New Federal Regulations in Opioid Treatment Programs: What does this mean for Massachusetts? Webinar Transcript

Melissa Schoemmell:

Welcome to the new federal regulations in OTPs. And what that means for Massachusetts Webinar, training, learning opportunity for for all of you today. Thank you for being here.

Next slide. Just a couple session reminders. If you could introduce yourself in the chat and let us know who you are, where you're coming from, and, what you're looking forward to this summer. Let us know, a little bit about yourselves. The the JSI and the TA center is, new to all of you. And we are looking forward to getting to know all of you and be a support system to all of you. So, love to get to know you. Please introduce yourself. And if you are able to turn your camera on, we would love to see your faces. I do recognize it's probably been a long day already. And if you need to take a break and and not have your face on camera, that is completely okay. And we are going to be taking questions today via the chat. So, I'd love everyone putting in their chat introductions. Throughout the presentation, we really want to know kind of what is on your mind, what questions you have, about the content we're going over, that will really help to inform some of the later sessions that we have so we can get into the the questions you're asking and those details. And at the end, we're going to have an evaluation. So this is our second training on this particular topic, but there will be a lot more opportunities with the JSI, OTP TTA center with, in collaboration with BSAS. And so, if you fill out your evaluation at the end of today's session, that is just giving us information on how to better help you, and support you. So please do that. And, we really appreciate the feedback. And if you're having trouble hearing me, seeing me talking and communicating, anything IT, Gretchen on the JSI team can can help you out there.

Next slide please. All right. So I just want to introduce our presenters for today. You can see our faces on the screen. I'm Melissa Schoemmell. I'm joined by Jo Morrissey, Lili Njeim, and Nadia Syed, who are all part of the OT, OTP TTA team. We all work at JSI, and are contracted with BSAS. We have a. This is not even half of our team. We have a lot of other folks on the call who are, in support of this program and really working to, to be, responsive to the field and to the needs of the department. So, I just want to acknowledge that this is just the at the tip of the iceberg of our team. And we're really excited to be here. We, the bureau, just a little background. The bureau does. Oh, if everyone can just mute, just heard a little feedback. The Bureau of Substance Addiction Services contracted with JSI, which is a public health consulting organization. We are based out of Boston. And we were contracted to start a new training and technical assistance center, and specifically for opioid treatment programs. We were working on a statewide needs assessment, which had included review of patient satisfaction data. We conducted focus groups with staff. We put together a literature review, and had

consultation with staff, a staff advisory committee working within the OTP setting. So we we know that this time is critically important for OTPs and just really excited to support you through implementing, the changes that are on the horizon, and supporting promising practices to help increase access to medications for opioid use disorder. So thank you for being here.

Next slide, I'll walk through our agenda real quick. So you know what we're up to today. So just another reminder that we are recording the presentations. And that recording will be shared. We will provide a high-level update on some of the changes. Sorry. We will be, providing some background information on the changes that are happening at the federal level. And, what that, means for, for Massachusetts, particularly the waiver from certain regulatory requirements and guidance that was released by BSAS earlier this year. So walking through that document, pretty point by point, on the the points there. We will be doing some engaging activities to see if folks, how folks are feeling about all of that. And we'll wrap up with an evaluation and the upcoming opportunities and how we can engage going forward. I am going to pass it over to my colleague Lili, to talk through, some background information on how we got here today. So thank you, Lili. And thanks everyone again for being here.

Lili Njeim:

Thanks, Melissa, for the wonderful introduction. So as Melissa said, I'm going to talk about a bit of an overview and some background on why we're here today. But first, I'd like to let you all know that for the purpose of this presentation, we may refer to 42 CFR part as the Federal Regulations. And 105 CMR 164 .000 simply as the DPH BSAS regulations. So the US Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration, as we all know, as SAMHSA developed the final rule which modifies the current federal regulations. Well, now they're different, not current anymore. So the Bureau of Substance and Addiction Services business, BSAS under DPH, have revised their regulations pertaining to the licensure of substance use disorder programs to align with revisions to the federal regulations, and BSAS also issued blanket waivers, which we will dive deeper into in this presentation.

We have three main objectives for today. So we hope that by the end of the webinar, you all will be able to one, describe the Massachusetts waiver from certain regulatory requirements and guidance. Two, state how the waivers and guidance apply within the OTP setting. And three, provide suggestions and feedback regarding what topics in the new regulations may require training and technical assistance.

But before we delve into this exciting stuff, we wanted to do a quick check in with you all. So if you can, please open a new tab. Or open your browser and head to Menti.com. And my colleague Nadia will guide you through this process.

Nadia Syed:

Awesome. Thanks, Lili. Yeah. So if you also want to bring out your phone. Put in Menti.com, you can do that as well. I'm going to share my screen with the instructions too. So it has. You can either scan the QR code or go to menti.com and put in the code 1218 2407. I think Audrey's also going to put that in the chat. And so when I advance the slide, you'll be able to see the first question.

So how are you feeling today. So with menti what's really cool is you can see live results. So as you click on it you're going to see these these bars go up and down. So it's going to be kind of interesting to see what how people are feeling currently about these these regulations. If you have any issues please let us know. Message us in the chat.

Lili Njeim:

That's exciting to see so far. A bunch of you all are comfortable and clear and excited.

Nadia Syed:

Couple nervous. That's okay. Might be more. You could be overwhelmed as well. No, no shame in how you're feeling.

Melissa Schoemmell:

We give it another 10 seconds. Let everyone get those last thoughts in on how you're feeling. I know menti is is new and you may need some extra time to get on to share how you're feeling.

Nadia Syed:

Okay. Yeah. I mean, feel free to continue to add into this poll. We can also share these results. If it's helpful.

Lili Njeim:

Thank you all for participating in that. For the few that are nervous, that's okay, because we're here to help. But it's really, awesome to see that so many people are excited and comfortable. And our goal is that by the end of the session, you're feeling a little a bit less nervous if you are. And hopefully, more excited and comfortable.

So here's the timeline for the new federal regulations. The revisions were released about five months ago in January, and they went into effect about two months ago, almost three now in April. And full compliance of these changes are expected on October 2nd. So this is the first significant change to opioid treatment program treatments and methadone medication delivery standards in over 20 years. And these changes are supported by

evidence-based research, and they draw on many lessons learned from necessary policy and guideline changes, as well as regulatory exemptions, specifically, the exemptions that were initiated during the Covid-19 public health emergency.

It's a new day in OTPs. With this revised rule, SAMHSA's created many opportunities for increasing access to treatment. BSAS aligns with SAMHSA and shares the underlying values including shared practitioner and patient decision-making, practitioner's clinical judgment, responsive flexible OTP services, evidence-based practices, and the use of non-stigmatizing language. And these shared values create opportunity to see more patients, to improve retention in care, to expand the reach of OTP with mobile units, and to expand the reach of OTP with medical units and other services.

So BSAS aligns with SAMHSA Revised Rule, which supports the low barrier access to care by increasing access to treatment for people with SUD. The revised rule supports people by helping prevent injury, infectious disease transmission and death, and it meets people where they are and promotes any positive change. It also addresses social determinants of health and focuses on increasing protective factors. My colleague Audrey provided a link in the chat to a resource by SAMHSA regarding low barrier models of care for substance use disorders. And while the primary audience may be for PCPs, FQHCs, and other health care settings and focuses on the Bup, the sentiments in this advisory echo those in the final rule for those who are interested in that resource.

All right, so we've given you a bit of general context about the updated regulations. And I'm sure you want to know how does this apply to me. What does this mean for my OTP So let's get into it. We're going to go through the guidelines for licensed and or approved providers and review BSAS' waivers from certain regulatory requirements. And I'm going to now pass it off to Jo to go through the regulations by topic area.

Jo Morrissey:

Thank you, Lili, I really appreciate it. So I'm going to do something I normally don't do. Then I'm going to turn off my video feed. My computer has decided it does not like the heat and I'm experiencing quite the lag. So instead you're going to have to look at my mug while I go through these slides. I appreciate your flexibility. And besides, I posed for that one. So I'm Jo Morrissey, I'm a senior associate here at JSI, and I'm going to walk you through some of the regulation topics that are on this slide over the next couple of slides. And these are the areas that really have been impacted by the final rule. So after I review these top topics that are listed, we're going to have also another quick check in on menti. So it's great that we had that practice earlier. And then Melissa will review the topics and we'll have it during that check-in. And then also I just want to remind you, as I go through this presentation, we know that you are going to have lots of questions. And so today our job is to provide you with an overview, an uninterrupted overview of these changes, but that we really want to hear from you. And we encourage you, as we go through this presentation, to please drop your questions into the chat box or direct your questions. If you don't want to share your question with everyone, you can direct message

Gretchen and she will collect those for you. And we are collecting all the questions to then compile and answer and submit into our Frequently Asked Questions document within the next couple of weeks after this presentation. So I just wanted to make sure you knew how we were playing this game.

Okay, so required services. So, just a reminder that, the required services for the OTPs that they must provide include the adequate medical counseling, vocational, educational and other screening, assessment and treatment services to meet a patient's needs. It's important that those are available with the combination and frequency of services tailored to each individual patient based on their assessment. So it's that sort of patient-centered approach where those although you're still required to provide those, those needs, they they need to be offered to meet the needs of those individually tailored assessments from each of your patients.

Another update in the federal regulations that was mirrored and carried over into the BSAS regulations are the definitions, roles and responsibilities for the medical director and practitioners. The department, as in BSAS, is issuing a blanket waiver from the requirements that only a medical director shall ensure all dosing of an opioid agonist treatment medication is ordered. Prior to the federal regulation changes, only physicians could initiate and make dosing changes in an OTP. The final rule, the federal final rule, allows for practitioners to initiate and make dosing changes, and to write all medication orders in an OTP. That includes mid-level practitioners. So therefore a mid-level waiver exemption submission is no longer needed from SAMHSA or the state opioid treatment authorities, the SOTA. Therefore, mid-level exemption applications are no longer being accepted by BSAS as of April 2nd, 2024. And again, to drive that point home, appropriately licensed mid-level practitioners are now able to order all medications for an opioid use disorder in an OTP.

Another change is in the assessment in the examinations. It is now the updates to the new regulations clear a path for removing barriers and expediting OTP admissions, ultimately benefiting the program and patients in reducing the time to get into treatment. The next several slides will discuss these changes and options in more in depth, but as an overview, these are intended to help expedite and streamline OTP admissions, and the updated regulations separate the admissions intake into two separate sections.

The first section is the screening examination and allows for medication to commence at the time of intake. SAMHSA and BSAS recommend that methods of medication induction not be delayed until full examination is complete. The initial medical examination must be completed by an appropriately licensed practitioner, as defined in the Federal Message and Massachusetts Regulations. This is updated language to reflect the additional scope of practice granted to those mid-level practitioners in an OTP. So the part one is the screening examination. The screening examination ensures that the patient meets the criteria for admission. It also ensures that there are no contraindications to treatment with an MOUD. And note that the refusal of lab testing for co-occurring physical health conditions should not preclude a patient from accessing treatment, provided that such refusal does not have the potential to negatively impact treatment with medications.

The second part is a full history and examination. It should be noted that the serology testing and other testing deemed medically appropriate by the licensed OTP practitioner should be based on the screening or a full examination, and drawn not more than 30 days prior to the admission at an OTP. And may be part may become part of the full history examination. Please note that BSAS has recently learned that only the screening portion of the medical intake can be done by telehealth, with caveats. The physical examination, that second part must be done in person within 14 days of admission. BSAS has consulted with SAMHSA, seeking clarification regarding this and whether an in-person exam versus the use of telehealth is required. SAMHSA stated that they intend on providing further guidance on this as soon as practical. BSAS will keep OTPs updated as we learn more.

So some common questions are what if the practitioner is not an OTP practitioner? And what if the examination is performed outside of an OTP? So the other changes that these changes can help OTPs expedite the admissions process. And these new regulations allow for a practitioner outside of an OTP to complete the screening examination. This is an opportunity to decrease the amount of time a patient may wait to get into treatment, as the OTP can now review a non-OTP practitioner's examination results, document that they agree and reviewed, and use that as the required screening exam prior to writing the medication order. It is recommended that OTP collaborate with their local referral partners to discuss what information is needed and helpful in order to expedite the admissions process for patients. If the OTP practitioner is not an OTP, if the practitioner is not an OTP practitioner, the screening and full examination list can still be performed by them, but not done more than seven days prior to admission. Any written results and narrative of the examination from an outside OTP provider, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws to the OTP and verified by the OTP practitioner.

More on assessments and examinations. The annual medical exam not just the admissions process, but this the subsequent annual medical exam, must be completed by an OTP practitioner in addition to the periodic behavioral health assessments. The combination and frequency of various services should be dictated by an individualized assessment and shared decision-making between the patient and the clinical team. The plan must be reviewed and updated to reflect the responses to treatment and recovery support services that has been experienced by the patient. Adjustments are made to the plan that reflect changes in the context of a person's life, including their current needs for and interest in medical, psychiatric, social and physiological services. Additionally, current needs for an interest in education, vocational training, and employment services should also be addressed.

It is important to note that drug screening shall, at a minimum, test for opioids, including but not be limited to, buprenorphine, methadone, and fentanyl. Screens can also test for cocaine, benzodiazepines, alcohol and any other drugs that the licensed or approved provider determines are clinically indicated or as approved by the Commissioner of the Department of Public Health and listed in BSAS guidance. Furthermore, drug screening does not preclude the distribution of legal harm reduction supplies that allow for an

individual to test their own personal drug supply for adulteration with substances that increase the risk of overdose. Drug screening is to be used as a clinical tool to aid in treatment decisions, and trauma-informed care and measures should be incorporated into program policies and decision makings. Next slide please.

More on assessment and examinations. I'm not going to read this list to you, but I think it’s pretty intuitive. So these new regulations remove these potential barriers to accessing OTP treatment. And BSAS has aligned with these changes through the provision of regulatory waivers. And at this point, I'll remind you that we do intend to share out the slides once we do finish these presentations. So if you're feverishly writing notes, I apologize. We will be sharing these slides out later at a later date.

Assessment and examinations. Some more on this. As mentioned, the underlying spirit of these new regulations call for individualized treatment and shared decision-making to meet each patient's needs. The new paradigm prioritizes the need for patients to get and stay in treatment. Note the term treatment plan has been changed to care plan. This demonstrates the shared decision-making, which should occur when developing each patient's plan to reflect their own specific goals, needs and circumstances. There should not be a one-size-fits-all when approaching to care planning. Care plans should, however, be based on an individual, based on an individualized assessment created using shared decision making between the patient and the clinical team, updated, reviewed with the patient and amended as necessary. Again tailored to meet each patient needs. Reflective of each patient's individualized counseling needs and also ability to engage in counseling. And, their initial care plan should be prepared within 14 days of admission and include the initial psychosocial evaluation results.

One important update to these regulations is that patients should not be discharged from treatment for not attending counseling, and medication should not be contingent upon attending counseling either.

Next topic medication dosing and supervised withdrawal. As a reminder, medical orders dosing initiation decisions can be determined by practitioner who can be either either a physician, physician assistant, or advanced practice registered nurse. In line with providing individual care and not a one-size-fits-all all approach, the new regulations allow for the use of practitioners' clinical discretion when admitting patients. Specifically, initial dosing caps for the first day of treatment has been increased to a cap of 50mg. However, these initial caps can be increased if the OTP practitioner finds a sufficient medical rationale which must be reported in the patient's medical record. Examples include potentially transferring from the patient from another OTP, or the initial dose does not alleviate withdrawal symptoms.

More on medically supervised withdrawal. The following points are specific to medically supervised withdrawal. In alignment with the changes to the federal rule, the department waived the one week waiting period requirement between withdrawal attempts. Providers should use clinical judgment in consultation with the patient when deciding on supervised withdrawal and the rationale for the decision should be recorded in the patient's file. Waived, BSAS has also waived the requirement that a physician determine the rate of

decreased dosing, as opposed to instead of either a program physician or a practitioner can make that determination for each patient. The department waived the requirement for licensed or approved providers to obtain at least one drug screen per month, and instead, there should be at least. I'm sorry I went off script. The department has waived the requirement for monthly drug screens during the withdrawal period if it extends beyond 30 days. The department has also waived the requirement prohibiting the licensed or approved providers from providing take-home medications for withdrawal management. This adjustment aligns with the new federal OTP regulations for take home medications. And additionally, licensed or approved OTPs are expected to evaluate each patient's eligibility for take home medications upon admission, and monthly during treatment. And with that, I'm going to hand things over to Melissa to walk us through a sort of a recap, get a temperature in the room and see how we're doing, and then do another menti. And again, I'll remind you, if there are any questions, please feel free to direct chat them or drop them in the chat box. We will be collecting those and answering those after within the next couple of weeks. Melissa, take it away.

Melissa Schoemmell:

Thank you, Jo. I know that was a lot of information. And and details. So, we are going to liven up a little bit and switch screens to our our second Menti poll. And you can see in the chat that Audrey put in the link in the code there. We already know how are feeling.

But now a little pop quiz. The definition of a practitioner now includes…and, I'm going to give you a few seconds to to answer that. And, we can all watch cookie. And, and it's pretty clear, that we were all paying attention. I don't know if now it's kind of like a bias thing. And anyone who's like, I think it was a counselor or clinical supervisor is like, but everyone else is saying physician, physician assistant, or advanced practice nurse, registered nurse. You are all correct. That has been revised. And the the, new guidance. Another question. True or false? 50mg is the recommended cap, but the amount can be increased if the OTP practitioner finds medical rationale. I, I'm just looking at what the answer is here. We have two falses and 26 truths. But. Was that a trick question in the way that we phrased that? I'm wondering, we say false. 50mg is the recommended cap. But the amount can be increased if the OTP practitioner finds that rationale. That was written wrong. Now that I'm reading it over again and it was a trick question. You are all right. It is true. And and that is that is the true statement. So, first, thank you for paying attention. I think I need to put my thinking cap on in the next time I draft that. Sorry about that. Thank you for paying attention. Let's get those slides back up. I am going to run through the other side of that list that Joe had mentioned are the main topics of the the guidance that has been released.

So the first one being telehealth. So the expansion of the use of telehealth is another example of the intention of these regulatory changes to provide opportunities to increase immediate access to treatment and make treatment more accessible to patients, whether it is through the admission process or receiving counseling via telehealth. As discussed in one of Jo’s slides before, the physical exam needs to be performed in person, and

therefore the use of audio-visual telehealth only applies to the screening aspect of the evaluation, meaning the patient is screened and deemed appropriate candidate for MOUD. As discussed earlier, a non-OTP practitioner can conduct that physical exam. Thanks for that question. Keep them coming. As mentioned earlier, BSAS has consulted with SAMHSA seeking clarification regarding the use of telehealth for the entire medical intake, including the screening and the physical. Overall. Main takeaways. Each program is expected to develop telehealth policies and protocols, provide appropriate training to staff and abide by all relevant privacy laws in implementing this, this feature of the new regulations.

Next topic take home medications. Thank you Jonah. Unsupervised or take home medication doses may be provided under the following circumstances. There is a new risk benefit analysis that should consider the following items. Absence of active substance use disorders. Other physical or behavioral conditions that increase the potential for overdose, or the ability to function safely. Regularity of attendance for supervised medication administration. Absence of serious behavioral problems that endanger the patient, the public, or others. Absence of known recent diversion activity. Understanding whether take home medication can be safely transported and stored. And any other criteria that the medical director or medical practitioner considers to be relevant to the patient’s safety and the public's health. The decisions on dispensing MOUD to patients for unsupervised use shall be determined by an appropriately licensed OTP practitioner.

Next slide. Besides the revised criteria moving toward more of an individual risk-benefit analysis, time and treatment requirements have also changed. The changes allow for patients to receive methadone, take homes earlier and treatment, and also a higher number of take homes. This is more patient-centered. This is more of a patient-centered approach and considers patient preferences, their needs and values and allows take homes, the decision around take homes to be individualized. In order to align with the new take home regulations, the department waived specific regulations, including the requirement for a licensed or appropriate approved providers to dispense opioid agonist treatment medications daily under direct supervision at the facility. This aligns with the new federal OTP regulations on take home medications. The department waived the requirement prohibiting licensed or approved providers from providing take home medications for withdrawal management. This adjustment aligns with the new federal OTP regulations on take home medications. The department waived the requirement for the medical director to solely reduce the number of times patients must present themselves for observed medication ingestion by providing take home doses.

So next slide in order to ensure that patient that every patient is assessed for the amount of take homes that they're eligible for, it is the department's expectation that OTPs assess each patient's eligibility for take home medication upon admission, and monthly during treatment. The the spirit and intention of this requirement is to ensure that OT that the OTP is assessing for eligibility, but not mandating that the patient attend the assessment session. BSAS guidance discusses this minimally. And we're trying to outline the spirit and explanation. The cadence of the meeting schedule for the assessment should be discussed with the patient. And the patient should be offered a meeting schedule and

cadence that works for their specific situation. For example, if a patient receives 14 take homes and it's documented in the patient record that they want to stay on this amount for three months, that the patient should not be required to come in monthly for the assessment, because the record clearly states that that is their mutual decision, that they will stay on this dose for the next three months. It's documented. And the rationale for providing take home doses should and should should be documented clearly in that patient record to ensure that you are meeting that, patient where they are at. And, and making note of that.

And next slide. I'm going to just again to reiterate that the spirit of this guidance is to ensure that each patient is being assessed for take-home eligibility based on the new regulations at admission and monthly thereafter. The expectation is to create opportunities for patients, regardless of where they are in their course of treatment. To have a touchpoint, to engage with OTP staff, to discuss their treatment plans, and to learn what is needed to advance their take homes. SAMHSA is setting the foundational expectations that BSAS is building off of to ensure that there is individualized care in Massachusetts. If the patient does not receive, take homes, or does not meet eligibility status, the patient record should clearly indicate the reason, and there should be evidence that the patient understands the reason, including how to work towards getting take homes or more take homes, and when they can meet with the team again. Programs should be taking the time now to revise their take-home policies, incorporate all of these changes and requirements.

All right. Next topic pregnant women. Per federal and state regulations, OTPs must maintain current policies and procedures that reflect the special needs and priority for treatment admission of patients with OUD who are pregnant after assessment by an OTP practitioner and documentation confirms that the clinical appropriateness of such an evidence-based treatment protocols. So the the main points around treating this population is that admission should be prioritized. Split dosing is allowed, and prenatal care and other sex-specific services shall be provided and documented either by the OTP or through a referral.

All right. Next slide. Couple, two more topics to get through. Thank you, Heidi, for your question. Keep them coming. So consent to treat. In addition, a health care practitioner shall ensure that each patient voluntarily chooses treatment with MOUD and that all relevant facts concerning the use of MOUD are clearly and adequately explained to the patient, and that each patient provides informed consent to treatment. Whenever possible, written consent should be gathered. When not possible and if it presents a barrier to access, verbal consent can be acceptable. The evidence of verbal consent must be documented in the patient record. And, it will be important that programs should or must include verbal and electronic consent to treatment and in your policies and your protocols.

Last topic interim treatment. The final rule extends the potential duration of interim treatment from 120 days to 180 days. It also clarifies the circumstances in which interim treatment may apply, and maintains priority access to comprehensive services for pregnant individuals. The rule finalizes removal of the requirement for observation of all

daily doses during interim treatment. It also finalizes the expectation that crisis services and information pertaining to locally available, community-based resources for ancillary services be made available to individual patients while they're in interim treatment. A requirement of a plan for continuing treatment beyond 180 days of interim service is also a requirement.

So I think my face has has gone back to its normal color and we can accept questions again and go back to our polls, which I think are accurate. In our next session. Thank you. You are right. Heidi or Doctor Ginter. I appreciate that. So we are going to ask you to go back to Menti. And, I'm going to pass it to my colleague Jo to run us through these questions.

Jo Morrissey:

Hey, great job Melissa. That's also a, quite a bit of material to get through here. So, I would like to share screen, and launch the Menti poll. So this is regarding how each program is expected to… And we'll give folks a few minutes to make sure that they we have all those who wish to participate in an opportunity to do so. As Casper the Ghost is checking in our little side thing there, for those of you who've already answered, we've got some entertaining for you while we're waiting for others to, participate. So far the winning answer seems to be all of the above. Just going to give that one more second. And for those of you who chose all of the above, you win. And the prize is pride. You get to glow in the fact that you knew the answer. Let's move on to the next question. What are treatment plans referred to in the new and the updated final rule? What's the new term for treatment plans? Just giving everyone a, I love the Pepto pink, by the way. My daughter's bedroom was painted Pepto pink, and it was a really great color until she had the flu one year. And we repainted. All right. It seems the prevailing winds are telling us that care plans is the new term for treatment plans referred in the final rule. And indeed, whoever chose that question, you win. You win the prize. No Pepto pink for you. So the next question we have for you is a little bit of fun that we want to have, and that is what topics would you like us to discuss with you in our upcoming sessions during the month of July?

We've identified a list of eight topics that we have received a number of questions on from our previous presentation and our previous, questions today, and, we would love for you to take a moment and put them in a prioritized list terms. So do you want to talk about definitions, roles and responsibilities? Do you want to talk about assessments and examinations? I knew that was going to rise to the top. Medication, nursing and supervised withdrawal. Not a surprise there. Interim treatment has been a topic of interest. Assessments and examinations, little interim treatment dropped. Consent to treatment, interesting.

Melissa Schoemmell:

I love watching when the new one comes in.

Jo Morrissey:

Right? The definitions, roles and responsibilities is hanging steady there at topic number four. Take home medication. I'm not surprised that that's making the top three. Look and just as I said. So far we have 12 responses. We've had about 25. So I'm going to give everyone a minute to really think this through. Complex question.

Certainly the use of telehealth came up quite a bit in a number of questions that we had during the last session, but I think that was related to the fact that it was kind of news that was sprung on us that day. So maybe folks have had a moment to really soak that in.

Melissa Schoemmell:

Also ties into the assessments and examinations.

Jo Morrissey:

It does. It really really does. Who can do them? When can they be done? In-person? Telehealth? What's the cadence for timing? It gets complicated. So 17 responses. And we also are, sending out an evaluation for you to another, opportunity to share with us any questions or concerns that you may have for upcoming future topics are also included in those evaluation questions that we're asking. So I believe that concludes the Menti fun for the day.

Melissa Schoemmell:

I mean, I oh, oh, I have a I have a thing in our slack. I'm sorry. Can we pull it up again? I'm going to do this before we go into the last slides. Thank you. All right, so after hearing everything and I know that SAMHSA has held some learning sessions and I'm sure that you have been digesting the, the guidances and talking to your colleagues about these changes. What is one word to describe the most exciting thing to you around these changes? Opportunity. Overwhelming. Humanistic. Progressive. It is different. There will be, I think there will be a lot of conversations around around how to to come to a new way of, doing business, you know. Patient-centered. Patient-centered. Patient-centered. If we could combine those, I bet that would be enormous. Right in the middle. Flexibility. I like that, I like that that just came in right in the middle there. And it's staying. Research based, client centered patients centered, new, evidence based, progressive, opportunity, change, respectful, responsive, humanistic. More access to care. These are all so exciting. I, have been working in this field for eight years, and I, have not worked in methadone, in the world of methadone particularly. And I feel very excited to be kind of

landing or the team landing at such an opportune time to support, to support this, this whole process around this transition. So, we are all very, very excited.

Thank you so much for sharing your thoughts on what excites you. Yes. So while Gretchen pulls up our final slides, I'm going to have, Audrey, throw in our evaluation survey link. Please. We are popping in this into the chat now, as we kind of wrap up. So you might open up the link and, fill that out following the session or start filling it out now. We, we really are just starting our engagement with all of you. And so learning from you as far as what is needed. What topics, trainings, resources? Really. Anything that can help to refine, our, our TA in the services that we, provide to you. So, we want you to keep coming back to our trainings and feel like they are a valuable use of your time. So let us know how we can do that. Thank you. And let's go to the next slide.

We have, few sessions coming up to, open to this group. We have a roundtable discussion scheduled for Wednesday, July 10th, from 2 to 330. We are planning this currently. And we will be in touch around the topics that may be discussed during that first roundtable discussion. The roundtable discussion, later in the month will, definitely be focusing on some of the the input that we heard from you all today as far as where we need to dive deeper and what, community conversations we can engage in with all of you as far as learning, listening to you and your experiences and, gathering just some more information around, your systems and, and what your concerns are or your worries around these changes. And then also learning kind of some of the success stories that you've had and how we might be able to share that across the state.

So really looking forward to those. Please register, if you can join. And we would encourage you to share that with your teams. There's also a Massachusetts ASAM SUD pearls for practice later this year, September 13th and 14th. The registration for that opportunity just opened. So, please register for that if you are able to. They just released their fourth edition of the ASAM criteria, and a lot of that edition is around, person-centered care and how to do that in the treatment setting. So I, I'm looking forward to hearing that conference later this year. And I think we have one more slide.

So our resources, so the obviously the 42 CFR part eight regulations, there's a table of changes, and FAQs that is on the federal side. Just kind of a general, what is happening at the federal level? We also put in the, we linked in the waiver, memo that BSAS has published in response to those regulations. And then also, there are letters that are, to to providers and then, also letters for patients, describing these changes. The patient letter, I would encourage folks to share that, with your referral agencies, so folks know about how things are changing with OTPs and how, the access to care may be different if they have experienced it before or have heard, things in the past around what, treatment at the OTPs looks like. So that letter really explains kind of the changes there and so, we would encourage you to post that letter and share that letter with patients or potential patients. Yes. Thank you. Mike, just put it in a chat that the the patient and provider letters have been posted in that link, and, that the patient letter has been, translated into multiple languages as well.

So as you complete your evaluation, I just wanted to thank you again, for joining us today. Thank you for inputting your, your thoughts and, your suggestions around language and that incorrect answer that is what we need, that conversation and, safe place to, to be, called out and also called in and, learning from each other. So, I hope that you continue to engage with the OTP TTA center. You can email us at that email listed there and we encourage you to join our listserv. If you are getting our emails already, please do join that so you can be kept up to date on any upcoming events, resources, anything that we are working on. Let us know.

And if you do have questions, thank you for your question, Jennifer. I will take them here or you can put those into your your evaluation. There's another opportunity for questions there. We will be compiling all those questions and working with BSAS, Jen and Mike are on the call today, we'll be working with them to get those answers to you, make sure that they are clear and not providing any misinformation. So, I'm going to close that out. Thank you all so much. Really looking forward to establishing this TA center with with all of you and, learning from all of you.