**Department of Health and Mental Hygiene**

**Behavioral Health Administration**

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

**Minutes for September 27th, 2016**

Attendees: K. Rebbert-Franklin, BHA; C. Trenton, BHA; L. Burns-Heffner, BHA; K. Bright, BHA; B. Page, BHA; M. Donohue, BHA; F. Dyson, BHA; R. Faulkner, BHA; E. Hall, MA; G. Ott, SEC; H. Ashkin; M. Currens; C. Halpin; Y. Israel; D. Madden; Y. Olsen; J. Severn; K. Stoller; B. Wahl

On Phone: D. Madden; J. Sperlein; V. Walter

Non-Workgroup attendees: Lisa Lowe

1. Welcome and Approval of Draft Minutes from September 13th meeting

Minutes approved as provided. Two suggestions were made for changes to the Recommended Standards Grid: Medical coverage- change “rapid” to “timely” and under

Patient Outcome, evaluation measures –leave in 30 day retention.

A comment was made regarding Board of Professional Counselor meetings being open to the public, and when the next meeting is being held.

1. Continue work on Overall Quality Standards

*Coordinates Care, Employ a multidisciplinary approach -*

* BHA stated that suggested recommendations are subject to review by the Office of the Attorney General, and OAG requested 42 CFR reference to be included as implementation considerations in 3 areas.
* OMHC’s are required by COMAR to have a psychiatrist (see citation in grid). Therefore, the workgroup could consider adding a staffing requirement for OTP’s that could include addiction psychiatrists with appropriate training and/or addiction medicine specialists.
* There’s a big overlap between chronic pain and SUD, patients often don’t get good pain management treatment. OTPs are in a position to provide good combined care, how can we incentivize programs that provide chronic pain treatment? There is growing evidence that some of same interventions are effective with both issues. Not every OTP can meet this expectation, so therefore, an alternative may be to require screening and referral to a pain management physician that could coordinate care and consult with the OTP. Providers in the room indicated they are seeing a lot of chronic pain patients in OTPs.
* Suggest we align with accreditation standards; be careful not to hold OTPs to higher standards. Perhaps include directory of programs that provide specialty services such as pain management, similar to deaf services. Recommend warm hand-off? General agreement with this concept was expressed.
* For Suggested Recommendations-1- a. 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, and 1-b.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; 2-Have a registry of programs self-identified as equipped as specialty providers for whatever specialty; 3-Incentivize those that provide the specialty. 4-Ensure universal training for baseline level competency re chronic pain, etc.-(refer to sub-group for training in general). Training plan should extend beyond OTPs but can start there.
* Would this be an area to include communication between SUD providers as well? Goes to issue of patients bouncing from program to program, often no communication between programs when transferring patients. Important to have good communication prior to transfer-Suggest we discuss this issue in the last category re transferring patients.

*Management of co-occurring psychiatric disorders-*

* This seems very similar to the last issue, should address as part of screening, and then referral. May be able to coordinate services with other specialty service.
* What should happen beyond screening, refer to treatment and coordination of care? –what else would we need to see? We could look at charts, look for ROI, & communication between providers, check-ins. This is hard to do without a record review. Having consent in chart is first step, be aware that some patients refuse.
* Sometimes symptoms are visible to staff at OTP, but the patient doesn’t have an identified mental health provider. OTP staff needs to be able to recognize & identify people who need to be connected to psychiatric care. – (also refer to sub-group for training).
* Sometimes patient’s self-report psychiatric disorders, but once they are properly medicated; their need for service may disappear.
* It is important to follow up and have consistency over system as to when problems are identified, that they are followed up. Treatment plan reviews are key in this.
* Having staff that are trained and can intervene when someone is symptomatic is important.
* Are we saying that there are advantages to having more licensed staff available to identify and address psychiatric issues, do emergency petitions, etc.?
* Where does CARF stand on this? Screen & refer, but does not go as far as to require mental health staff. What about a broader system response? CARF requires programs access resources for services not available in clinic, such as care coordination, etc. Doesn’t have to be in clinic, but address and refer. *Actual statement says “appropriate services for individuals who have co-occurring health and psychosocial issues are either: a. directly provided or b. referred appropriately. When possible, co-morbidities are concurrently managed on site.* *This includes management of multiple drug use problems as well as psychiatric and medical disorders. Co-existing conditions, especially in persons from disenfranchised populations, are most effectively treated at a single site.*
* Another factor is the high degree of lack of interest in the patient population in participating in these services when they are available.
* It’s important to have someone on staff available to intervene when symptoms are exhibited.
* How would BHA monitor? Proof of policy and procedure, sampling case records? Make sure we align with CARF and other regulations.
* Make sure there is a policy to communicate.
* Is there an ability to access data measures from Beacon by provider to get sense of prevalence of these conditions in programs, and cross match with mental health provider claims? Does Dr. Ott know the answer to this? No, not as familiar with mental health data.
* Suggest dashboard of data measures- looking at % patients in treatment for mental health & in OTP
* Anyone with an ongoing benzodiazepine prescription needs to have a psychiatrist prescribing it.
* A problem noted with that requirement is that these prescriptions don’t always come from psychiatrists.
* Best practice would indicate the need for a psychiatrist.
* Issue with benzodiazepines is complicated; need to weigh risks of not taking a patient on benzodiazepines.
* Not suggesting that we not treat a patient on benzodiazepines, it’s just that patients are not always able to readily access a psychiatrist in timely manner.
* Do we have philosophical agreement to encourage benzodiazepine prescriptions to only be provided through a psychiatrist? No agreement across the board on this, considering complications from MA, & patients under care without insurance.
* Is this an epidemic to the point where there needs to be training for doctors on this? Across the state we hear the same issue of state shortage of psychiatrists.
* Co-prescribing these medications is contraindicated, every one of those patients deserve a psychiatric evaluation and treatment if taking medication that is problematic –may take some time, but need to get them in to proper care.
* Having a psychiatrist doesn’t guarantee good care, can use psychiatric extenders like nurse practitioners.
* At minimum, programs should address recent FDA black box warnings.
* Suggest if it is medically necessary to be on a benzodiazepine, prescribe and monitor in planful way, with proper psychiatric evaluation. Must have a plan in place. This should be a standard.
* Is there something inherent in that medication that requires it to be prescribed by a psychiatrist?
* BHA called for a vote on whether or not the prescribing physician for patients using benzodiazepines should be a psychiatrist. This would mean that patients with benzodiazepine prescriptions from a general practitioner be transitioned by OTP staff to a psychiatrist. No vote was taken as workgroup was not satisfied with options. The benzodiazepine issue is broader than who is prescribing. Don’t believe there is a common ground-agree that it is important, and dangerous, but good care is hard to get. A request was made to come back to this topic.
* **Emailed comment**: Our policy at ATS is that patients cannot be prescribed benzodiazepines. We will either work with the existing provider to help the patients taper off of benzodiazepines or have the patient seen by Dr. Gandotra to work on tapering off of them. From 2006-2009, I was the supervisor of our CAST program (Community Access to Specialized Treatment). During that time period, programs affiliated with BSAS within Baltimore City would refer patients to our program for IOP care. We worked with the programs and their patients to provide a higher level of services than they were able to provide and help them taper off of benzodiazepines. It was clear back then that most programs were not equipped to handle this problem. It would really be helpful if all programs were on the same page with benzodiazepines so that patient’s weren’t going from program to program to avoid addressing this problem.
* AATOD is getting close to releasing recommendation in this area.
* Can BHA determine real time access to psychiatric care, as wait times are long and access is limited in some areas of the state? If psychiatrist access isn’t available or if the general practitioner is exceptionally skilled, programs could work with BHA re particular exceptions.
* From focus group input, people want care coordination within OTPs. Every situation is different. Some PC doctors are good providers.
* Should we just be addressing benzodiazepine use in general, beyond who is prescribing? Issues such as withdrawal management, and are there other ways to increase access to external benzodiazepine withdrawal?
* Urinalysis does not give a specific reading as to whether the result is for a prescribed or illicit benzodiazepine. What is the expected %? There is so much more to this issue that really relates to why we are here, such as pill selling, nodding, & misuse.
* Bottom line is if a person really needs it, they deserve a psychiatric workup.
* An example was provided of a patient who had medication inappropriately reduced by a psychiatrist and had a seizure, so-agree in principle, but need to look at the whole picture.
* BHA stated that the minimal standard of care is screening for co-occurring disorders is necessary and patients should receive closely coordinated care.
* CARF reference- “appropriate services for individuals who have co-occurring health and psychosocial issues are either: a. directly provided or b. referred appropriately. When possible, co-morbidities are concurrently managed on site.

*Adaptive care is provided based on outcome and individual response-*

*-Varying doses* *of both individual and group based verbal therapies*….

* Should be aligned with accreditation and regulation expectations.
* This goes to individualizing care.

-*Patients must be offered a menu of services…*

* A reaction expressed to word “must”, suggest change to “patients *are* offered a menu of services”
* Needs change with individuals enrolled in the program. Services should be variable, as per patient needs as identified by survey, etc.
* 1-philisophic agreement for variety of services; 2- variety based on patient need
* This should be the one standard we do require, assuming re-bundling.
* This doesn’t just affect those providers in the room, are we willing to say this for all programs?
* CARF and Beacon require this, must have individualized care, not cookie cutter.
* This is already a requirement; why not spell out in a mandatory fashion? Seems to be a core piece.
* Would Beacon be able to identify how much clinical care is going on in a program, match to population being served? Data pull would be to give a program feedback, like patient satisfaction information is for program.
* FYI, Beacon will start their audits soon, started with large providers, now its 2 years later, expect audits of smaller providers.
1. Assign Tasks for Next Meeting
2. Next Meeting: October 18th, 2016 **@ 2:30 pm** Dix Building

**Final Remaining Meeting:**

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