvert	355	0.93%	3
20616	Bryans Road	Charles	5,151	0.93%	48
20617	Bryantown	Charles	770	0.93%	7
20618	Bushwood	St. Mary's	744	0.93%	7
20619	California	St. Mary's	8,273	0.93%	77
20620	Callaway	St. Mary's	1,124	0.93%	10
20621	Chaptico	St. Mary's	1,050	0.93%	10
20622	Charlotte Hall	St. Mary's	4,155	0.93%	39
20623	Cheltenham	Prince George's	2,357	1.05%	25
20624	Clements	St. Mary's	1,073	0.93%	10
20625	Cobb Island	Charles	518	0.93%	5
20626	Coltons Point	St. Mary's	227	0.93%	2
20628	Dameron	St. Mary's	103	0.93%	1
20629	Dowell	Calvert	244	0.93%	2
20630	Drayden	St. Mary's	209	0.93%	2
20632	Faulkner	Charles	292	0.93%	3
20634	Great Mills	St. Mary's	5,070	0.93%	47
20636	Hollywood	St. Mary's	8,142	0.93%	76
20637	Hughesville	Charles	4,408	0.93%	41
20639	Huntingtown	Calvert	11,892	0.93%	111
20640	Indian Head	Charles	8,199	0.93%	76
20645	Issue	Charles	869	0.93%	8
20646	La Plata	Charles	15,396	0.93%	143
20650	Leonardtown	St. Mary's	10,629	0.93%	99
20653	Lexington Park	St. Mary's	19,773	0.93%	184
20657	Lusby	Calvert	15,299	0.93%	142
20658	Marbury	Charles	835	0.93%	8
20659	Mechanicsville	St. Mary's	19,016	0.93%	177

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
20660	Morganza	St. Mary's	28	0.93%	0
20662	Nanjemoy	Charles	2,394	0.93%	22
20664	Newburg	Charles	2,323	0.93%	22
20667	Park Hall	St. Mary's	471	0.93%	4
20670	Patuxent River	St. Mary's	975	0.93%	9
20674	Piney Point	St. Mary's	714	0.93%	7
20675	Pomfret	Charles	1,227	0.93%	11
20676	Port Republic	Calvert	3,287	0.93%	31
20677	Port Tobacco	Charles	1,864	0.93%	17
20678	Prince Frederick	Calvert	9,975	0.93%	93
20680	Ridge	St. Mary's	1,201	0.93%	11
20684	Saint Inigoes	St. Mary's	837	0.93%	8
20685	Saint Leonard	Calvert	5,215	0.93%	48
20686	St. Mary's City	St. Mary's	986	0.93%	9
20687	Scotland	St. Mary's	360	0.93%	3
20688	Solomons	Calvert	1,473	0.93%	14
20689	Sunderland	Calvert	1,176	0.93%	11
20690	Tall Timbers	St. Mary's	462	0.93%	4
20692	Valley Lee	St. Mary's	1,410	0.93%	13
20693	Welcome	Charles	1,076	0.93%	10
20695	White Plains	Charles	4,008	0.93%	37
20701	Annapolis Junction	Howard	92	0.87%	1
20705	Beltsville	Prince George's	20,740	1.05%	218
20706	Lanham	Prince George's	30,559	1.05%	321
20707	Laurel	Prince George's	25,743	1.05%	270
20708	Laurel	Prince George's	19,437	1.05%	204
20710	Bladensburg	Prince George's	7,456	1.05%	78
20711	Lothian	Anne Arundel	5,368	0.97%	52
20712	Mount Rainier	Prince George's	7,155	1.05%	75
20714	North Beach	Calvert	3,632	0.93%	34
20715	Bowie	Prince George's	21,901	1.05%	230

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
20716	Bowie	Prince George's	16,862	1.05%	177
20720	Bowie	Prince George's	17,832	1.05%	187
20721	Bowie	Prince George's	22,500	1.05%	236
20722	Brentwood	Prince George's	4,701	1.05%	49
20723	Laurel	Howard	24,001	0.87%	209
20724	Laurel	Anne Arundel	13,583	0.97%	132
20732	Chesapeake Beach	Calvert	7,909	0.93%	74
20733	Churchton	Anne Arundel	2,236	0.97%	22
20735	Clinton	Prince George's	31,201	1.05%	328
20736	Owings	Calvert	7,680	0.93%	71
20737	Riverdale	Prince George's	15,809	1.05%	166
20740	College Park	Prince George's	25,709	1.05%	270
20742	College Park	Prince George's	8,565	1.05%	90
20743	Capitol Heights	Prince George's	31,263	1.05%	328
20744	Fort Washington	Prince George's	43,741	1.05%	459
20745	Oxon Hill	Prince George's	24,450	1.05%	257
20746	Suitland	Prince George's	22,321	1.05%	234
20747	District Heights	Prince George's	30,266	1.05%	318
20748	Temple Hills	Prince George's	31,745	1.05%	333
20751	Deale	Anne Arundel	1,940	0.97%	19
20754	Dunkirk	Calvert	5,406	0.93%	50
20755	Fort George G Meade	Anne Arundel	6,297	0.97%	61
20758	Friendship	Anne Arundel	471	0.97%	5
20759	Fulton	Howard	2,604	0.87%	23

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
20762	Andrews Air Force Base	Prince George's	2,027	1.05%	21
20763	Savage	Howard	1,962	0.87%	17
20764	Shady Side	Anne Arundel	3,618	0.97%	35
20765	Galesville	Anne Arundel	565	0.97%	5
20769	Glenn Dale	Prince George's	5,441	1.05%	57
20770	Greenbelt	Prince George's	20,578	1.05%	216
20772	Upper Marlboro	Prince George's	36,009	1.05%	378
20774	Upper Marlboro	Prince George's	36,141	1.05%	379
20776	Harwood	Anne Arundel	2,678	0.97%	26
20777	Highland	Howard	2,700	0.87%	23
20778	West River	Anne Arundel	1,733	0.97%	17
20779	Tracys Landing	Anne Arundel	1,101	0.97%	11
20781	Hyattsville	Prince George's	9,248	1.05%	97
20782	Hyattsville	Prince George's	27,119	1.05%	285
20783	Hyattsville	Prince George's	39,156	1.05%	411
20784	Hyattsville	Prince George's	22,596	1.05%	237
20785	Hyattsville	Prince George's	28,146	1.05%	296
20794	Jessup	Howard	12,317	0.87%	107
20812	Glen Echo	Montgomery	194	0.88%	2
20814	Bethesda	Montgomery	23,790	0.88%	209
20815	Chevy Chase	Montgomery	25,007	0.88%	220
20816	Bethesda	Montgomery	12,957	0.88%	114
20817	Bethesda	Montgomery	28,532	0.88%	251
20818	Cabin John	Montgomery	1,562	0.88%	14
20832	Olney	Montgomery	20,955	0.88%	184
20833	Brookeville	Montgomery	6,407	0.88%	56
20837	Poolesville	Montgomery	4,706	0.88%	41
20838	Barnesville	Montgomery	152	0.88%	1
20839	Beallsville	Montgomery	111	0.88%	1

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
20841	Boyds	Montgomery	7,878	0.88%	69
20842	Dickerson	Montgomery	1,593	0.88%	14
20850	Rockville	Montgomery	38,163	0.88%	336
20851	Rockville	Montgomery	11,783	0.88%	104
20852	Rockville	Montgomery	37,505	0.88%	330
20853	Rockville	Montgomery	24,630	0.88%	217
20854	Potomac	Montgomery	40,597	0.88%	357
20855	Derwood	Montgomery	11,739	0.88%	103
20860	Sandy Spring	Montgomery	2,014	0.88%	18
20861	Ashton	Montgomery	1,697	0.88%	15
20862	Brinklow	Montgomery	140	0.88%	1
20866	Burtonsville	Montgomery	10,294	0.88%	91
20868	Spencerville	Montgomery	923	0.88%	8
20871	Clarksburg	Montgomery	10,992	0.88%	97
20872	Damascus	Montgomery	10,484	0.88%	92
20874	Germantown	Montgomery	44,934	0.88%	395
20876	Germantown	Montgomery	20,409	0.88%	180
20877	Gaithersburg	Montgomery	28,532	0.88%	251
20878	Gaithersburg	Montgomery	49,998	0.88%	440
20879	Gaithersburg	Montgomery	20,115	0.88%	177
20880	Washington Grove	Montgomery	457	0.88%	4
20882	Gaithersburg	Montgomery	11,762	0.88%	104
20886	Montgomery Village	Montgomery	27,126	0.88%	239
20895	Kensington	Montgomery	15,061	0.88%	133
20896	Garrett Park	Montgomery	763	0.88%	7
20897	Suburb Maryland Fac	Montgomery	131	0.88%	1
20901	Silver Spring	Montgomery	28,683	0.88%	252
20902	Silver Spring	Montgomery	40,274	0.88%	354
20903	Silver Spring	Montgomery	19,600	0.88%	172
20904	Silver Spring	Montgomery	45,624	0.88%	401
20905	Silver Spring	Montgomery	14,812	0.88%	130
20906	Silver Spring	Montgomery	56,911	0.88%	501
20910	Silver Spring	Montgomery	34,093	0.88%	300
20912	Takoma Park	Montgomery	20,244	0.88%	178
21001	Aberdeen	Harford	18,180	0.92%	167

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21005	Aberdeen Proving Ground	Harford	1,758	0.92%	16
21009	Abingdon	Harford	23,285	0.92%	214
21010	Gunpowder	Harford	59	0.92%	1
21012	Arnold	Anne Arundel	16,847	0.97%	163
21013	Baldwin	Baltimore	4,317	1.03%	44
21014	Bel Air	Harford	28,173	0.92%	259
21015	Bel Air	Harford	22,639	0.92%	208
21017	Belcamp	Harford	5,826	0.92%	54
21028	Churchville	Harford	3,014	0.92%	28
21029	Clarksville	Howard	9,975	0.87%	87
21030	Cockeysville	Baltimore	20,940	1.03%	216
21031	Hunt Valley	Baltimore	25	1.03%	0
21032	Crownsville	Anne Arundel	7,232	0.97%	70
21034	Darlington	Harford	2,959	0.92%	27
21035	Davidsonville	Anne Arundel	6,399	0.97%	62
21036	Dayton	Howard	2,042	0.87%	18
21037	Edgewater	Anne Arundel	16,851	0.97%	163
21040	Edgewood	Harford	19,246	0.92%	177
21042	Ellicott City	Howard	32,103	0.87%	279
21043	Ellicott City	Howard	34,142	0.87%	297
21044	Columbia	Howard	34,617	0.87%	301
21045	Columbia	Howard	31,746	0.87%	276
21046	Columbia	Howard	12,821	0.87%	112
21047	Fallston	Harford	9,679	0.92%	89
21048	Finksburg	Carroll	8,685	0.87%	76
21050	Forest Hill	Harford	15,288	0.92%	141
21051	Fork	Baltimore	210	1.03%	2
21052	Fort Howard	Baltimore	221	1.03%	2
21053	Freeland	Baltimore	2,812	1.03%	29
21054	Gambrills	Anne Arundel	8,054	0.97%	78
21056	Gibson Island	Anne Arundel	249	0.97%	2
21057	Glen Arm	Baltimore	3,560	1.03%	37
21060	Glen Burnie	Anne Arundel	25,819	0.97%	250
21061	Glen Burnie	Anne Arundel	45,063	0.97%	437
21071	Glyndon	Baltimore	395	1.03%	4
21074	Hampstead	Carroll	11,769	0.87%	102
21075	Elkridge	Howard	22,061	0.87%	192

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21076	Hanover	Anne Arundel	11,516	0.97%	112
21077	Harmans	Anne Arundel	166	0.97%	2
21078	Havre De Grace	Harford	15,482	0.92%	142
21082	Hydes	Baltimore	291	1.03%	3
21084	Jarrettsville	Harford	6,298	0.92%	58
21085	Joppa	Harford	13,298	0.92%	122
21087	Kingsville	Baltimore	4,785	1.03%	49
21090	Linthicum Heights	Anne Arundel	8,340	0.97%	81
21093	Lutherville Timonium	Baltimore	31,515	1.03%	325
21102	Manchester	Carroll	8,942	0.87%	78
21104	Marriottsville	Carroll	3,921	0.87%	34
21105	Maryland Line	Baltimore	16	1.03%	0
21108	Millersville	Anne Arundel	14,215	0.97%	138
21111	Monkton	Baltimore	3,547	1.03%	37
21113	Odenton	Anne Arundel	25,475	0.97%	247
21114	Crofton	Anne Arundel	20,220	0.97%	196
21117	Owings Mills	Baltimore	45,833	1.03%	472
21120	Parkton	Baltimore	5,781	1.03%	60
21122	Pasadena	Anne Arundel	49,379	0.97%	479
21128	Perry Hall	Baltimore	11,605	1.03%	120
21130	Perryman	Harford	273	0.92%	3
21131	Phoenix	Baltimore	5,604	1.03%	58
21132	Pylesville	Harford	2,064	0.92%	19
21133	Randallstown	Baltimore	24,941	1.03%	257
21136	Reisterstown	Baltimore	27,312	1.03%	281
21140	Riva	Anne Arundel	2,804	0.97%	27
21144	Severn	Anne Arundel	25,211	0.97%	245
21146	Severna Park	Anne Arundel	21,481	0.97%	208
21152	Sparks Glencoe	Baltimore	4,797	1.03%	49
21153	Stevenson	Baltimore	252	1.03%	3
21154	Street	Harford	5,690	0.92%	52
21155	Upperco	Baltimore	2,226	1.03%	23
21156	Upper Falls	Baltimore	313	1.03%	3
21157	Westminster	Carroll	30,825	0.87%	268
21158	Westminster	Carroll	16,171	0.87%	141

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21160	Whiteford	Harford	1,994	0.92%	18
21161	White Hall	Harford	4,738	0.92%	44
21162	White Marsh	Baltimore	3,126	1.03%	32
21163	Woodstock	Howard	5,925	0.87%	52
21201	Baltimore	Baltimore City	14,472	1.25%	181
21202	Baltimore	Baltimore City	19,555	1.25%	244
21204	Towson	Baltimore	17,918	1.03%	185
21205	Baltimore	Baltimore City	12,298	1.25%	154
21206	Baltimore	Baltimore City	40,386	1.25%	505
21207	Gwynn Oak	Baltimore	39,942	1.03%	411
21208	Pikesville	Baltimore	28,450	1.03%	293
21209	Baltimore	Baltimore City	21,801	1.25%	273
21210	Baltimore	Baltimore City	13,118	1.25%	164
21211	Baltimore	Baltimore City	15,167	1.25%	190
21212	Baltimore	Baltimore City	25,806	1.25%	323
21213	Baltimore	Baltimore City	23,818	1.25%	298
21214	Baltimore	Baltimore City	17,070	1.25%	213
21215	Baltimore	Baltimore City	51,202	1.25%	640
21216	Baltimore	Baltimore City	21,606	1.25%	270
21217	Baltimore	Baltimore City	31,801	1.25%	398
21218	Baltimore	Baltimore City	42,511	1.25%	531
21219	Sparrows Point	Baltimore	7,668	1.03%	79
21220	Middle River	Baltimore	32,642	1.03%	336
21221	Essex	Baltimore	32,793	1.03%	338
21222	Dundalk	Baltimore	45,080	1.03%	464
21223	Baltimore	Baltimore City	19,157	1.25%	239
21224	Baltimore	Baltimore City	41,006	1.25%	513
21225	Brooklyn	Baltimore City	25,348	1.25%	317
21226	Curtis Bay	Anne Arundel	5,646	0.97%	55
21227	Halethorpe	Baltimore	27,598	1.03%	284
21228	Catonsville	Baltimore	41,058	1.03%	423
21229	Baltimore	Baltimore City	37,055	1.25%	463
21230	Baltimore	Baltimore City	29,068	1.25%	363
21231	Baltimore	Baltimore City	14,816	1.25%	185
21234	Parkville	Baltimore	56,770	1.03%	585
21236	Nottingham	Baltimore	30,940	1.03%	319
21237	Rosedale	Baltimore	25,154	1.03%	259
21239	Baltimore	Baltimore City	26,233	1.25%	328

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21244	Windsor Mill	Baltimore	28,770	1.03%	296
21250	Baltimore	Baltimore	3,029	1.03%	31
21251	Baltimore	Baltimore City	820	1.25%	10
21252	Baltimore	Baltimore	2,683	1.03%	28
21286	Towson	Baltimore	17,324	1.03%	178
21401	Annapolis	Anne Arundel	31,822	0.97%	309
21402	Annapolis	Anne Arundel	5,613	0.97%	54
21403	Annapolis	Anne Arundel	25,124	0.97%	244
21404	Annapolis	Anne Arundel	444	0.97%	4
21409	Annapolis	Anne Arundel	16,243	0.97%	158
21502	Cumberland	Allegany	37,014	0.98%	363
21520	Accident	Garrett	1,698	0.98%	17
21521	Barton	Allegany	1,084	0.98%	11
21522	Bittinger	Garrett	131	0.98%	1
21523	Bloomington	Garrett	229	0.98%	2
21524	Corriganville	Allegany	421	0.98%	4
21529	Ellerslie	Allegany	493	0.98%	5
21530	Flintstone	Allegany	1,552	0.98%	15
21531	Friendsville	Garrett	1,981	0.98%	19
21532	Frostburg	Allegany	13,653	0.98%	134
21536	Grantsville	Garrett	3,483	0.98%	34
21538	Kitzmiller	Garrett	485	0.98%	5
21539	Lonaconing	Allegany	2,277	0.98%	22
21540	Luke	Allegany	79	0.98%	1
21541	Mc Henry	Garrett	972	0.98%	10
21542	Midland	Allegany	566	0.98%	6
21543	Midlothian	Allegany	76	0.98%	1
21545	Mount Savage	Allegany	1,721	0.98%	17
21550	Oakland	Garrett	11,986	0.98%	117
21555	Oldtown	Allegany	1,535	0.98%	15
21557	Rawlings	Allegany	1,691	0.98%	17
21561	Swanton	Garrett	2,166	0.98%	21
21562	Westernport	Allegany	2,403	0.98%	24
21601	Easton	Talbot	20,012	0.92%	184
21607	Barclay	Queen Anne's	515	0.92%	5
21610	Betterton	Kent	313	0.92%	3
21612	Bozman	Talbot	318	0.92%	3
21613	Cambridge	Dorchester	14,119	0.93%	131
21617	Centreville	Queen Anne's	8,072	0.92%	74

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21619	Chester	Queen Anne's	4,990	0.92%	46
21620	Chestertown	Kent	10,917	0.92%	100
21622	Church Creek	Dorchester	652	0.93%	6
21623	Church Hill	Queen Anne's	1,783	0.92%	16
21624	Claiborne	Talbot	109	0.92%	1
21625	Cordova	Talbot	2,170	0.92%	20
21626	Crapo	Dorchester	122	0.93%	1
21627	Crocheron	Dorchester	74	0.93%	1
21628	Crumpton	Queen Anne's	493	0.92%	5
21629	Denton	Caroline	7,681	0.92%	71
21631	East New Market	Dorchester	2,242	0.93%	21
21632	Federalsburg	Caroline	4,624	0.92%	43
21634	Fishing Creek	Dorchester	342	0.93%	3
21635	Galena	Kent	1,832	0.92%	17
21636	Goldsboro	Caroline	953	0.92%	9
21638	Grasonville	Queen Anne's	4,106	0.92%	38
21639	Greensboro	Caroline	3,504	0.92%	32
21640	Henderson	Caroline	1,136	0.92%	10
21641	Hillsboro	Caroline	47	0.92%	0
21643	Hurlock	Dorchester	4,133	0.93%	38
21644	Ingleside	Queen Anne's	67	0.92%	1
21645	Kennedyville	Kent	862	0.92%	8
21647	McDaniel	Talbot	185	0.92%	2
21648	Madison	Dorchester	298	0.93%	3
21649	Marydel	Caroline	1,522	0.92%	14
21650	Massey	Kent	88	0.92%	1
21651	Millington	Kent	2,657	0.92%	24
21652	Neavitt	Talbot	169	0.92%	2
21653	Newcomb	Talbot	69	0.92%	1
21654	Oxford	Talbot	851	0.92%	8
21655	Preston	Caroline	4,144	0.92%	38
21657	Queen Anne	Queen Anne's	759	0.92%	7
21658	Queenstown	Queen Anne's	3,113	0.92%	29
21659	Rhodesdale	Dorchester	1,276	0.93%	12
21660	Ridgely	Caroline	3,346	0.92%	31
21661	Rock Hall	Kent	2,331	0.92%	21
21662	Royal Oak	Talbot	690	0.92%	6
21663	Saint Michaels	Talbot	2,738	0.92%	25

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21664	Secretary	Dorchester	632	0.93%	6
21665	Sherwood	Talbot	273	0.92%	3
21666	Stevensville	Queen Anne's	9,755	0.92%	90
21667	Still Pond	Kent	217	0.92%	2
21668	Sudlersville	Queen Anne's	1,535	0.92%	14
21669	Taylors Island	Dorchester	147	0.93%	1
21671	Tilghman	Talbot	820	0.92%	8
21672	Toddville	Dorchester	164	0.93%	2
21673	Trappe	Talbot	2,765	0.92%	25
21675	Wingate	Dorchester	72	0.93%	1
21676	Wittman	Talbot	391	0.92%	4
21677	Woolford	Dorchester	554	0.93%	5
21678	Worton	Kent	2,003	0.92%	18
21679	Wye Mills	Talbot	371	0.92%	3
21701	Frederick	Frederick	30,101	0.98%	295
21702	Frederick	Frederick	30,180	0.98%	296
21703	Frederick	Frederick	25,394	0.98%	249
21704	Frederick	Frederick	10,982	0.98%	108
21705	Frederick	Frederick	4	0.98%	0
21710	Adamstown	Frederick	3,966	0.98%	39
21711	Big Pool	Washington	734	0.98%	7
21713	Boonsboro	Washington	7,707	0.98%	76
21714	Braddock Heights	Frederick	47	0.98%	0
21716	Brunswick	Frederick	3,979	0.98%	39
21717	Buckeystown	Frederick	34	0.98%	0
21718	Burkittsville	Frederick	133	0.98%	1
21719	Cascade	Washington	1,080	0.98%	11
21722	Clear Spring	Washington	4,706	0.98%	46
21723	Cooksville	Howard	545	0.87%	5
21727	Emmitsburg	Frederick	5,524	0.98%	54
21733	Fairplay	Washington	715	0.98%	7
21734	Funkstown	Washington	691	0.98%	7
21737	Glenelg	Howard	1,271	0.87%	11
21738	Glenwood	Howard	2,836	0.87%	25
21740	Hagerstown	Washington	49,698	0.98%	487
21742	Hagerstown	Washington	26,234	0.98%	257
21746	Hagerstown	Washington	3,077	0.98%	30
21750	Hancock	Washington	3,190	0.98%	31

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21754	Ijamsville	Frederick	5,078	0.98%	50
21755	Jefferson	Frederick	5,001	0.98%	49
21756	Keedysville	Washington	2,920	0.98%	29
21757	Keymar	Carroll	2,585	0.87%	22
21758	Knoxville	Frederick	3,798	0.98%	37
21762	Libertytown	Frederick	165	0.98%	2
21766	Little Orleans	Allegany	453	0.98%	4
21767	Maugansville	Washington	805	0.98%	8
21769	Middletown	Frederick	9,243	0.98%	91
21770	Monrovia	Frederick	4,475	0.98%	44
21771	Mount Airy	Frederick	23,883	0.98%	234
21773	Myersville	Frederick	4,424	0.98%	43
21774	New Market	Frederick	9,281	0.98%	91
21776	New Windsor	Carroll	4,406	0.87%	38
21777	Point Of Rocks	Frederick	1,328	0.98%	13
21778	Rocky Ridge	Frederick	963	0.98%	9
21779	Rohrersville	Washington	746	0.98%	7
21780	Sabillasville	Frederick	1,370	0.98%	13
21781	Saint James	Washington	93	0.98%	1
21782	Sharpsburg	Washington	3,651	0.98%	36
21783	Smithsburg	Washington	7,089	0.98%	69
21784	Sykesville	Carroll	32,114	0.87%	279
21787	Taneytown	Carroll	9,156	0.87%	80
21788	Thurmont	Frederick	9,659	0.98%	95
21790	Tuscarora	Frederick	45	0.98%	0
21791	Union Bridge	Carroll	4,469	0.87%	39
21793	Walkersville	Frederick	8,008	0.98%	78
21794	West Friendship	Howard	2,060	0.87%	18
21795	Williamsport	Washington	7,684	0.98%	75
21797	Woodbine	Howard	6,773	0.87%	59
21798	Woodsboro	Frederick	2,168	0.98%	21
21801	Salisbury	Wicomico	25,338	0.93%	236
21802	Salisbury	Wicomico	66	0.93%	1
21803	Salisbury	Wicomico	30,998	0.93%	288
21804	Salisbury	Wicomico	270	0.93%	3
21811	Berlin	Worcester	18,244	0.93%	170
21813	Bishopville	Worcester	2,149	0.93%	20
21814	Bivalve	Wicomico	460	0.93%	4

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21817	Crisfield	Somerset	3,807	0.93%	35
21821	Deal Island	Somerset	805	0.93%	7
21822	Eden	Worcester	1,825	0.93%	17
21824	Ewell	Somerset	108	0.93%	1
21826	Fruitland	Wicomico	4,184	0.93%	39
21829	Girdletree	Worcester	586	0.93%	5
21830	Hebron	Wicomico	2,932	0.93%	27
21835	Linkwood	Dorchester	711	0.93%	7
21837	Mardela Springs	Wicomico	2,364	0.93%	22
21838	Marion Station	Somerset	1,433	0.93%	13
21840	Nanticoke	Wicomico	499	0.93%	5
21841	Newark	Worcester	936	0.93%	9
21842	Ocean City	Worcester	10,074	0.93%	94
21849	Parsonsburg	Wicomico	2,913	0.93%	27
21850	Pittsville	Wicomico	2,102	0.93%	20
21851	Pocomoke City	Worcester	6,011	0.93%	56
21853	Princess Anne	Somerset	9,307	0.93%	87
21856	Quantico	Wicomico	735	0.93%	7
21861	Sharptown	Wicomico	784	0.93%	7
21862	Showell	Worcester	488	0.93%	5
21863	Snow Hill	Worcester	4,358	0.93%	41
21864	Stockton	Worcester	632	0.93%	6
21865	Tyaskin	Wicomico	388	0.93%	4
21866	Tylerton	Somerset	44	0.93%	0
21867	Upper Fairmount	Somerset	32	0.93%	0
21869	Vienna	Dorchester	702	0.93%	7
21871	Westover	Somerset	2,942	0.93%	27
21872	Whaleyville	Worcester	583	0.93%	5
21874	Willards	Wicomico	2,119	0.93%	20
21875	Delmar	Wicomico	5,245	0.93%	49
21890	Westover	Somerset	2,692	0.93%	25
21901	North East	Cecil	14,511	0.92%	134
21902	Perry Point	Cecil	214	0.92%	2
21903	Perryville	Cecil	5,006	0.92%	46
21904	Port Deposit	Cecil	6,236	0.92%	57
21911	Rising Sun	Cecil	8,569	0.92%	79

Zip Code Tabulation Area	City	County	Estimated Population Age 15+	NSDUH Dependence / Abuse in the Past Year, adjusted for only Opioids	Estimated Number of People in Need of Opioid Treatment in the Past Year, age 15+
21912	Warwick	Cecil	890	0.92%	8
21913	Cecilton	Cecil	529	0.92%	5
21914	Charlestown	Cecil	419	0.92%	4
21915	Chesapeake City	Cecil	2,336	0.92%	21
21916	Childs	Cecil	36	0.92%	0
21917	Colora	Cecil	2,430	0.92%	22
21918	Conowingo	Cecil	3,430	0.92%	32
21919	Earleville	Cecil	2,922	0.92%	27
21920	Elk Mills	Cecil	212	0.92%	2
21921	Elkton	Cecil	33,768	0.92%	311
21930	Georgetown	Cecil	127	0.92%	1

It is important to note that the above are rough estimates, as they are applying NSDUH data for a jurisdiction or region of Maryland to a smaller area, and it is unlikely that all ZIP codes have exactly the same opioid abuse or dependence rate as the jurisdiction or region to which they belong. Therefore, the above table should only be used as a guide in OTP capacity planning.

ZIP code level data was selected for this report for a few reasons. First, ZIP codes are familiar to the expected audience of the report, and therefore expected to be more easily understood. Second, applying regional NSDUH data to yet smaller areas, such as some census tracts, make it even less likely that the jurisdiction or regional NSDUH rates are the same as the rates for the census tracts. Third, with over 1,400 census tracts in Maryland, it was deemed a better use of time, resources, and space to present data on the 467 ZIP codes.

However, because zip codes can be linked to census tracts, jurisdictions can use the NSDUH values adjusted for opioids for each ZIP code above and apply them to each census tract that is associated with the ZIP code to estimate need at the census tract level.

Information regarding what census tracts are associated with which ZIP code is available at:

- https://www.census.gov/geo/maps-data/data/zcta_rel_download.html

Population data for census tracts, broken down by age and sex, is available at:

- http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

References

1. Maryland Department of Health and Mental Hygiene. Maryland Medical eHealth Statistics. http://www.md-medicaid.org/eligibility/index.cfm.
2. United States Substance Abuse and Mental Health Administration, National Survey on Drug Use and Health, 2012-2014. http://www.samhsa.gov/data/population-data-nsduh/reports?tab=34.
3. United States Substance Abuse and Mental Health Services Administration. Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. September 10, 2015. http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf
4. United States Census Bureau, http://factfinder.census.gov/faces/nav/jsf/pages/download_center.xhtml.

Opioid Treatment Programs in Maryland

Needs Assessment Report

Jurisdiction Summaries

prepared by
University of Maryland Baltimore
Systems Evaluation Center

for the
Maryland Behavioral Health Administration

September 2016

Table of Contents

Introduction

This report provides additional and supplemental information regarding the need for Opioid Treatment Programs (OTPs) and Medication-Assisted Treatment (MAT) in Maryland. This document is meant to be a companion document to the main Opioid Treatment Programs in Maryland Needs Assessment Report, and references data from that report. It is strongly suggested that readers go through the main report before reviewing this report to better understand the data and its limitations.

Data Sources and Descriptions

Estimated Total Population, Age 12+ is taken from American Community Survey data obtained from the Maryland Department of Planning.

Estimated Need is the Midpoint Estimate from the main OTPs in Maryland Needs Assessment report, based on NSDUH data, overdose deaths, and claims data. It is important to note that some jurisdictions had significant variation between Restrictive and Expansive Estimates, which means that choosing to use one of those estimates can significantly increase or decrease the estimated need in a jurisdiction.

Estimated OTP Capacity is based on a phone survey of OTPs in Maryland, and summing the estimated capacities of each OTP in a given jurisdiction for both methadone and buprenorphine patients. This total capacity is not above and beyond the current censuses; it is the overall capacity of the OTPs at the time of the call.

Estimated Difference between Need and Capacity is the Estimated Need minus the OTP capacity. Note that this estimated difference does not account for the fact that some of those people may be receiving treatment outside of an OTP. It is again important to note that some jurisdictions had significant variation between Restrictive and Expansive Estimates, which means that choosing to use one of those estimates can significantly increase or decrease the difference between estimated need and capacity in a jurisdiction.

Estimated Additional Potential Buprenorphine Capacity is based on the article "Not Enough Doctors Are Treating Heroin Addiction With A Life-Saving Drug" by Shane Shifflett, Hilary Fung, Nicky Forster and Jason Cherkis, December 30, 2015, in the Huffington Post (http://projects.huffingtonpost.com/projects/dying-to-be-free-heroin-treatment/opioid-abuse-outpace-treatment-capacity). Their methodology (personal communication) used data from the US Drug Enforcement Agency's database of DATA-waivered doctors. Important limitations in trying to estimate their treatment capacity include:

- When OTPs utilize DATA-waivered doctors in their programs, capacity of the programs will overlap with the capacity of the doctors.
- Doctors providing buprenorphine treatment may change their capacity over time, moving from 30 to 100 to 275 patients over time.
- While there are hundreds of DATA-waivered doctors in Maryland who can prescribe buprenorphine, and an estimate can be made based on DEA records of the number of people they are legally allowed to treat, it is not certain that all doctors would be willing to treat up the legal maximum number of patients.
- It is also not certain that all DATA-waivered doctors have remained in the state in which they received their waiver.

- It is likely that some DATA-waivered doctors don't treat at all, but are based in Maryland due to their occupations in government entities located in Maryland (SAMHSA, NIDA, etc.).

OTP locations are based on addresses provided by BHA in May of 2016. The OTPs included are:

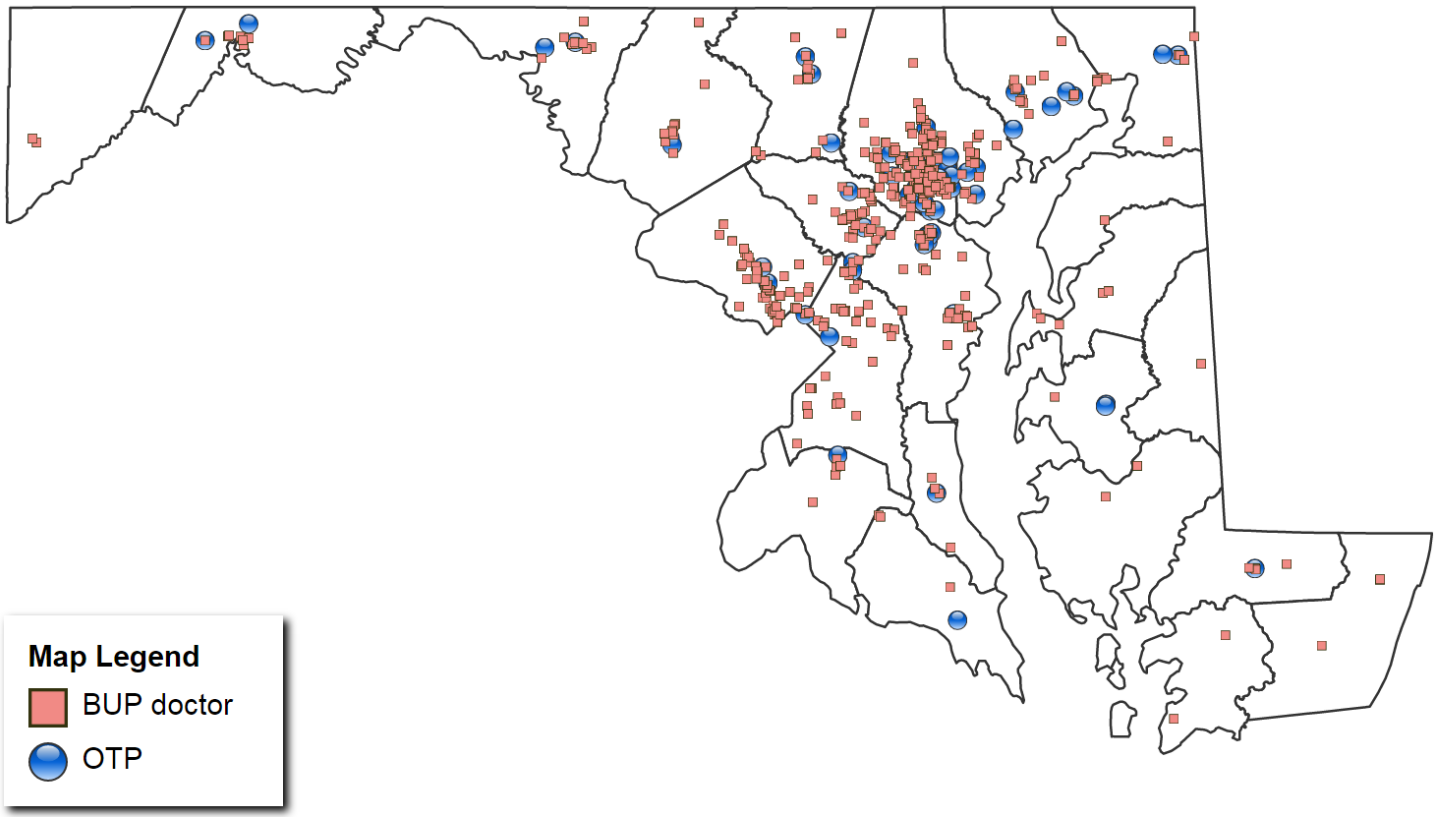
1. A Helping Hand Health Services
2. Allcare Treatment Services
3. Another Way, Inc.
4. ARS of Aberdeen LLC
5. ATS at Bayview - MFL Building
6. ATS at Bayview - BBRC Building
7. ATS of Cecil County, Inc. (Elkton)
8. B.N.J. Health Services (Baltimore)
9. B.N.J. Health Services (Glen Burnie)
10. Bayside Recovery, LLC
11. BD Health Services, Inc.
12. Belair Health Solutions, Inc.
13. BH Health Services, Inc.
14. Bon Secours' ADAPT Cares
15. Bon Secours New Hope Treatment Center
16. Bon Secours Next Passage
17. BPH, Inc. t/a Starting Point
18. By Grace Counseling Services
19. Center for Addiction Medicine
20. Chesapeake Treatment Services
21. Concerted Care Group, LLC
22. Cumberland Treatment Center
23. Department of Health Adult Addictions Clinic (Anne Arundel)
24. E.J.A.L. Health Services, Inc.
25. Eastern Avenue Health Solutions, Inc.
26. Easton Treatment Solutions, LLC
27. Father Martin's Ashley Outpatient
28. Frederick County Health Department
29. Genesis Treatment Services
30. Glenwood Life Counseling Center, Inc.
31. Hampden Health Solutions at the Rail, Inc.
32. Institutes for Behavioral Resources, Inc., REACH Health Services
33. J.A.E.L. Health Services, Inc.
34. Johns Hopkins Broadway Center for Addiction
35. Joppa Health Services, Inc.
36. Man Alive, Inc.
37. Medication Assisted Treatment Program (Montgomery County)
38. Medmark Treatment Centers Awakenings
39. Medmark Treatment Centers Baltimore Downtown 101
40. Medmark Treatment Centers Baltimore Downtown 201
41. Medmark Treatment Centers Belcamp
42. MedMark Treatment Centers Cherry Hill

43. Medmark Treatment Centers Daybreak
44. MedMark Treatment Centers Essex
45. Medmark Treatment Centers Timonium
46. Metro Treatment of Maryland, LP
47. Metwork Health Services, Inc.
48. Montgomery Recovery Services, Inc.
49. New Horizons Health Services, Inc.
50. New Journey, Incorporated
51. Northern Parkway Treatment Services, Inc.
52. Open ARMMS, Inc.
53. Outlook Recovery, LLC
54. Phoenix Health Center, LLC
55. Pikesville Health Services
56. Pine Heights Treatment Center
57. Prince George's County Health Department
58. Reflective Treatment Center
59. Riverside Treatment Services
60. Secondd Chancee, Inc. (BNJ)
61. Serenity Health (Aberdeen)
62. Serenity Health (Elkton)
63. Sinai Hospital Addictions Recovery Program
64. Smith-Berch, Inc.
65. SRR Treatment Solutions (Silverman)
66. Turning Point Substance Abuse Clinic
67. University of Maryland Methadone Treatment Program
68. We Care Arundel Health Services, Inc.
69. We Care Health Services, Inc.
70. Western Maryland Recovery Services
71. Wicomico County Health Department Methadone Program - PRMC

Buprenorphine doctor locations were obtained from the SAMHSA Treatment Locator (https://findtreatment.samhsa.gov/locator?sAddr=&submit=Go), accessed August 2, 2016.

Statewide

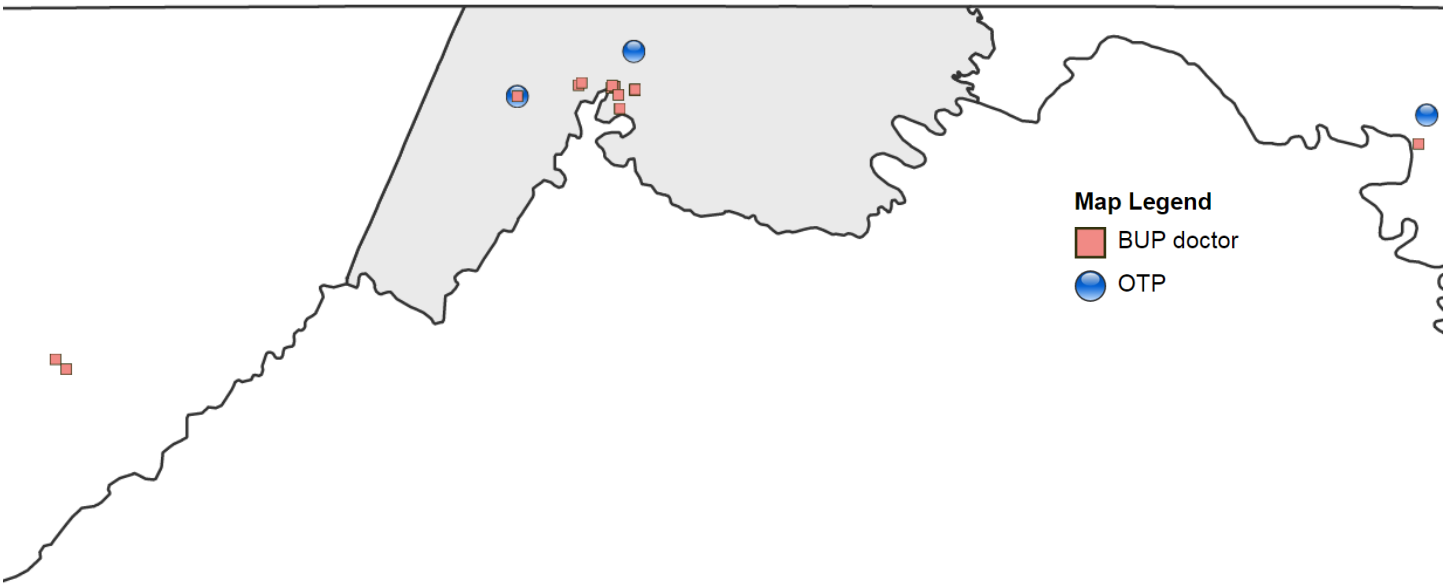
Estimated Total Population, Age 12+: 4,873,485
Estimated Need: 62,331
Estimated OTP Capacity (methadone & buprenorphine): 32,422
Estimated Difference between Need and Capacity: 29,909 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 51,120

Allegany

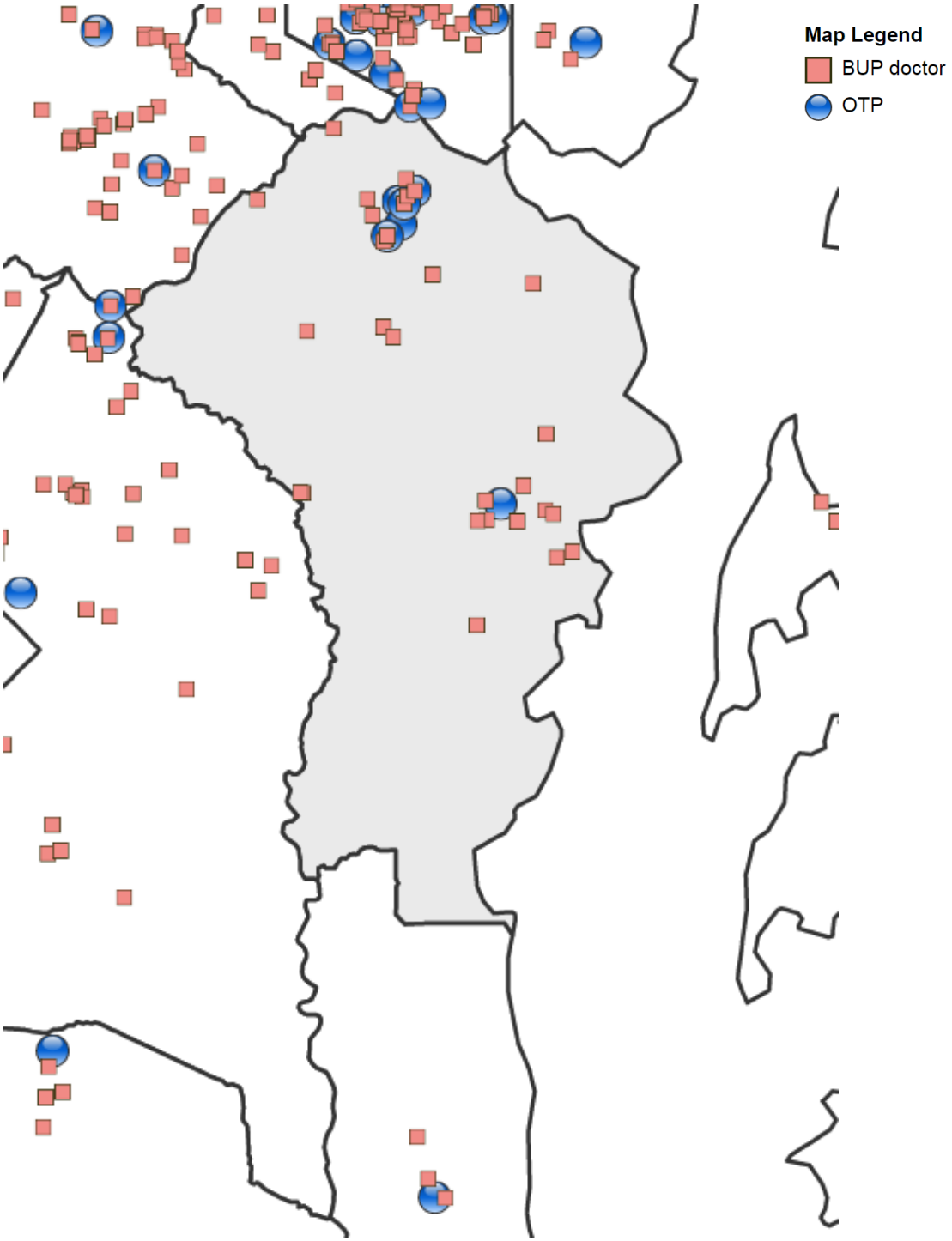
Estimated Total Population, Age 12+: 58,212
Estimated Need: 1,112
Estimated OTP Capacity (methadone & buprenorphine): 1,041
Estimated Difference between Need and Capacity: 71 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 780

Anne Arundel

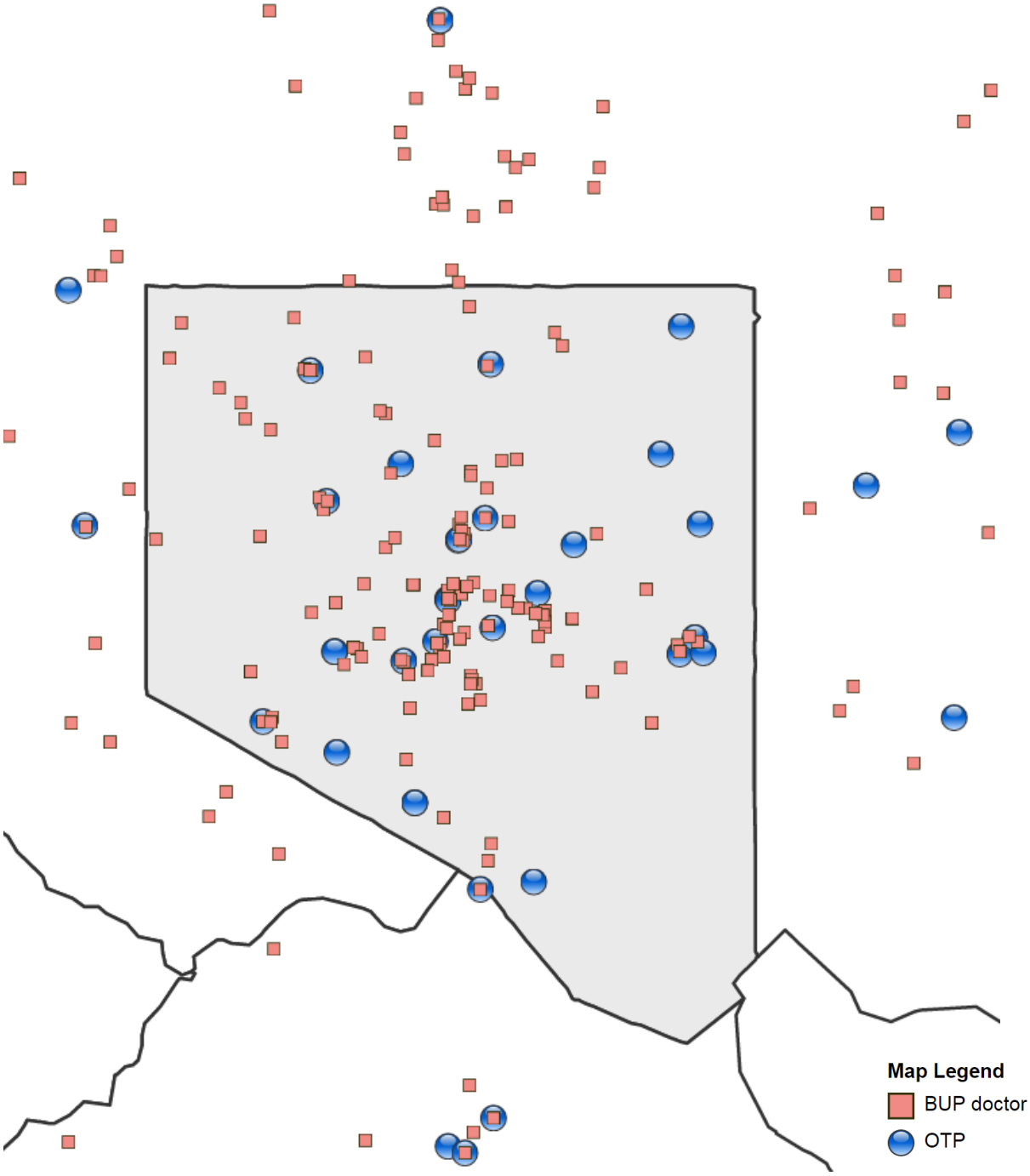
Estimated Total Population, Age 12+: 451,092
Estimated Need: 5,606
Estimated OTP Capacity (methadone & buprenorphine): 3,125
Estimated Difference between Need and Capacity: 2,481 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 3,380

Baltimore City

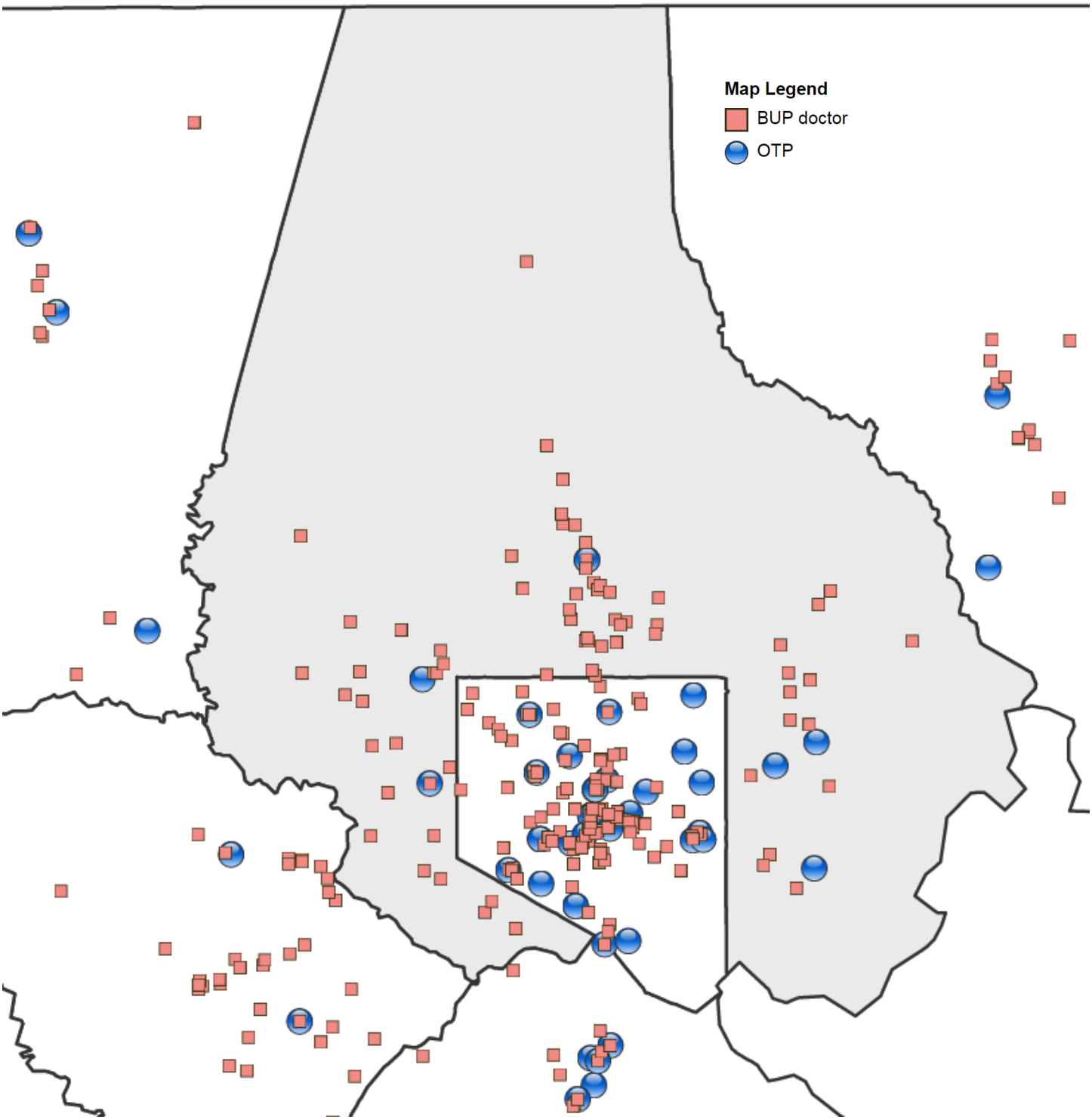
Estimated Total Population, Age 12+: 509,100
Estimated Need: 12,504
Estimated OTP Capacity (methadone & buprenorphine): 15,463
Estimated Difference between Need and Capacity: 2,959 Capacity above Need



Estimated Additional Potential Buprenorphine Capacity: 14,720

Baltimore County

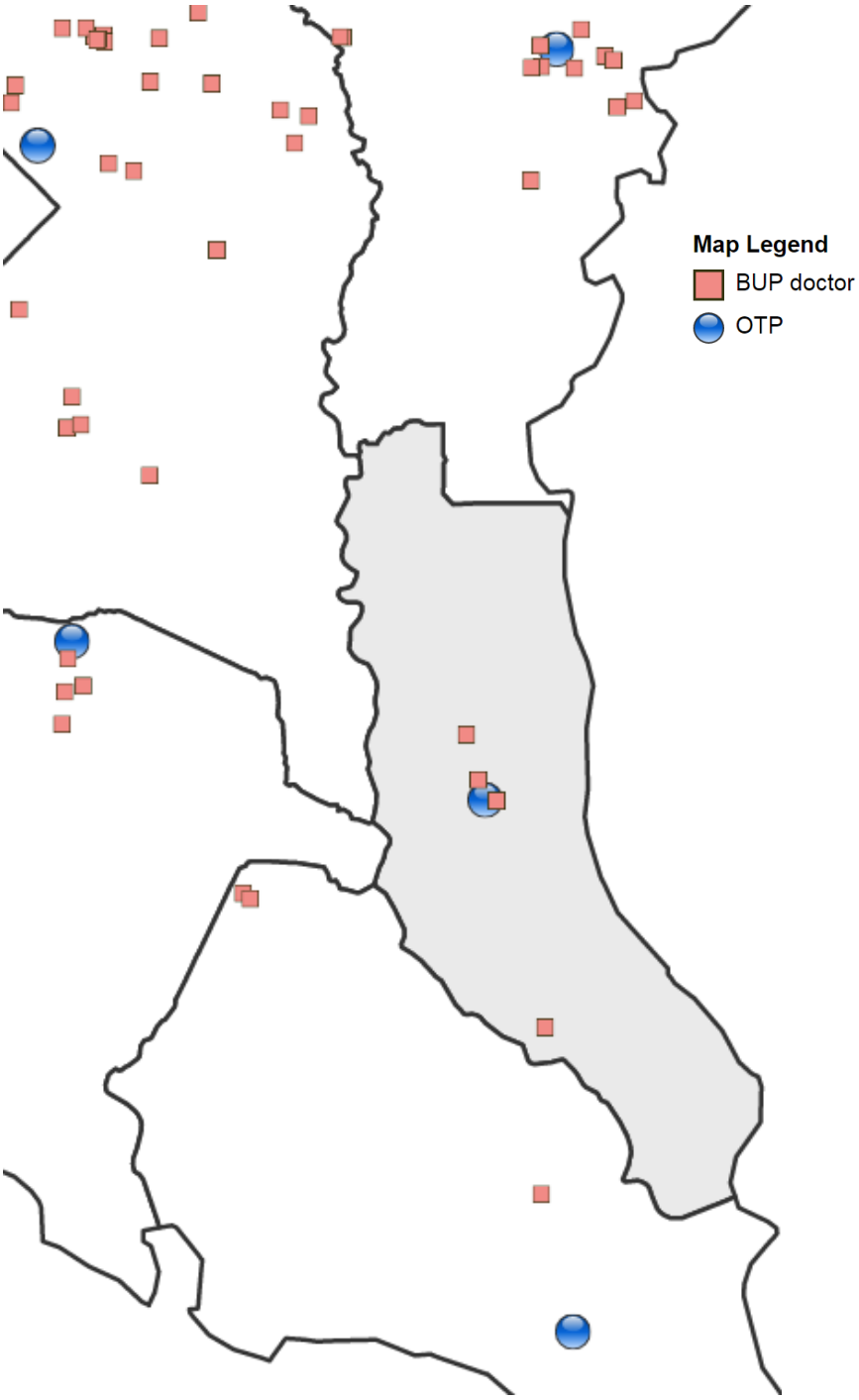
Estimated Total Population, Age 12+: 681,997
Estimated Need: 9,686
Estimated OTP Capacity (methadone & buprenorphine): 3,404
Estimated Difference between Need and Capacity: 6,282 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 8,170

Calvert

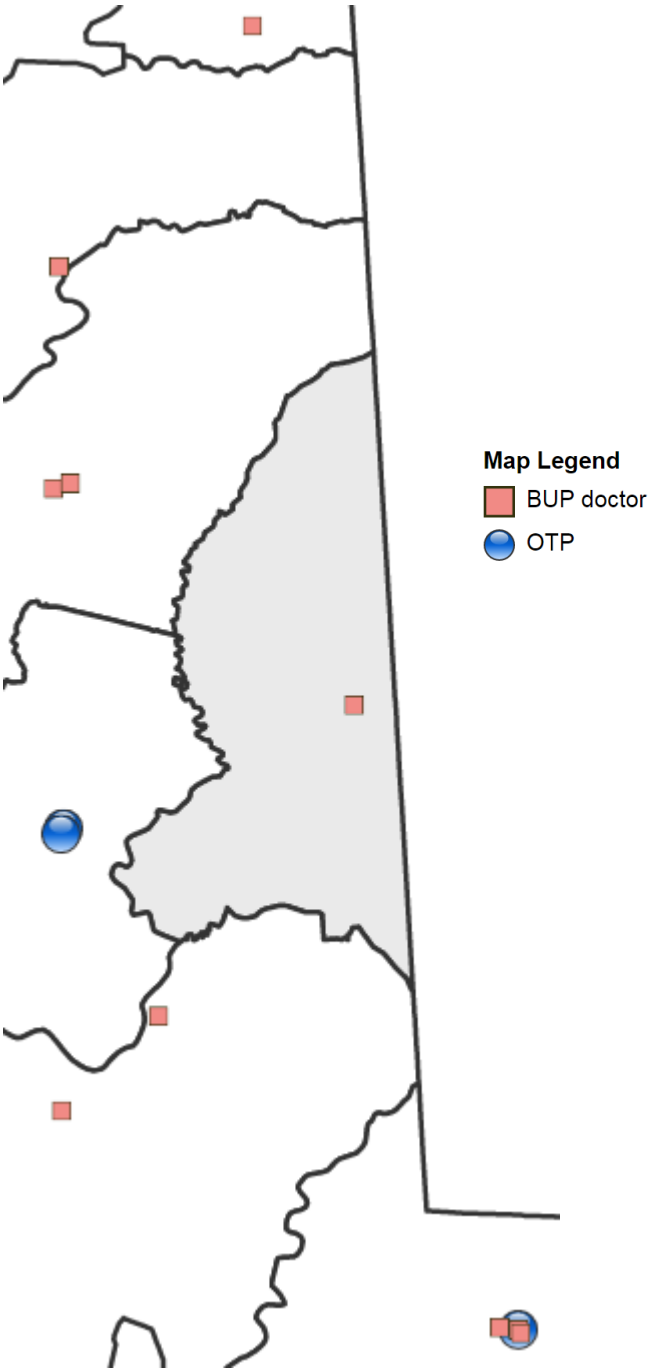
Estimated Total Population, Age 12+: 76,321
Estimated Need: 769
Estimated OTP capacity (methadone & buprenorphine): 200
Estimated Difference between Need and Capacity: 569 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 330

Caroline

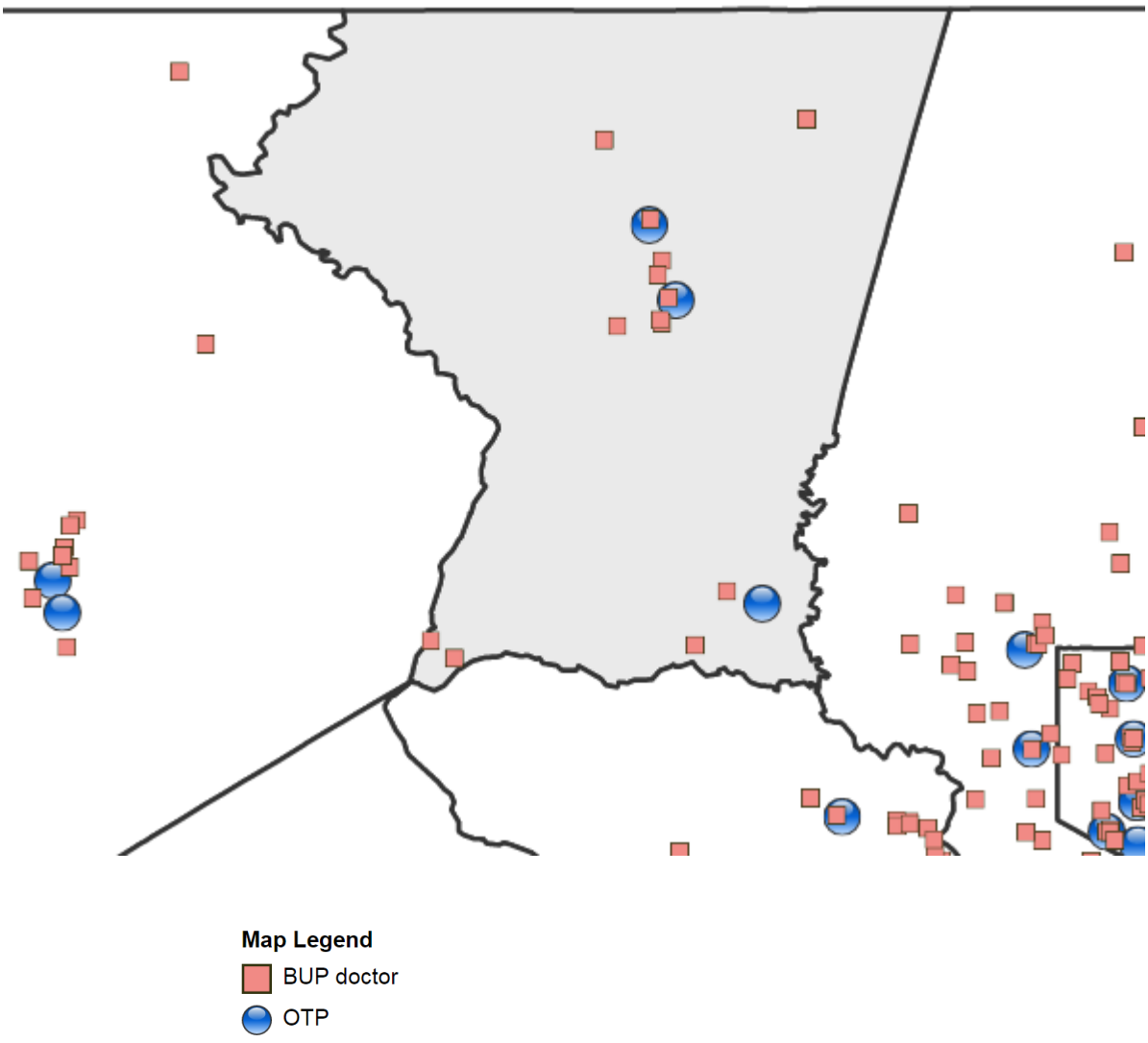
Estimated Total Population, Age 12+: 26,816
Estimated Need: 270
Estimated OTP capacity (methadone & buprenorphine): 0
Estimated Difference between Need and Capacity: 270 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 30

Carroll

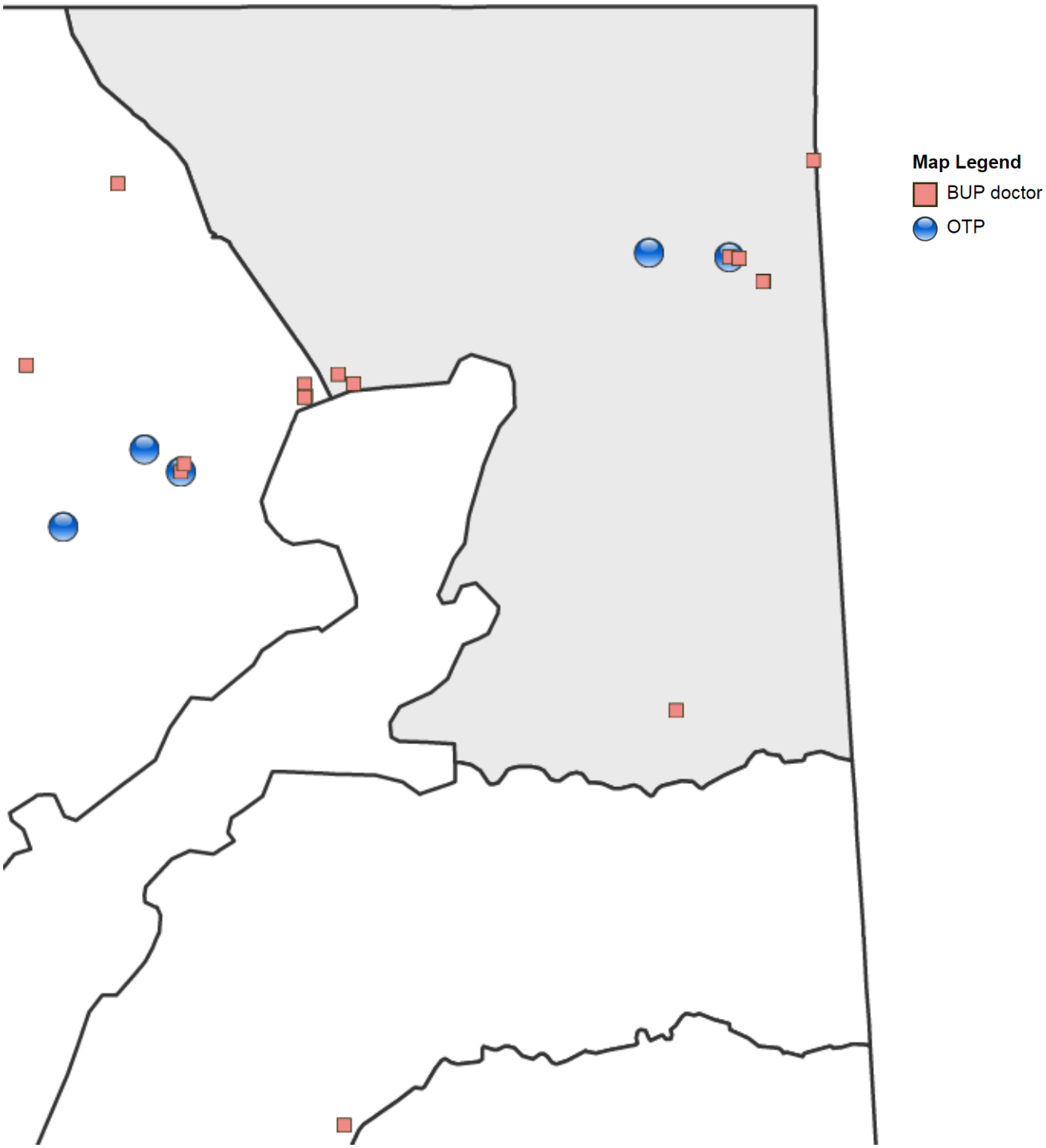
Estimated Total Population, Age 12+: 139,765
Estimated Need: 1,542
Estimated OTP Capacity (methadone & buprenorphine): 874
Estimated Difference between Need and Capacity: 668 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 1,760

Cecil

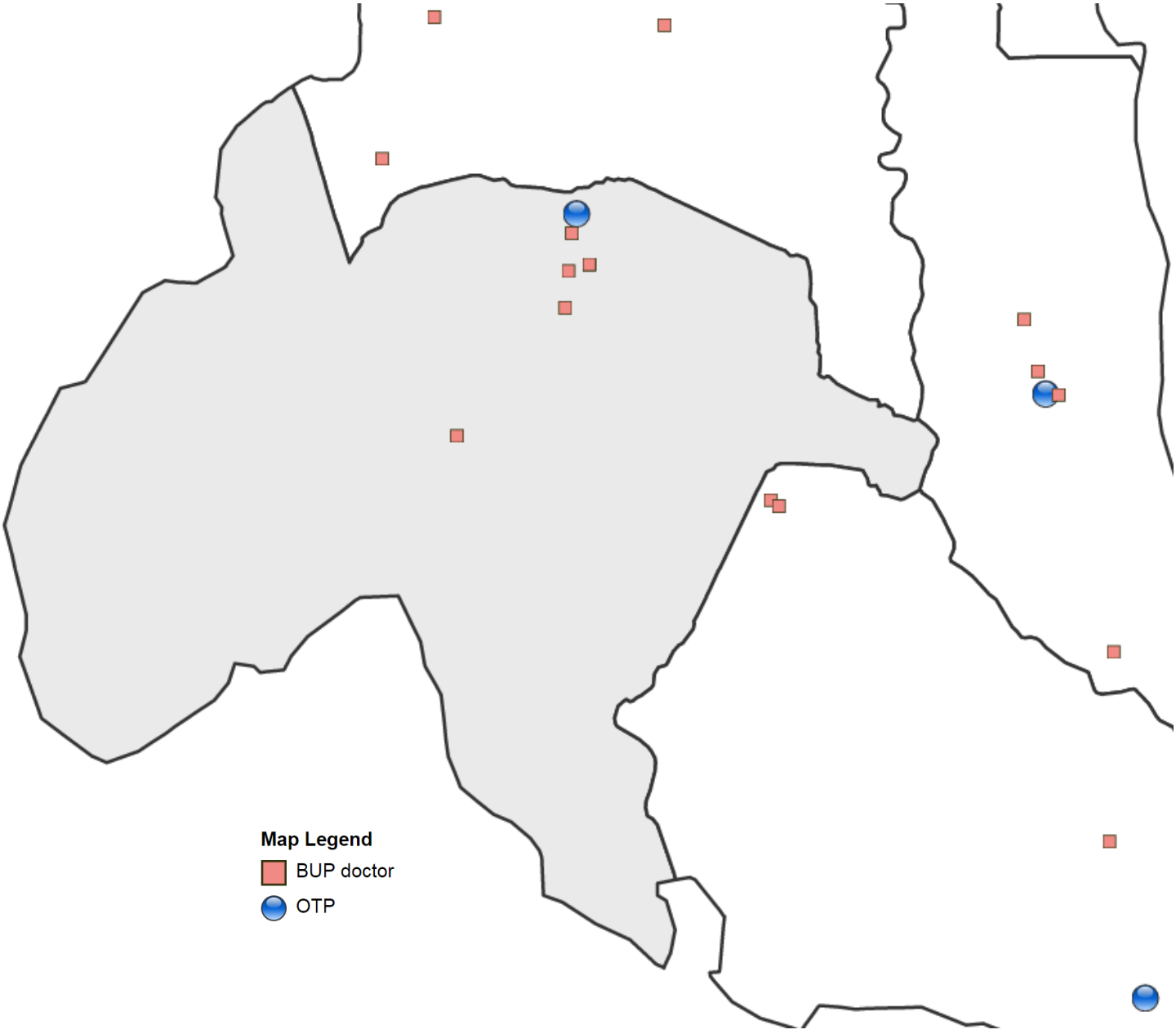
Estimated Total Population, Age 12+: 84,402
Estimated Need: 1,473
Estimated OTP Capacity (methadone & buprenorphine): 1,104
Estimated Difference between Need and Capacity: 369 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 1,500

Charles

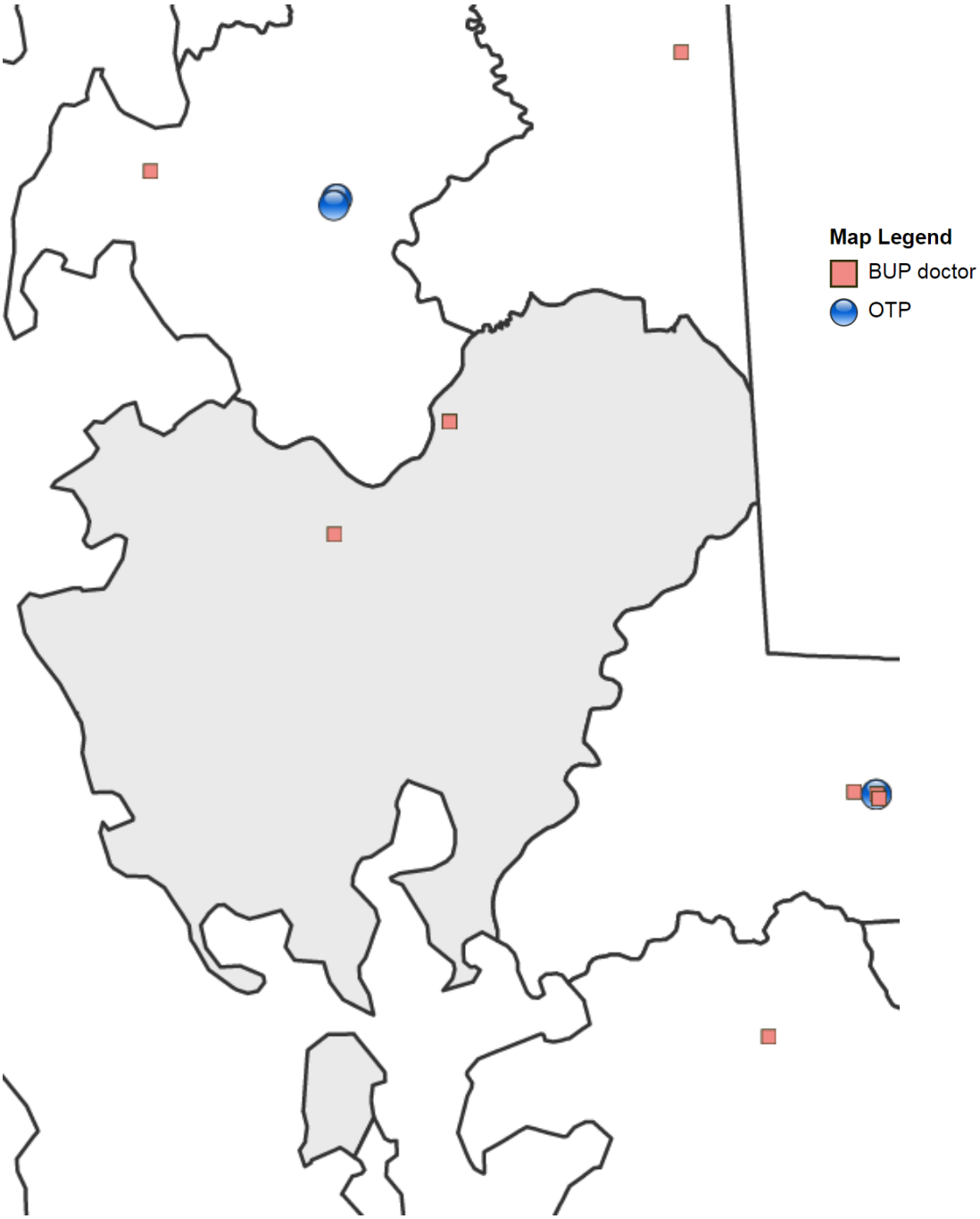
Estimated Total Population, Age 12+: 125,652
Estimated Need: 1,233
Estimated OTP Capacity (methadone & buprenorphine): 250
Estimated Difference between Need and Capacity: 983 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 480

Dorchester

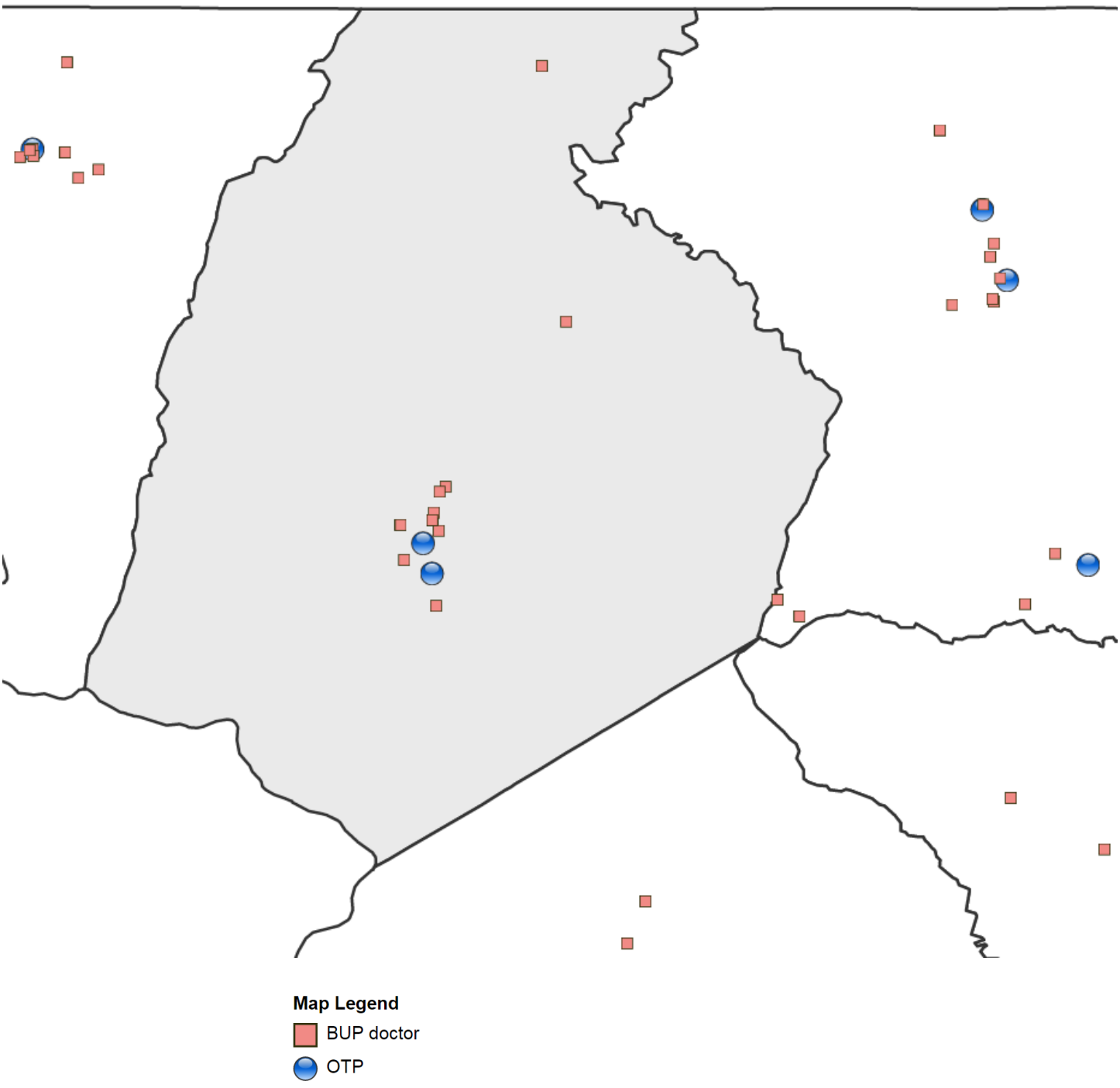
Estimated Total Population, Age 12+: 27,497
Estimated Need: 268
Estimated OTP Capacity (methadone & buprenorphine): 0
Estimated Difference between Need and Capacity: 268 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 380

Frederick

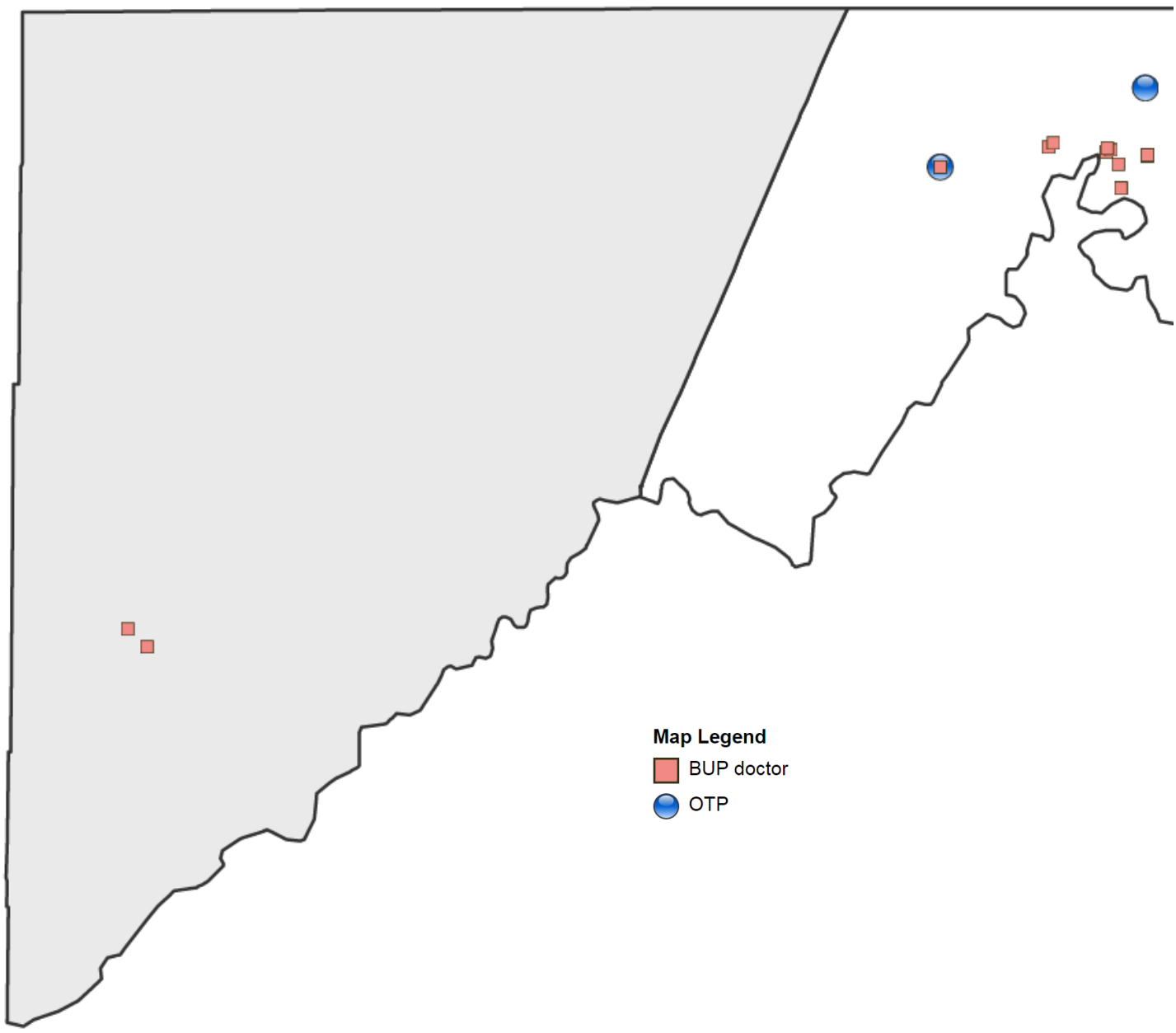
Estimated Total Population, Age 12+: 198,081
Estimated Need: 2,179
Estimated OTP Capacity (methadone & buprenorphine): 591
Estimated Difference between Need and Capacity: 1,588 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 1,610

Garrett

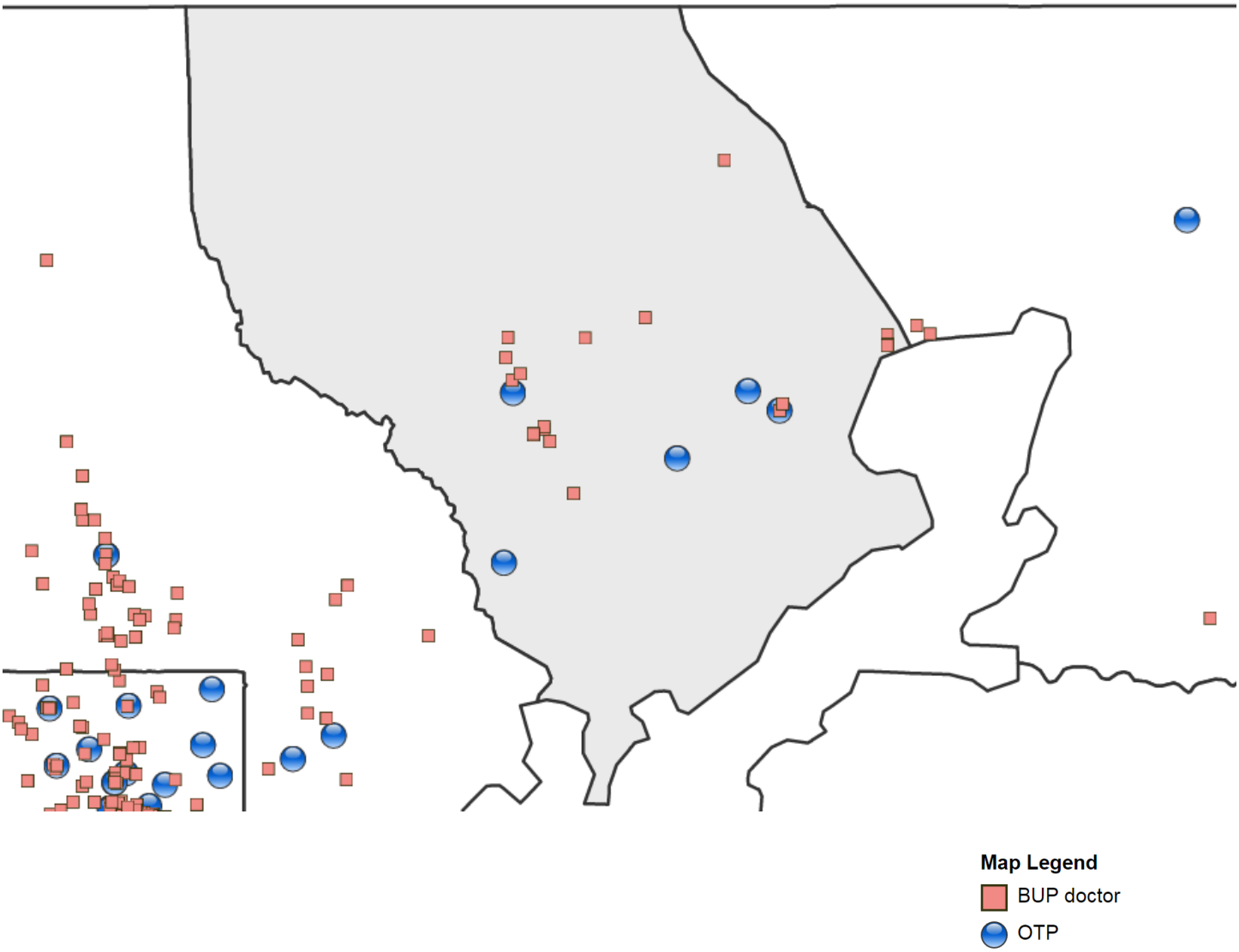
Estimated Total Population, Age 12+: 25,297
Estimated Need: 316
Estimated OTP Capacity (methadone & buprenorphine): 0
Estimated Difference between Need and Capacity: 316 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 160

Harford

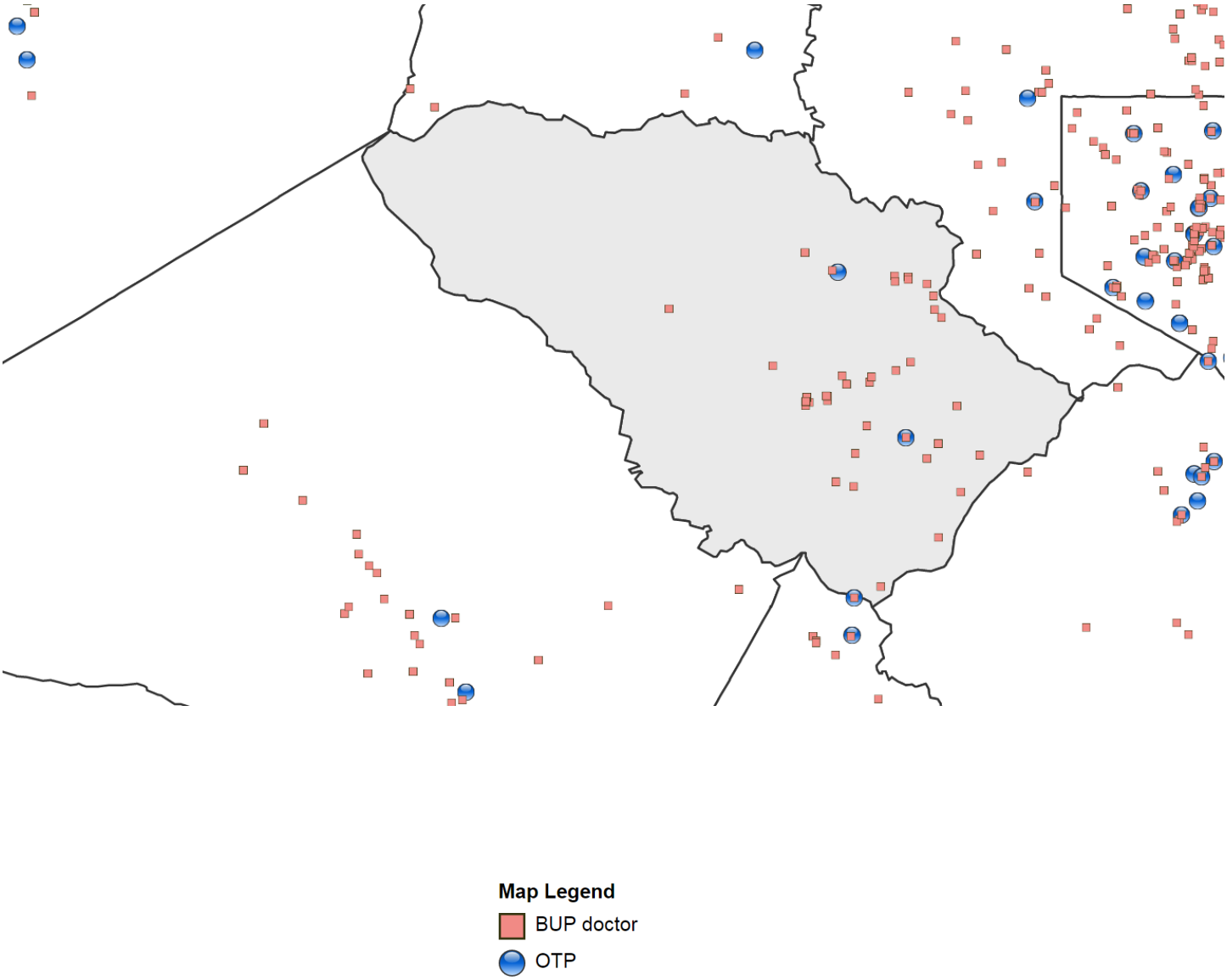
Estimated Total Population, Age 12+: 208,742
Estimated Need: 2,570
Estimated OTP Capacity (methadone & buprenorphine): 1,687
Estimated Difference between Need and Capacity: 883 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 1,460

Howard

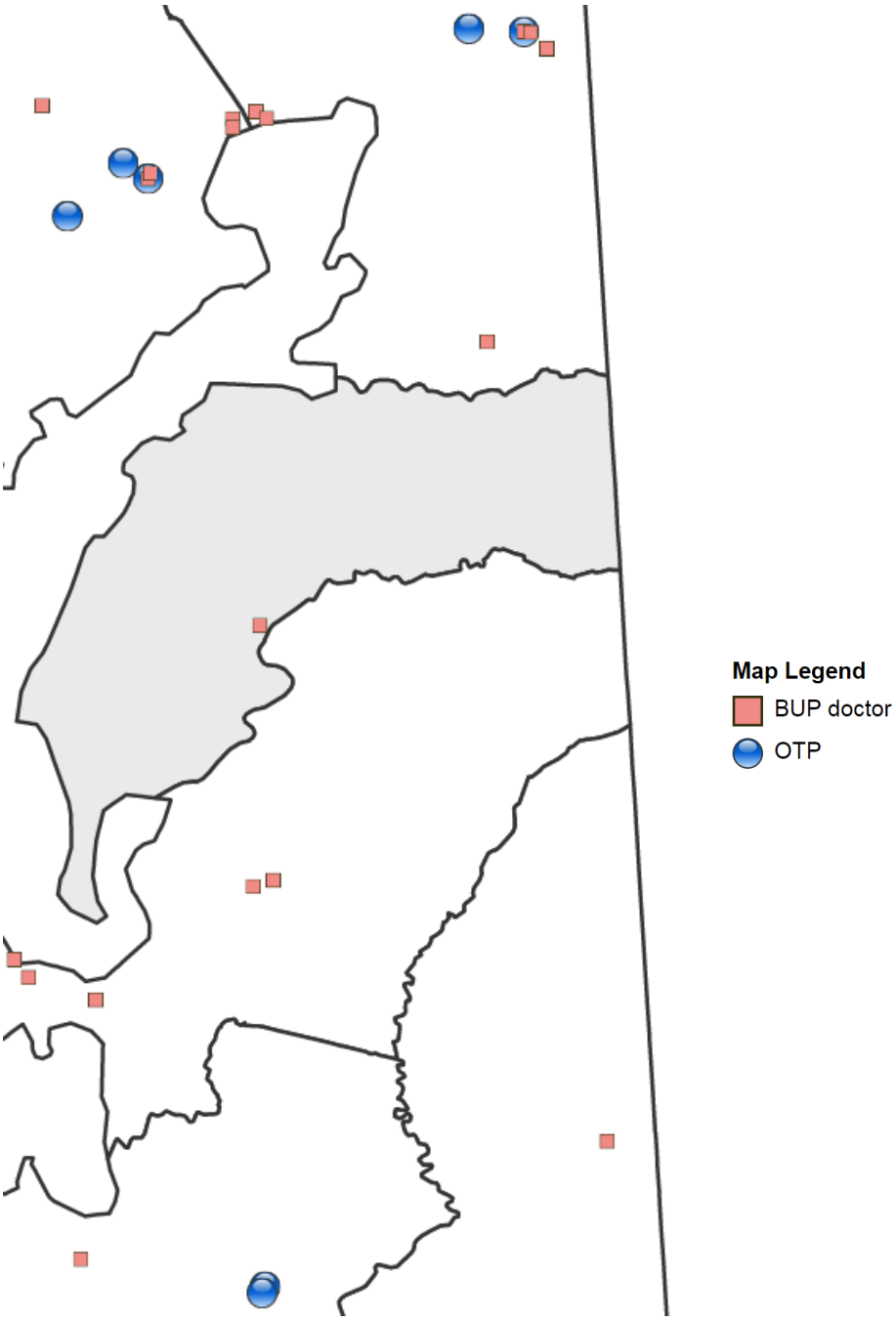
Estimated Total Population, Age 12+: 249,939
Estimated Need: 2,387
Estimated OTP Capacity (methadone & buprenorphine): 658
Estimated Difference between Need and Capacity: 1,729 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 4,000

Kent

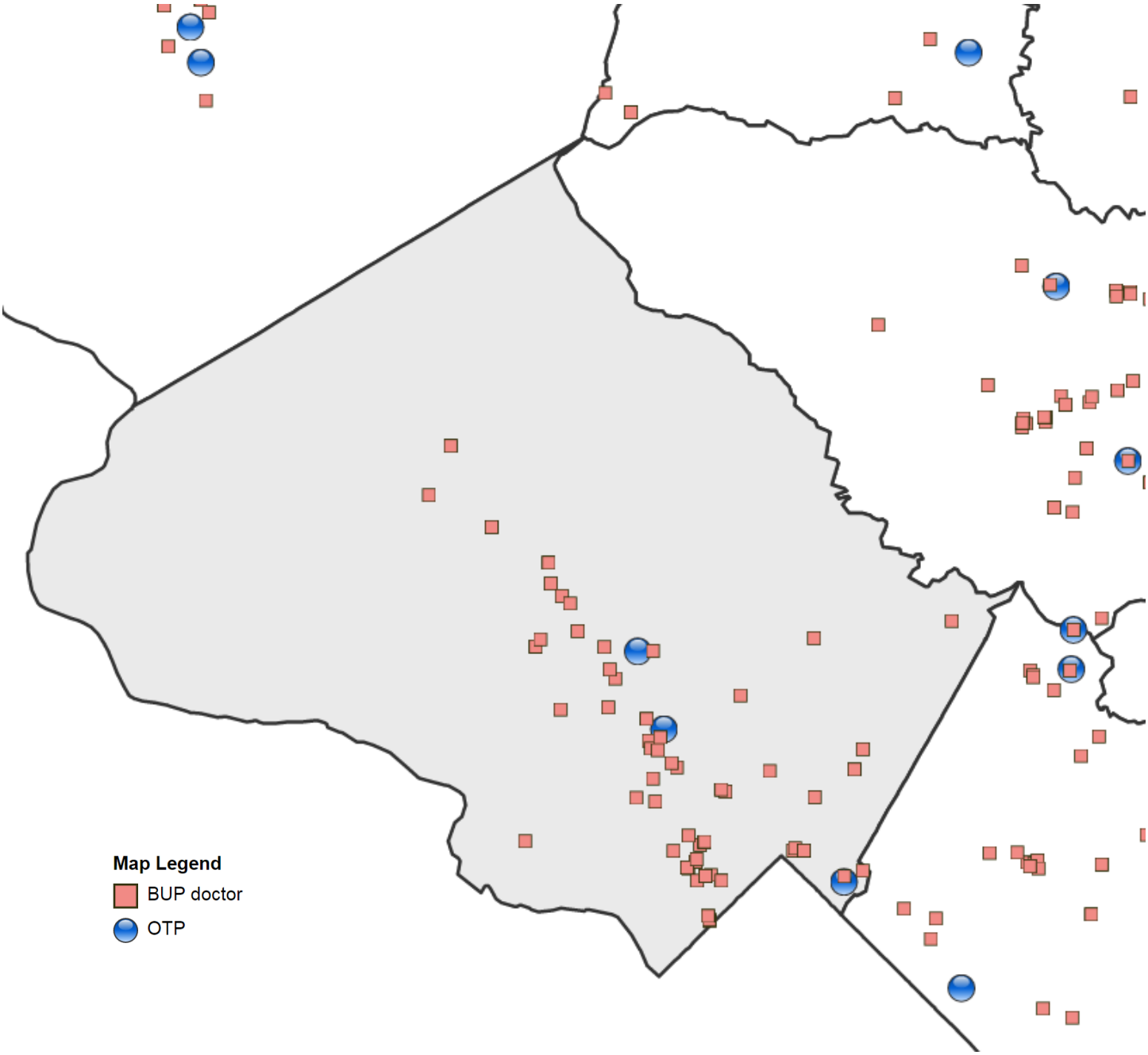
Estimated Total Population, Age 12+: 16,373
Estimated Need: 183
Estimated OTP Capacity (methadone & buprenorphine): 0
Estimated Difference between Need and Capacity: 183 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 190

Montgomery

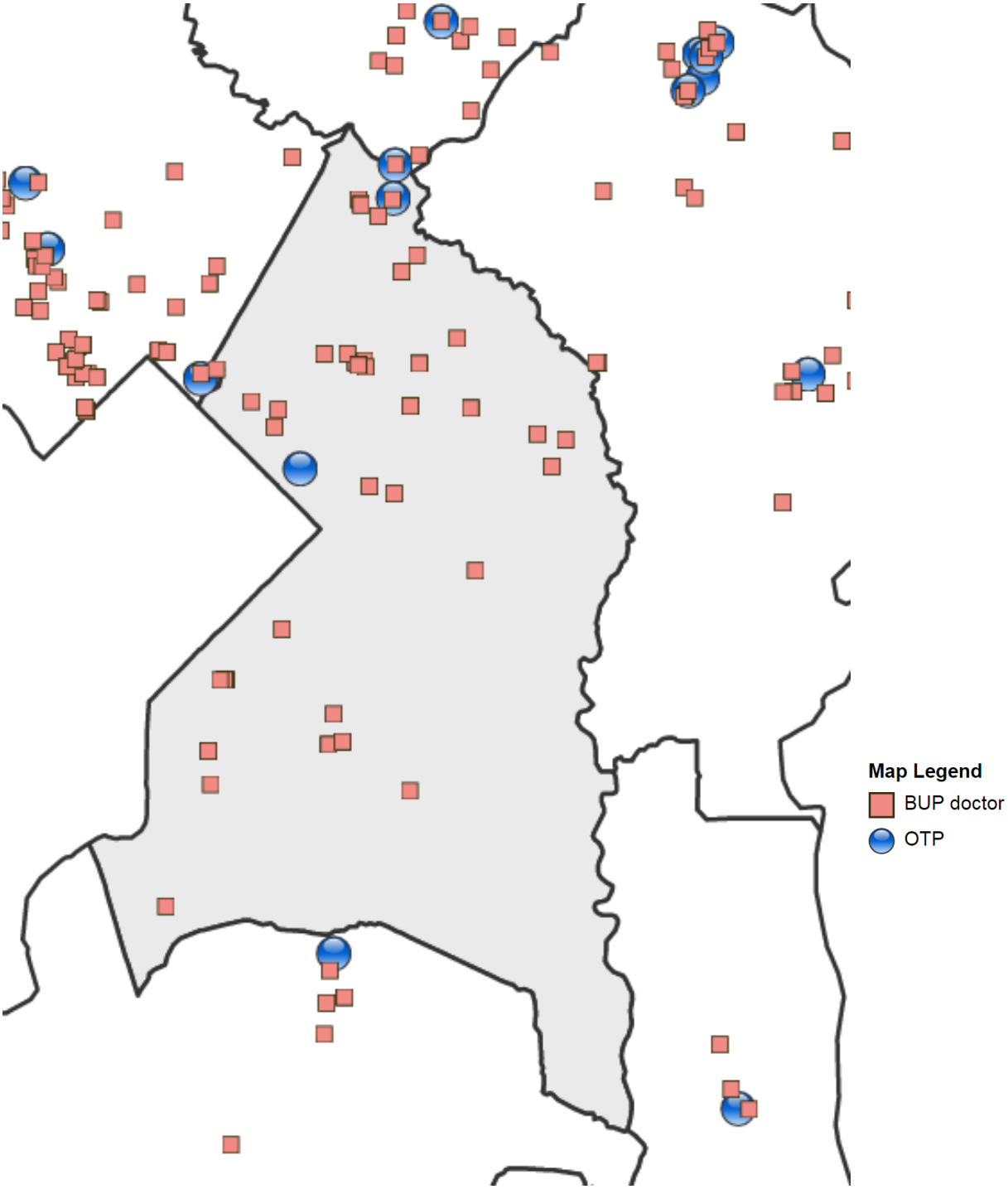
Estimated Total Population, Age 12+: 840,748
Estimated Need: 7,571
Estimated OTP Capacity (methadone & buprenorphine): 682
Estimated Difference between Need and Capacity: 6,889 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 6,750

Prince George's

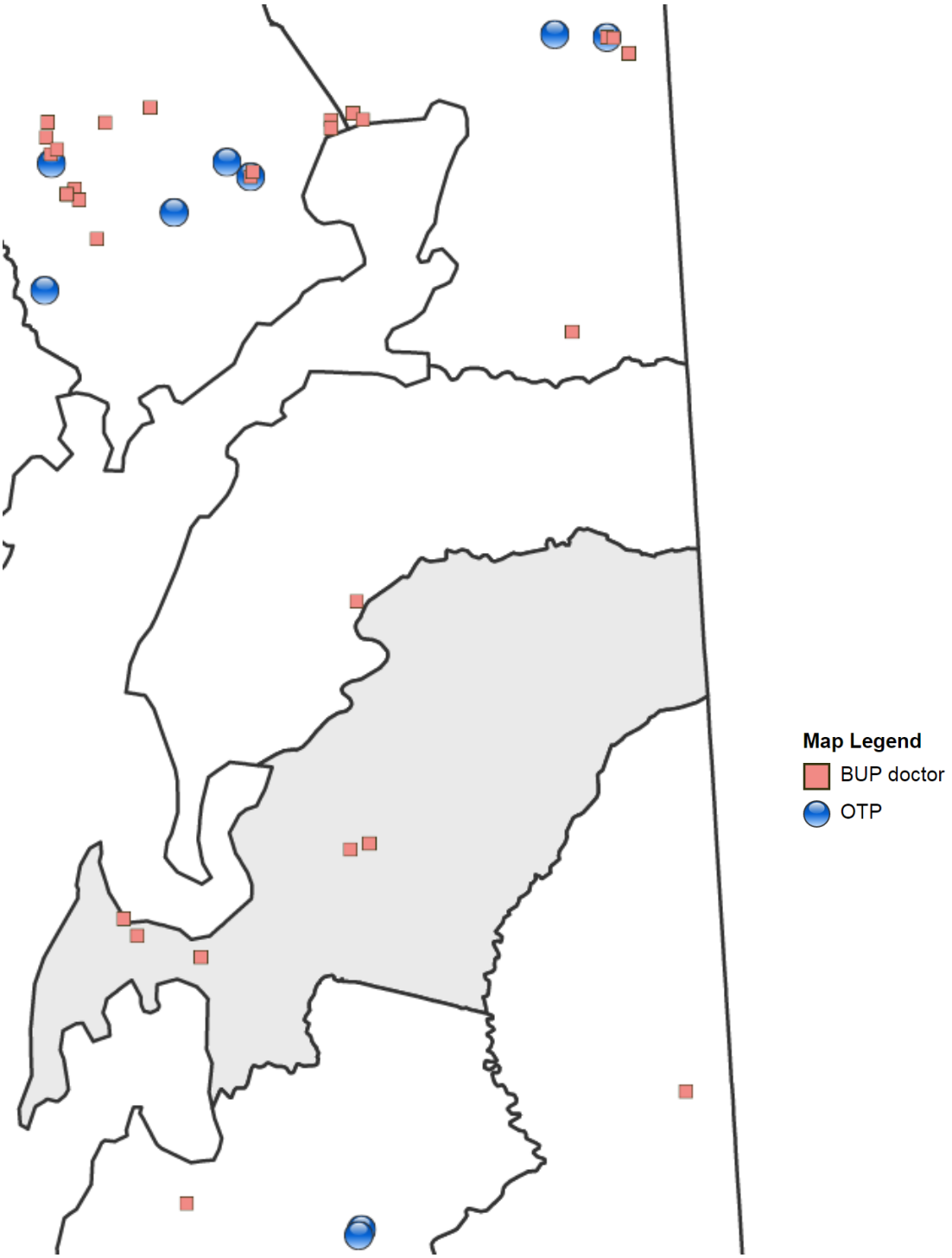
Estimated Total Population, Age 12+: 729,896
Estimated Need: 7,792
Estimated OTP Capacity (methadone & buprenorphine): 505
Estimated Difference between Need and Capacity: 7,287 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 2,850

Queen Anne's

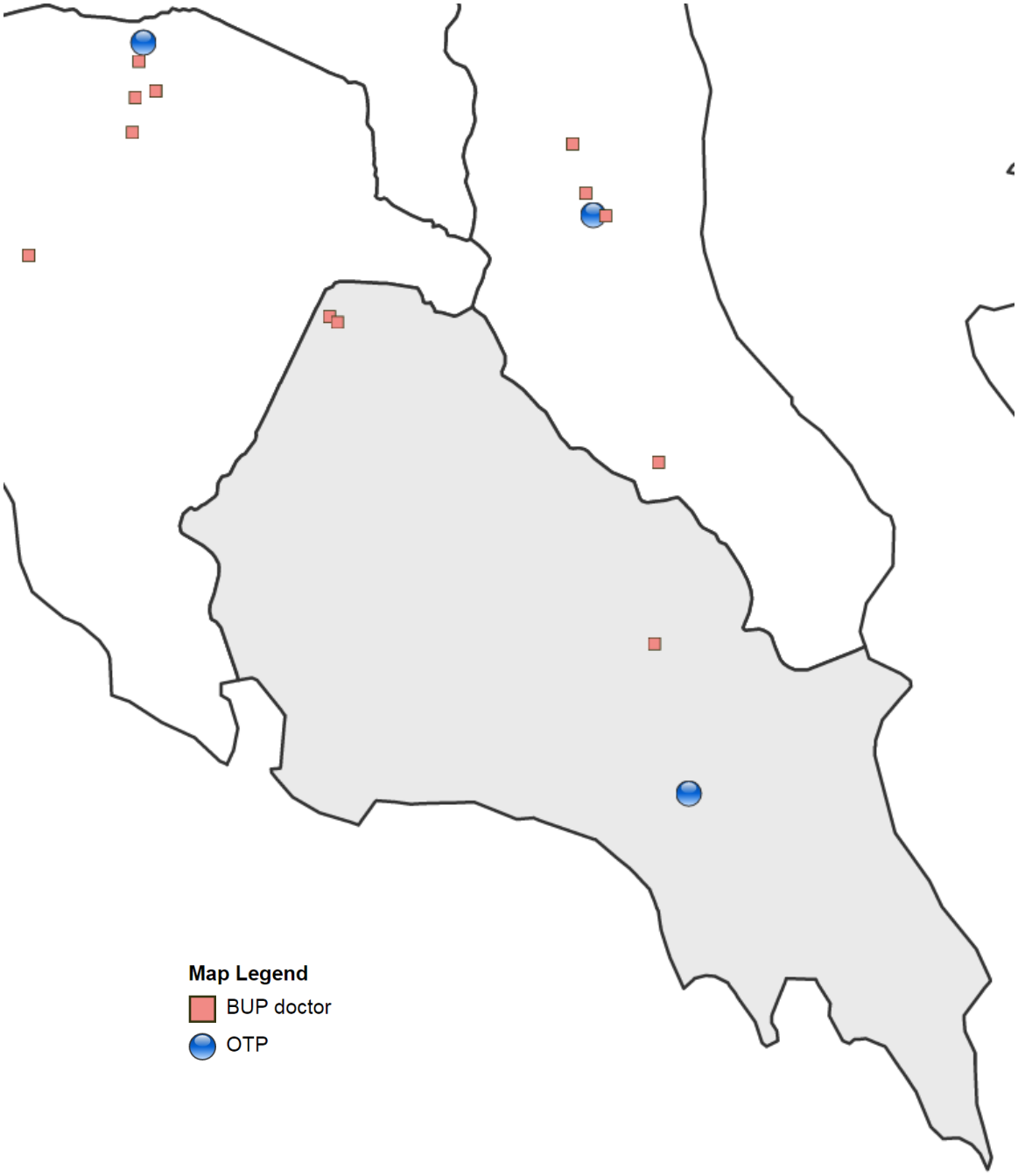
Estimated Total Population, Age 12+: 41,026
Estimated Need: 434
Estimated OTP Capacity (methadone & buprenorphine): 0
Estimated Difference between Need and Capacity: 434 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 290

St. Mary's

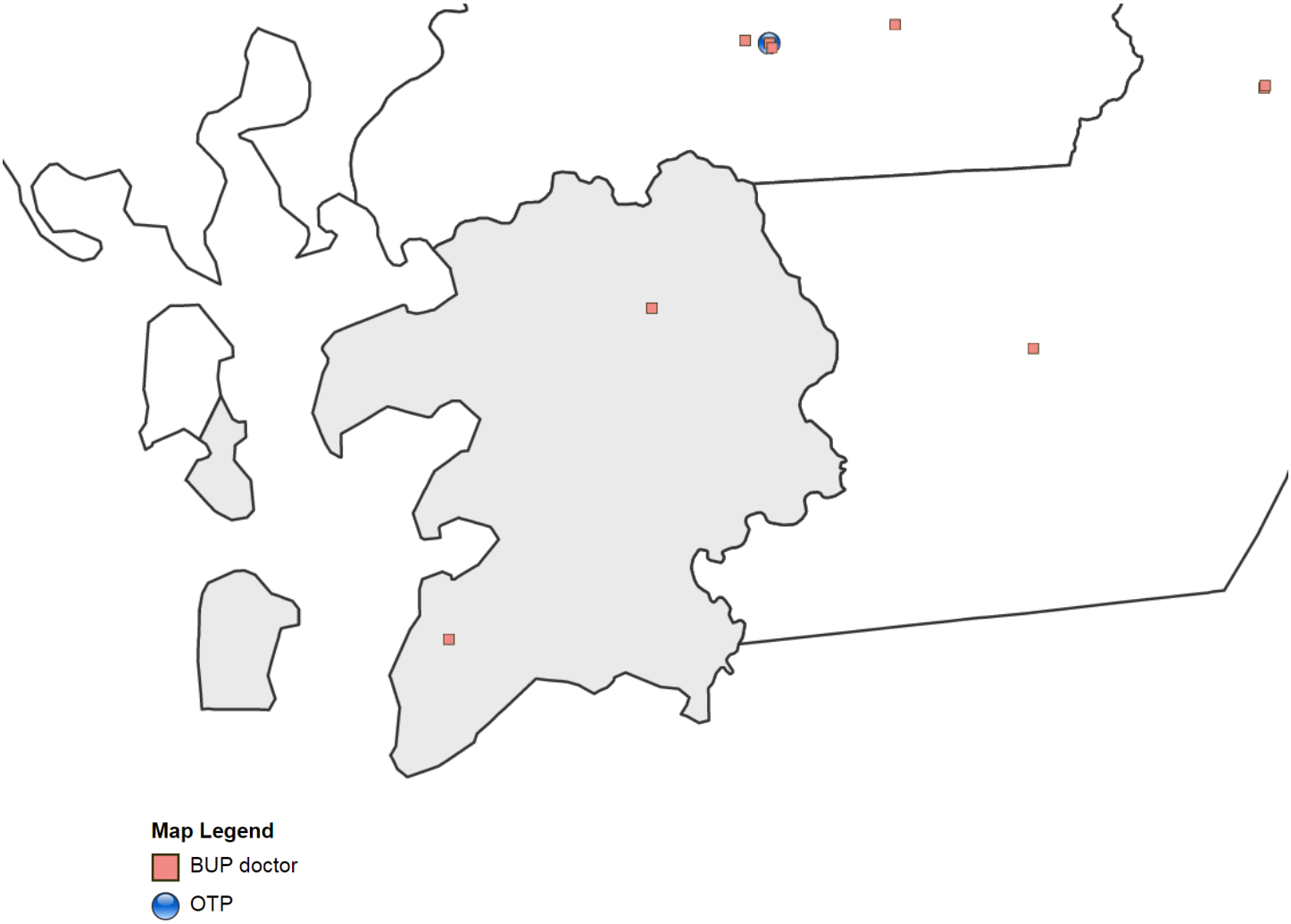
Estimated Total Population, Age 12+: 87,274
Estimated Need: 937
Estimated OTP Capacity (methadone & buprenorphine): 400
Estimated Difference between Need and Capacity: 537 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 60

Somerset

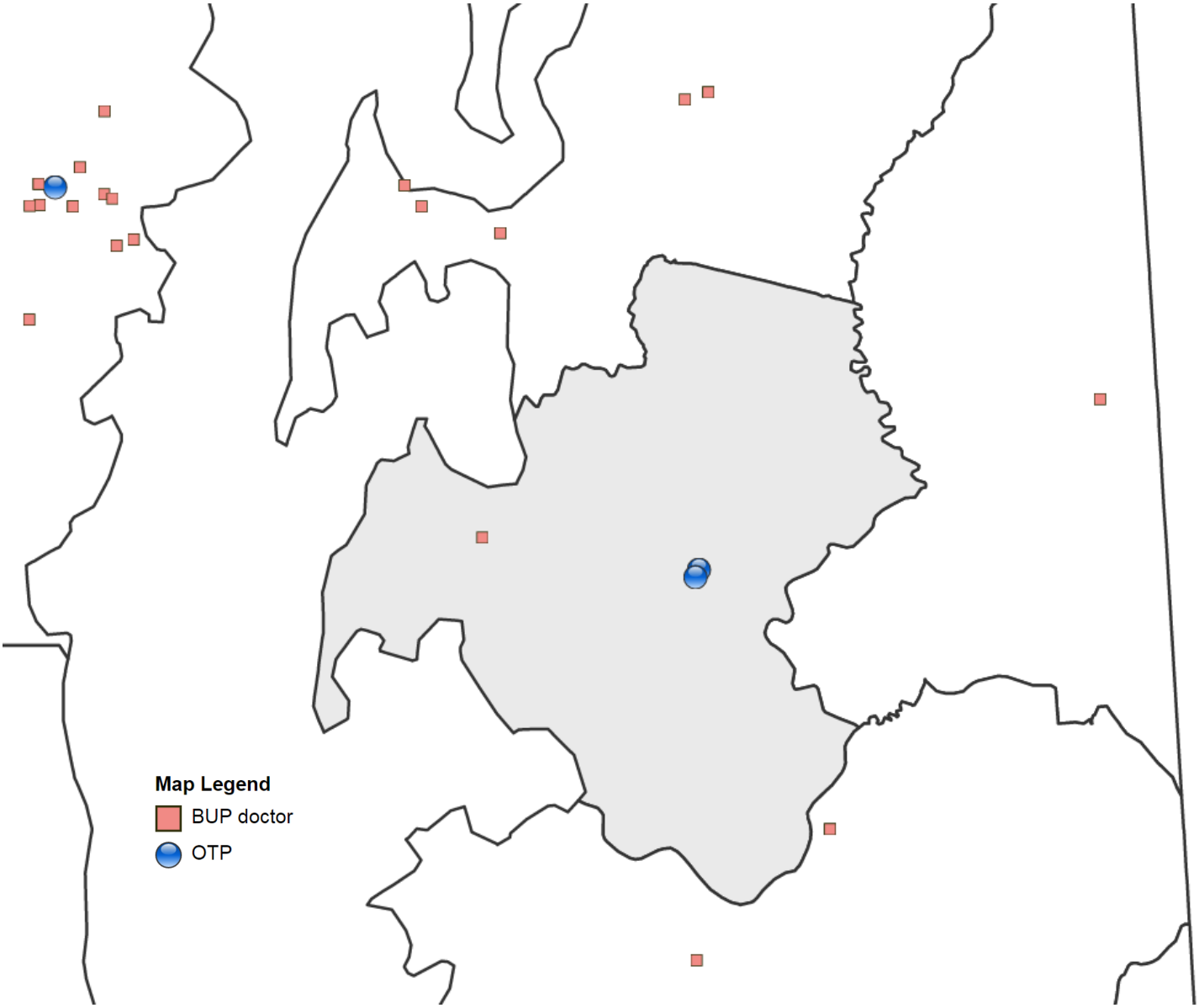
Estimated Total Population, Age 12+: 16,446
Estimated Need: 168
Estimated OTP Capacity (methadone & buprenorphine): 0
Estimated Difference between Need and Capacity: 168 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 130

Talbot

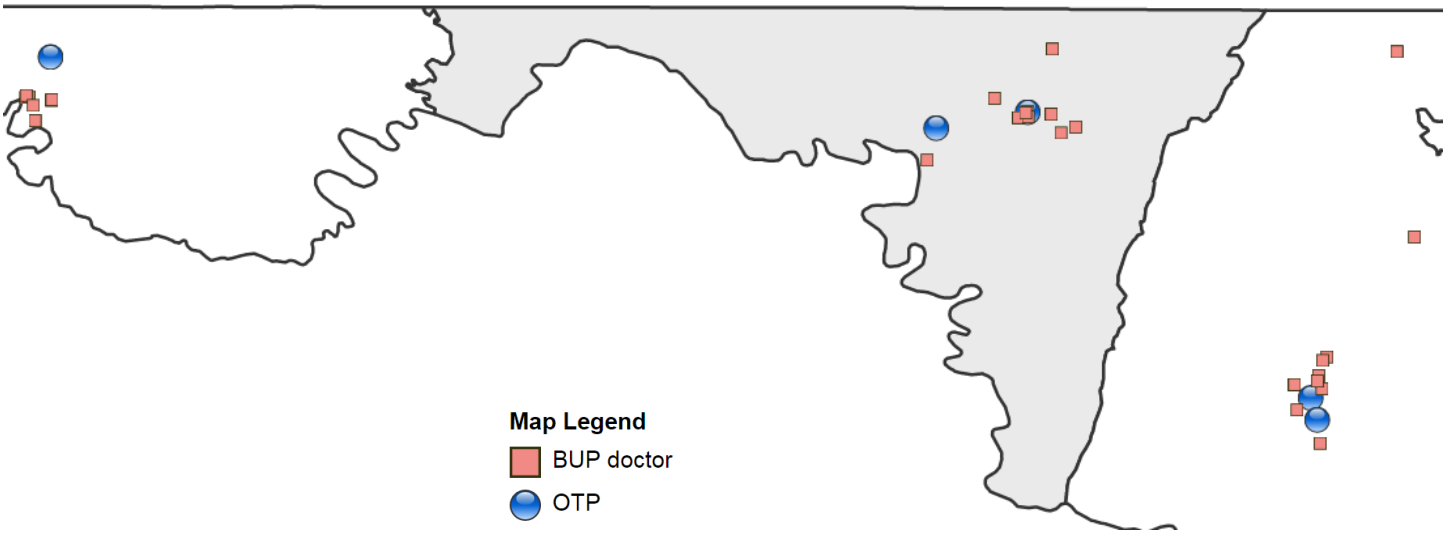
Estimated Total Population, Age 12+: 32,734
Estimated Need: 313
Estimated OTP Capacity (methadone & buprenorphine): 470
Estimated Difference between Need and Capacity: 157 Capacity above Need



Estimated Additional Potential Buprenorphine Capacity: 60

Washington

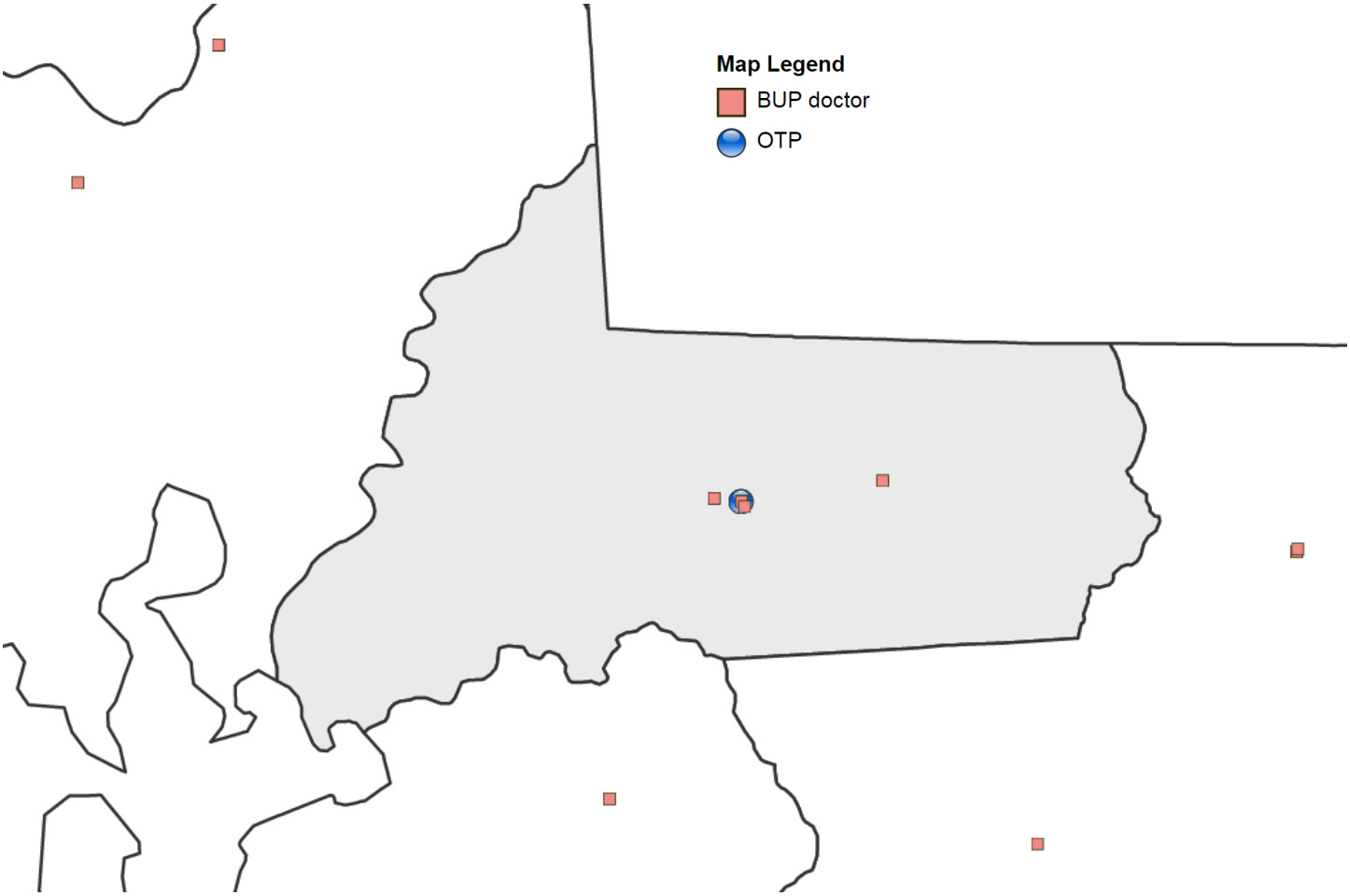
Estimated Total Population, Age 12+: 119,160
Estimated Need: 1,694
Estimated OTP Capacity (methadone & buprenorphine): 1,672
Estimated Difference between Need and Capacity: 22 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 1,260

Wicomico

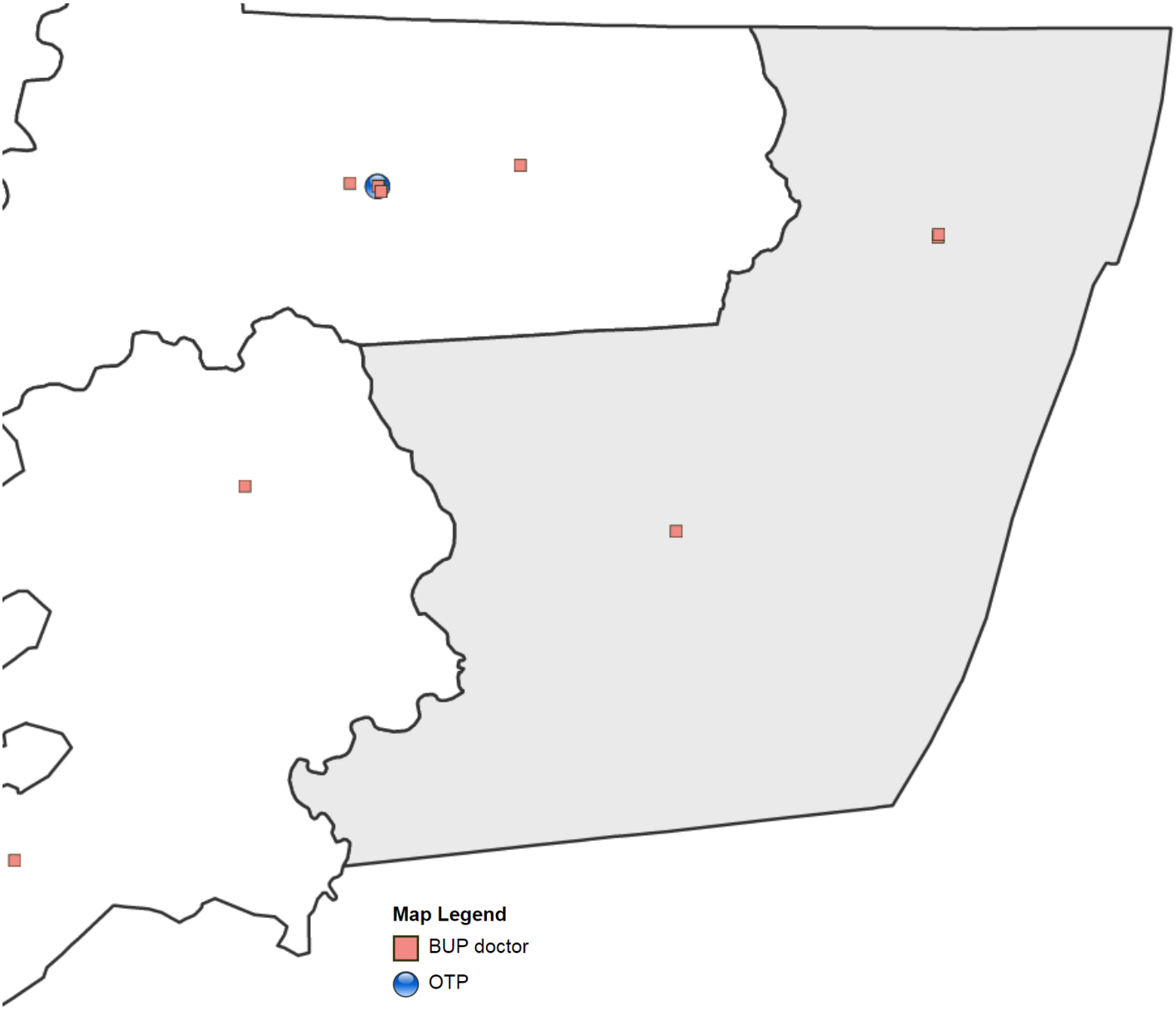
Estimated Total Population, Age 12+: 82,110
Estimated Need: 873
Estimated OTP Capacity (methadone & buprenorphine): 296
Estimated Difference between Need and Capacity: 577 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 420

Worcester

Estimated Total Population, Age 12+: 44,805
Estimated Need: 451
Estimated OTP Capacity (methadone & buprenorphine): 0
Estimated Difference between Need and Capacity: 451 persons in Need above Capacity



Estimated Additional Potential Buprenorphine Capacity: 350

Attachment 2
Workgroup Recommendations to BHA
Program Criteria Related to Managing Potential Impacts of Programs in a Community Setting

Practice Standards/Themes	Suggested Criteria	Method for measurement or monitoring	By Who	Implementation Considerations	Ref-docs
Positive Community Relations/Liaising	Programs should develop specific policy/procedure for establishing good community relations in accordance with SAMHSA guidance.	-Proof of Policy and Procedure related to establishing/maintaining good community relationships and attempts to meet key community groups; -Use of Guideline Documents provided by BHA related to establishment and maintenance of good community relationships.	BHA/ LAA	-Identification of committed stakeholders -LAA to have a role in introduction of program to key community groups -BHA to develop Guidance Documents for distribution	1, 2, 4, 5
Physical Facility Management and Sanitation	Programs should maintain clean and orderly facilities with regular, posted hours.	-Proof of Policy and Procedure related to Facility Maintenance, expectations and mechanisms to maintain cleanliness of facility and premises; -Documentation of regular patrol of premise; -Premises are clean and reasonably free of trash.	BHA/ LAA		1, 2, 4, 5
Patient Flow Management (Loitering) – Before Service **Program Design and physical space considerations (Indoor waiting space, Number of dosing windows, Hours of operation, staffing, Parking)**	Programs should provide: • Sufficient indoor space to accommodate patients who are waiting for treatment. • Sufficient dosing windows/stations to manage flow of patients at peak hours • Hours of operation sufficient to manage flow of patients over a range of hours • Sufficient staff to provide counseling services as needed for all patients • Sufficient parking	-Proof of Policy and Procedure regarding elimination of people waiting outside of building for services, detailing mechanisms used to ensure sufficient patient flow management during normal hours as well as in emergency weather conditions; -Facility is free of persons waiting outside of building in line from time program opens for services.	BHA/ LAA		1, 2, 4, 5

Patient Flow Management (Loitering)- After Service	Programs should maintain and enforce pre- and post-treatment Patient flow management **(**loitering**)** policy	-Policy and Procedure to include: • Peer survey or method of determining individual or overall causes with modifications in patients' treatment plans as necessary; • Referral procedures to provide/refer for alternative recreational/socialization or recovery support activities; • Written instruction to patients regarding expected conduct related to leaving facility and premises promptly following service completion, and consequences for failing to comply with treatment and/or other program expectations; * -Documentation of lack of problematic conduct related to leaving the facility and general vicinity of program promptly following service completion.	BHA/ LAA	Resources available for recreation, vocational, day program, RSS, MARS	1, 2, 4, 5
Safety/Security	Programs should maintain and enforce safety and security of program participants in accordance with SAMHSA guidance	-Proof of Policy and Procedure detailing methods used to monitor the exterior of the program's building, and having trained staff available to intervene in cases of disruptive conduct; -Documentation of regular monitoring of premises.	BHA/ LAA	Fiscal constraints for programs related to installing equipment and staffing considerations	1, 2, 4, 5
Diversion control	Programs should maintain efforts to control diversion of medications	-Proof of Policy and Procedure that includes instruction to patients regarding expected conduct, diversion control policies and interventions as guided by senior clinical and medical review.	BHA/ LAA		1, 2, 4, 5
Problem resolution	Programs and communities should	-Proof of Policy and Procedure for	BHA/		1, 2,

	engage in ongoing discussions to collaboratively address issues as necessary and have a mechanism for addressing concerns, in accordance with SAMHSA guidance.	Problem Resolutions to include documentation of community concerns and resolution efforts and LAA involvement to facilitate and to arrange for mediation if necessary; -Use of Community Relationships Guidelines Documents.	LAA	Funding considerations for informal, non-binding mediation of problems	4, 5

Workgroup Recommendations to BHA
Program Criteria Related to Overall Quality Standards

Practice Standards/Themes	Suggested Criteria	Method for Measurement or monitoring	By Who	Implementation Considerations	Ref-docs
Program Related					
Staffing considerations	Establish a Supervisor to trainee ratio.	Mandatory in BHA Regulations	BHA LAA	Funding considerations	2
Use of PDMP and CRISP in patient treatment planning and evaluation	Programs must consult PDMP prior to prescribing, increasing take-homes, and every 3 months as part of treatment plan review.	Mandatory in BHA Regulations	BHA LAA	New law already requires prior to prescribing, and every 3 months. Add to regulations "prior to increasing take-home dosages." Implement any changes with established timeline of July 1, 2018. Continued improvements to PDMP technology.	OTP QIWG
Overdose Response through promoting use of, and co-prescribing of naloxone	Programs must offer a prescription for naloxone to all patients.	Mandatory in BHA Regulations documentation of offer of prescription	BHA/ LAA	Will be in regulations. LAA to help facilitate this. Funding considerations	OTP QIWP
Training	Programs should Identify areas of medical/clinical training needs and implement training to include reduction of internal stigma.	-Document mechanism to assess training needs of staff, to reflect patient satisfaction survey and accreditation results	BHA/ LAA	BHA will facilitate sub-committee to further determine training needs and plan.	OTP QIWP
Hours of operation	Programs should provide hours of service that meet the needs of the majority of patients, including before or after traditional 8-5 work day.	-Document mechanism to assess needs of patients in determining hours. - Documentation of information on programs with alternative hours.	BHA/ LAA		7

Patient Care Related					
Medical coverage	Programs should provide medical coverage with timely responsiveness to patient needs.	-Documentation of daily medical coverage available which includes type of provider available for coverage. - Policy & Procedure on timeframe for initial response -Documentation that medical need was address with patient, and when expected resolution of medical need will occur. -Documentation of patient survey question to address if medical staff communicated expected timeframe for resolution of a medical issue and if staff followed through with timeframe as indicated.	BHA/ LAA	Funding considerations	6
Coordination of care	Programs should share information among MH, primary care, and SUD providers.	-If treatment plan indicates need for psychiatric, medical or other SUD providers, provide documentation of: 1) presence of other providers, 2) release of information for said providers, 3) attempts to contact said providers to coordinate care, and 4) coordination with said providers prior to establishing take-home status. -Documentation of following through with items on the treatment plan	BHA/ LAA	Ensure compliance with 42 CFR Part 2	6

	Programs should employ a multidisciplinary approach for treating patients with chronic pain disorder and addiction, including addiction medicine specialists and pain medicine specialists.	-Identify and address issues regarding chronic pain by way of inclusion on the patient's treatment plan, use of internal clinical resources, or documenting ongoing coordination with outside clinicians who are treating chronic pain. -Provide clear documentation of rationale and ongoing plan for continued consideration when patients are being prescribed controlled substances, other than methadone or buprenorphine, for the treatment of pain.	BHA/ LAA BHA/ LAA	Ensure compliance with 42 CFR Part 2 Incentivize programs that provide the specialty. Ensure universal training for baseline level competency re chronic pain, etc. Funding considerations for training	7
	Programs should review BHA registry of OTPs for programs that self-identify as specializing in concurrent treatment of chronic pain disorder and addiction if necessary.	-Documentation of review or consultation with BHA when necessary.	BHA/ LAA	BHA to create and maintain a registry of OTPs self-identified as equipped as specialty providers with designated specialty.	

	Programs should employ a multidisciplinary approach for management of co-occurring psychiatric disorders, such as GAD, panic disorder, depression, etc.	-Identify and address co-occurring psychiatric disorders by way of inclusion on the patient's treatment plan, use of internal clinical resources, or documenting ongoing coordination with outside clinicians who are treating co-occurring disorder. -Facilitate psychiatric evaluation for any patient exhibiting symptoms of severe anxiety or other psychiatric disorder. -Facilitate psychiatric evaluation for patients who are prescribed benzodiazepines for extended periods of time. -Provide clear documentation of rationale and ongoing plan for continued consideration when patients are being prescribed benzodiazepines for the treatment of an anxiety disorder or other disorders, to include documentation of discussion of inherent risks of co-prescription of benzodiazepines and opioids.	BHA/ LAA BHA/ LAA BHA/ LAA BHA/ LAA	Ensure compliance with 42 CFR Part 2 OTP staff needs to have training to recognize & identify people who need to be connected to psychiatric care. Funding considerations for training Programs could work with BHA re particular exceptions. Real time access to psychiatric care AATOD draft recommendations: Patients admitted to MAT who are prescribed benzodiazepines should be referred for a psychiatric evaluation to verify diagnosis and determine the best course of treatment for their condition. Existing COMAR FOR MH 10.63.03.05 - Outpatient Mental Health Center. In order to be licensed under this subtitle, an outpatient mental health	OTP WG

				center shall: D. Employ multidisciplinary clinical treatment staff who is authorized to provide the services under Health Occupations Article, Annotated Code of Maryland.	
	-Programs should review BHA registry of OTPs for programs that self-identify as specializing in concurrent treatment of anxiety and other psychiatric disorder if necessary.	-Documentation of review or consultation with BHA when necessary.	BHA/ LAA	BHA to create and maintain a registry of OTPs self-identified as equipped as specialty providers with designated specialty of treatment of co-occurring anxiety & other psychiatric disorders to include withdrawal management. Incentivize programs that provide the specialty.	
Care is provided based on outcome and individual response	-Varying number of sessions of both individual- and group-based verbal therapies (i.e., standard schedules to IOP levels and beyond). -Different types of interventions (e.g., cognitive-behavioral, motivational, psychoeducational, supportive-	-Review of OMS and other Beacon data if available and applicable for overall range and type of service episodes provided, by individual and/or program levels. -Policy and Procedure showing clinical	BHA BHA/		6

	expressive therapies, toxicology testing) over the course of a treatment episode. -Patients are offered a menu of services that include client-centered offerings such as anger management, stress management, parenting, life skills, conflict management, budgeting, etc. Services provided are based on needs of clients as determined by client population	decision-making framework that includes how program makes treatment decisions, criteria used, range of services offered and how services are determined within each service type and level of care.	LAA		
Provide combination treatment	-Programs bring together pharmacotherapies and verbal-based therapies with behavior reinforcement interventions to improve overall patient adherence	-Review of OMS and other Beacon data if available and applicable for overall range and type of service episodes provided, by individual and/or program levels. -Policy and Procedure showing clinical decision-making framework that includes how program makes treatment decisions, criteria used, range of services offered and how services are determined within each service type and level of care.	BHA BHA/ LAA		6
Engagement	Use of Evidence-Based Practices to incentivize engagement and adherence (to treatment)	-Policy and procedure identifying Evidence-Based Practices that incentivize engagement and adherence to include program orientation protocol implemented when appropriate for patient.	BHA/ LAA	Funding considerations	6
Management of concurrent misuse of other drugs	-Programs provide concurrent treatment for multiple substances, addresses all alcohol and drug use, including tobacco and gambling disorders.	-Policy is in place to instruct staff to assess for other drugs of misuse; include in treatment plan and address in treatment sessions	BHA/ LAA		7, 2, 6

Discharge	-Use of a process for administrative withdrawal based on established protocol which is reviewed by a medical supervisor, implemented on an individual basis, using sound clinical judgment and with supportive options available to patient and review by treatment team. Elements of a desirable discharge protocol are outlined in guidance documents. -Ongoing drug use is not necessarily a reason for discharge unless patient refuses recommended care. -The program shall offer to transfer patients to a program that may better meet patient needs.	-Policy and procedure identifying process for administrative withdrawal, to include medical supervisor approval and selected suggested elements from guidance document.	BHA/ LAA		7, 6

Resource Documents-

1. Substance Abuse and Mental Health Services Administration. *Federal Guidelines for Opioid Treatment Programs.* HHS Publication No. (SMA) PEP15-FEDGUIDEOTP. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015 (http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf).
2. SAMHSA-Treatment Improvement Protocol 43 (TIP 43): Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs (http://www.ncbi.nlm.nih.gov/books/NBK64164/pdf/TOC.pdf). Chapter 14, Administrative Considerations
3. Baltimore Mayor's Heroin Treatment & Prevention Task Force Report, July 2015, Chapter III. Practice Standards Workgroup Report (http://health.baltimorecity.gov/sites/default/files/Mayor%20Heroin%20Treatment%20Prevention%20Task%20Force%20Final%20Report%20July%2013%202015.pdf)
4. Baltimore Mayor's Heroin Treatment & Prevention Task Force Report, July 2015, Chapter IV. Neighborhood Workgroup Report
5. Baltimore Mayor's Heroin Treatment & Prevention Task Force Report, July 2015, Appendix III. Service Agency good Neighborhood Agreement
6. Baltimore Mayor's Heroin Treatment & Prevention Task Force Report, July 2015, Appendix IV. Suggested Practice Standards
7. The Joint Commission 2015 Standards for Behavioral Health Care, Care Treatment & Services sections (pages 6, 17, 41 & 125).

Attachment 3
Final Approved Recommendations for Implementation by Behavioral Health Administration (BHA)
December 15, 2016

Requirements	Evidence
Related to Impact on Community	
Programs should develop specific policy/procedure for establishing good community relations in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA) guidance.	-Proof of Policy and Procedure related to establishing/maintaining good community relationships and attempts to meet key community groups; OTPs should take steps to educate, engage and participate in the community they represent so as to coexist in a mutually respectful manner; -Use of Guideline Documents provided by BHA related to establishment and maintenance of good community relationships.
Programs should maintain clean and orderly facilities.	-Proof of Policy and Procedure related to Facility Maintenance and expectations and mechanisms to maintain cleanliness of facility and premises; -Documentation of regular patrol of premise; -Premises are clean and reasonably free of trash.
Programs should provide sufficient space, equipment, hours of operation and staffing to provide all required services and ensure that program operations do not affect community life adversely.	-Proof of Policy and Procedure regarding elimination of people waiting outside of building for services, detailing mechanisms used to ensure sufficient patient flow management during normal hours as well as in emergency weather conditions; -Facility is free of persons waiting outside of building in line from time program opens for services.
Programs should maintain and enforce pre- and post-treatment patient flow management **(**loitering**)** policy.	-Policy and Procedure to include: • Peer survey or method of determining individual or overall causes with modifications in patients' treatment plans as necessary; • Referral procedures to provide/refer for alternative recreational/socialization or recovery support activities; • Written instruction to patients regarding expected conduct related to leaving facility and premises promptly following service completion, and consequences for failing to comply with treatment and/or other program expectations; -Show lack of problematic conduct related to leaving the facility and

Requirements	Evidence
	general vicinity of program promptly following service completion.
Programs should maintain and enforce safety and security of program participants in accordance with SAMHSA guidance.	-Proof of Policy and Procedure detailing methods used to monitor the exterior of the program's building, and having trained staff available to intervene in cases of disruptive conduct; -Documentation of regular monitoring of premises.
Programs should maintain efforts to control diversion of medications.	-Proof of Policy and Procedure that includes instruction to patients regarding expected conduct, diversion control policies and interventions as guided by senior clinical and medical review.
Programs and communities should engage in ongoing discussions to collaboratively address issues as necessary and have a mechanism for addressing concerns, in accordance with SAMHSA guidance.	-Proof of Policy and Procedure for Problem Resolutions to include documentation of community concerns and resolution efforts and LAA involvement to facilitate and to arrange for mediation if necessary; -Use of Community Relationships Guidelines Documents.
Requirements	Evidence
Overall Quality Standards	
Establish a Supervisor to Trainee ratio.	BHA will make a formal request to the Board of Professional Counselors and Therapists to establish a Supervisor to Trainee ratio.
Programs must consult Prescription Drug Monitoring Program prior to prescribing, increasing take-homes, and every 3 months as part of treatment plan review.	Documentation of review in patient chart.
Programs must offer a prescription for naloxone to all patients.	Documentation of offer of prescription.
Programs should identify areas of medical/clinical training needs and implement training which could include reduction of internal stigma.	Document mechanism to assess training needs of staff, to reflect patient satisfaction survey and accreditation results.
Programs should provide hours of service that meet the needs of the majority of patients, including before or after traditional 8-5 work day.	-Document mechanism to assess needs of patients in determining hours. - Documentation of information on programs with alternative hours.
Programs should provide medical coverage to include description of timeliness of response to patient needs.	-Documentation of daily medical coverage available which includes type of provider available for coverage; - Policy & Procedure on timeframe for initial response; -Documentation that medical need was addressed with patient, and when expected resolution of medical need will occur; -Documentation of patient survey question to address if medical staff communicated expected timeframe for resolution of a medical issue and if staff followed through with timeframe as indicated.
Programs should share information between behavioral health and somatic care providers. Proper patient consent must be obtained by the	-If treatment plan indicates need for psychiatric, medical or other substance use disorders providers, document: 1) existence of other

Requirements	Evidence
program to seek medical records from other healthcare providers.	providers, 2) release of information for said providers, 3) attempts to contact said providers to coordinate care, and 4) coordination with said providers prior to establishing take-home status. -Documentation of following through with items on the treatment plan.
Programs should employ a multidisciplinary approach for treating patients with chronic pain disorder and addiction, including involving addiction medicine specialists and pain medicine specialists.	-Identify and address issues regarding chronic pain by including it in the patient's treatment plan, use of internal clinical resources, or documenting ongoing coordination with outside clinicians who are treating chronic pain; -Provide clear documentation of rationale and ongoing plan for continued consideration when patients are being prescribed controlled substances, other than methadone or buprenorphine, for the treatment of pain.
Programs should facilitate management of or manage co-occurring psychiatric disorders. *Note: BHA will be approaching CARF as to the need to include reference to use of a multidisciplinary team in this process, as in previous standard*.	Identify and address co-occurring psychiatric disorders by including it in the patient's treatment plan, use of internal clinical resources, or documenting ongoing coordination with outside clinicians who are treating co-occurring disorders. Co-occurring disorders, which include multiple drug use problems as well as psychiatric and medical disorders, are most effectively treated and managed at a single treatment site. -Facilitate psychiatric evaluation for any patient exhibiting symptoms of severe anxiety or other psychiatric disorder; -Facilitate psychiatric evaluation for patients who are prescribed benzodiazepines for extended periods of time; -Provide clear documentation of rationale and ongoing plan for continued consideration when patients are being prescribed benzodiazepines for the treatment of an anxiety disorder or other disorders, to include documentation of discussion of inherent risks of co-prescription of benzodiazepines and opioids.
Programs provide concurrent treatment for multiple substances, addresses all alcohol and drug use, including tobacco. *Note: BHA will be considering pursuit of additional regulation or accreditation standards related to concurrent treatment of gambling*	Policy in place instructing staff to assess for other drugs being misused; include in treatment plan and address in treatment sessions.

Requirements	Evidence
disorders.	
Use of a process for administrative withdrawal based on established protocol **prior to initiation of withdrawal protocol,** which includes: • offer to transfer patient to a program that may better meet patient needs; • review by a medical supervisor; • implementation on an individual basis; • use of sound clinical judgment; and may also include: • use of peer support; and • review by multidisciplinary treatment team.	Policy and procedure identifying process for administrative withdrawal, to include medical supervisor approval and selected suggested elements to be provided in guidance document.
Programs should establish a patient outcome tracking system that results in an internal quality improvement process to include individually selected program measures such as attendance, Against Medical Advice discharges, retention at 30, 90, and 180 days, and 1, 3 and 5 year marks.	Documentation of patient outcome tracking system.
Programs should establish a protocol re orientation at time of admission and when stabilized, to include program handbook, rights and responsibilities, and circumstances that could lead to discharge. Programs should attempt to ensure that the patient understands the language, terminology, and clarify 1-1 or in group setting as necessary.	Sample protocol will be made available within Guidance Documents to be developed.
Care is provided based on outcome and individual response.	-Policy and Procedure showing clinical decision making framework that includes how program matches treatment decisions, criteria used, range of services offered and how services are determined within each service type and level of care, against patient needs, to include: • varying number of sessions of both individual and group based verbal therapies; • different types of interventions over the course of a treatment episode; • client centered menu of services; • services provided based on needs of clients as determined by client population.

Appendix A
Stakeholder Workgroup Membership

Kathleen Rebbert-Franklin, Chair	Behavioral Health Administration (BHA)
Laura Burns-Heffner, Staff	BHA
Dr. Kim Bright	BHA
Audrey Chase	BHA
Margie Donohue	BHA
Frank Dyson	BHA
Rachael Faulkner/Lisa Fassett	BHA
Barry Page	BHA
Christina Trenton	BHA
Rebecca Frechard/Elaine Hall	MA
Major James Pyles	DHMH
Dr. Geoffry Ott	SEC
Dr. Joseph Adams	Hamden Health Services, MATOD
Minu Aghevli	VA Maryland Health Care System, MATOD
Ray Aramelli	Serenity, MATOD
Howard Ashkin	MedMark, MATOD
Dr. Robert Brooner	JH Bayview, MATOD
Adrienne Breidenstine	Behavioral Health Systems Baltimore
Marian Currens	CAM, MATOD
Sarah Drennan	Frederick county BBH
Jessica Formicola	Sinai Hospital, MATOD
Dr. Jim Gandotra	Johns Hopkins/Bayview
Christi Halpin	MD Coalition
Darrell Hodge	Advocate
Dr. Babak Imanoel	AA Co. Addictions, Behavioral Health and Northern Parkway Treatment, MATOD
Sister Yeshyah B. Israel	Pimlico Merchants Association, Inc.
Nicole Jones	Advocate
Dana Madden	JH Bayview, MATOD
Nicole McCleaf	Serenity, MATOD
Alan Mlinarchik	Central Baltimore Partnership
Dr. Yngvild Olsen	IBR Reach, MATOD
Jayme Severn	On Our Own MD
Ryan Smith	BHSB (LAA)
Joan Sperlein	IBR Reach, MATOD
Dr. Ken Stoller	JH Broadway Center, MATOD

Dr. Mishka Terplan	BHSB, MATOD
Nancy Turner	Serenity, MATOD
Mary Viggiani	Baltimore Co. BBH (LAA)
Barbara Wahl	Concerted Care Group, MATOD
Vickie Walters	IBR Reach, MATOD
Chuck Watson	BD Health Services, MATOD
Adam Winepol	Advocate