



OTP 101 For Community Partners: Collaboration and Connecting Systems of Care

Dr. Ruth Potee

April 30, 2026



Our Mission

To foster innovation at Massachusetts OTPs by equipping staff with resources and support to deliver patient-centered care, address treatment barriers, and improve health outcomes.

Our Vision

A future where all individuals seeking treatment through Massachusetts OTPs have access to equitable, high-quality, and effective care.

Our Purpose

- Expand access to medications for opioid use disorder
- Enhance patient care and improve treatment outcomes
- Address barriers to equitable care
- Reduce stigma
- Foster collaboration

Words Matter Examples

Instead of...

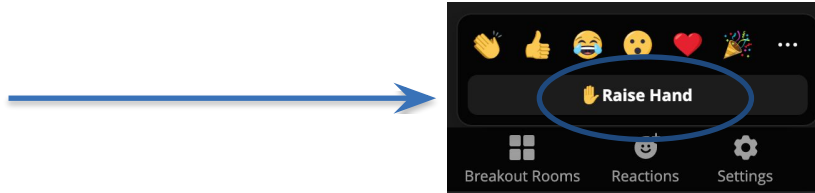
- ✗ Substance abuser
- ✗ Addict
- ✗ High-risk population
- ✗ Medication assisted treatment
- ✗ Relapse
- ✗ Clean or dirty urine
- ✗ Clean or dirty needles

Consider...

- ✓ Person with a substance use disorder (if so diagnosed)
- ✓ Person who uses drugs
- ✓ Person at high risk for overdose
- ✓ Medication for opioid use disorder
- ✓ Return to use
- ✓ Positive or negative toxicology screening
- ✓ New or used syringes and works/injection equipment

Housekeeping

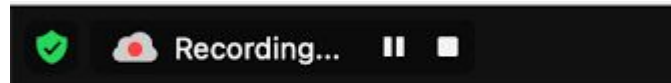
- Lines will be muted. Use the raise hand feature if you would like to come off mute.



- Use the chat to submit questions for speakers, panelists, and our TTA team








- We are recording today's session



Today we are joined by representatives from MA DPH Bureau of Substance Addiction Services (BSAS)

Session Reminders

-  Update your Zoom name
-  Complete our feedback form to receive CEUs
-  Email your questions or comments at: otptta-ma@jsi.com
-  Join our contact list to stay up-to-date
-  Visit our website massotptraining.org

Two CEU options:

1. **NAADAC CEUs** available through OTP TTA Center
2. Other **CEUs (LMHC, CME, CNE, Social Work)** available through Grayken Center

If you did not register with Grayken in advance, please email otptta-ma@jsi.com

To receive credits for attendance through either option, complete the evaluation form at the end of today's session!

Thank
You



Grayken Center
for Addiction
Boston Medical Center

Upcoming TA Center Events

OTP 101 *Featuring the same content as today*

June 25th, 1-2PM

*Know anyone who could benefit from today's webinar?
Please help us spread the word!*

Webinar | Insights from Mobile Opioid Treatment Clinics in MA

Wednesday, May 20, 1-2 pm

Webinar | Implementation of MOUD Within a Correctional Framework

Wednesday, June 17, 1-2 pm

Want to dive deeper into OTPs?

Check out our Quality of Care Toolkit for Massachusetts Opioid Treatment Programs

Quality of Care Toolkit for Massachusetts Opioid Treatment Programs

0% COMPLETE

- Introduction
- CHAPTER 1: NAVIGATING REGULATORY SHIFTS
 - 1.1 Understanding Federal and Massachusetts Changes in Opioid Treatment
 - 1.2 Implications for Massachusetts: BSAS Alignment and Regulatory Waivers
- CHAPTER 2: REIMAGINING PATIENT-CENTERED CARE IN OTPS
 - 2. Reimagining Patient-Centered Care in Opioid Treatment Programs
- CHAPTER 3 : INCREASING ACCESS TO TAKE-HOME MEDICATIONS
 - 3.1 Advancing Access and Patient-Centered Care through Updated Take-Home



Welcome! This toolkit provides actionable guidance for Massachusetts Opioid Treatment Programs (OTPs) to enhance patient care, expand access to medication for opioid use disorder (MOUD, particularly methadone), and navigate recent regulatory changes. Developed using feedback from staff and patients, it offers practical tools to help programs improve services and maintain compliance with updated standards.

This toolkit has been updated to align with the latest federal regulations and corresponding Massachusetts guidance. It incorporates the changes to [42 Code of Federal Regulations \(CFR\) Part 8](#), which took effect on April 2, 2024, with full implementation required by October 2, 2024.

To ensure state-level alignment, this resource also includes corresponding guidance from the Massachusetts Bureau of Substance Addiction Services (BSAS)

- "[Waiver from Certain Regulatory Requirements and Guidance – 42 CFR Part 8 and 105 CMR 164.000](#)" published on July 31, 2025.



Methadone Access and Delivery in Massachusetts

April 30, 2026

Ruth A. Potee, MD, DFASAM, FAAFP
Medical Director – Behavioral Health Network

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Medical Director – Behavioral Health




Dr. Ruth Potee is a board certified Family Physician and Addiction Medicine physician who works in western Massachusetts.

She is currently the Medical Director for the Franklin County House of Corrections, the Director of Addiction Services for Behavioral Health Network, the medical director for the Pioneer Valley Regional School District, and the Co-Chair of the Healthcare Solutions Committee of the Opioid Task Force of Franklin County and the North Quabbin Region.

She was named Franklin County Doctor of the Year by the Massachusetts Medical Society in 2015 and has won multiple teaching awards from medical students and residents.

By the end of this webinar, participants will be able to:

1. Identify basic treatment elements of Opioid Treatment Programs (OTPs)
 2. Assess how biases and other barriers affect patient care
 3. Summarize key changes in OTP patient care
 4. Identify opportunities to partner with OTPs
- 



1. Timeline and history of Methadone
2. Opioid Treatment Programs (OTPs)
 - 2024 Regulatory Changes
 - OTP Treatment Setting
services, benefits, admissions and barriers
3. OUD Landscape in Massachusetts
4. Opportunities for partnership



A Brief History of Methadone

Discovery and Early Use

● 1930s - 1940s

Regulation and the "War on Drugs"

● 1970s - 2000s

● 1960s

Shift to Addiction Treatment

● 2020s - Present

Current Status



2020: OTP Practice Changes




- Access to take home doses
- SUD no longer defined by toxicology alone
- Allowed individualized decisions about dosing, starting doses and split dosing
- Medical decision making left to the medical team
- In person admission but with flexibility (direct admission and AV telehealth)
- Jails and correctional facilities allowed to use methadone under DEA registration (hospital/clinic)
- Expanded definition of medical provider to include NP, PA, CNM and others

2024 - Final Rule

Changes to Federal Regulations (42 CFR, part 8)

BSAS aligned with Federal Regulatory changes (CMR)

Underlying Values and Principles of the Revised Rule

- Patient-centered care
 - Shared practitioner-patient decision-making
 - Practitioners' clinical judgment
 - Responsive, flexible OTP services
 - Evidenced-based practice
 - Non-stigmatizing language
- 

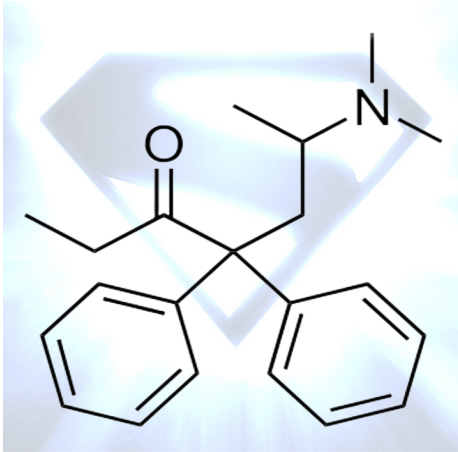
Required Services

42 CFR 8.12(f)(1)

- OTPs shall provide adequate medical, counseling, vocational, educational, and other screening, assessment, and treatment services to meet patient needs.
- The combination and frequency of services tailored to each individual patient based on an individualized assessment and the patient's care plan that was created after shared decision making between the patient and the clinical team.



Benefits of Treatment at an OTP



- Methadone is one of the most effective medications we have to treat Opioid Use Disorder
 - Cuts the risk of death by overdose in half
- Prescribed as part of a comprehensive treatment plan at Opioid Treatment Programs (OTPs)
- Helps restore functionality, improve quality of life and reintegrate families and communities.

1. [Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence - PubMed](#)

2. [Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence - PubMed](#)

Barriers to Treatment at an OTP

Layers of Stigma

- Misconception that addiction is a personal choice, a lack of willpower and a moral failing
- Medication for OUD is misunderstood, “just trading one drug for another”
- Increased severity for groups facing other forms of social marginalization (e.g., oppressed racial/ethnic groups, women, the economically disadvantaged)

Limitations in Access

- Rigid regulatory environment (3)
- Travel based barriers(4)
- Limitations related to geography and cost (5)

3. [Intervention stigma: How medication-assisted treatment marginalizes patients and providers - ScienceDirect](#)

4. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2844613>

5. [The intersection of substance use stigma and anti-Black racial stigma: A scoping review - PMC](#)

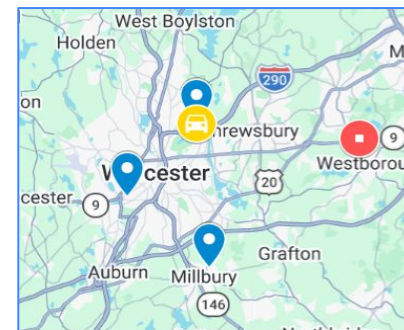
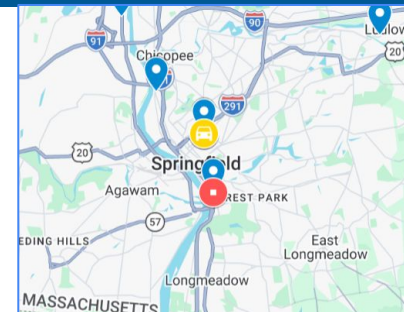
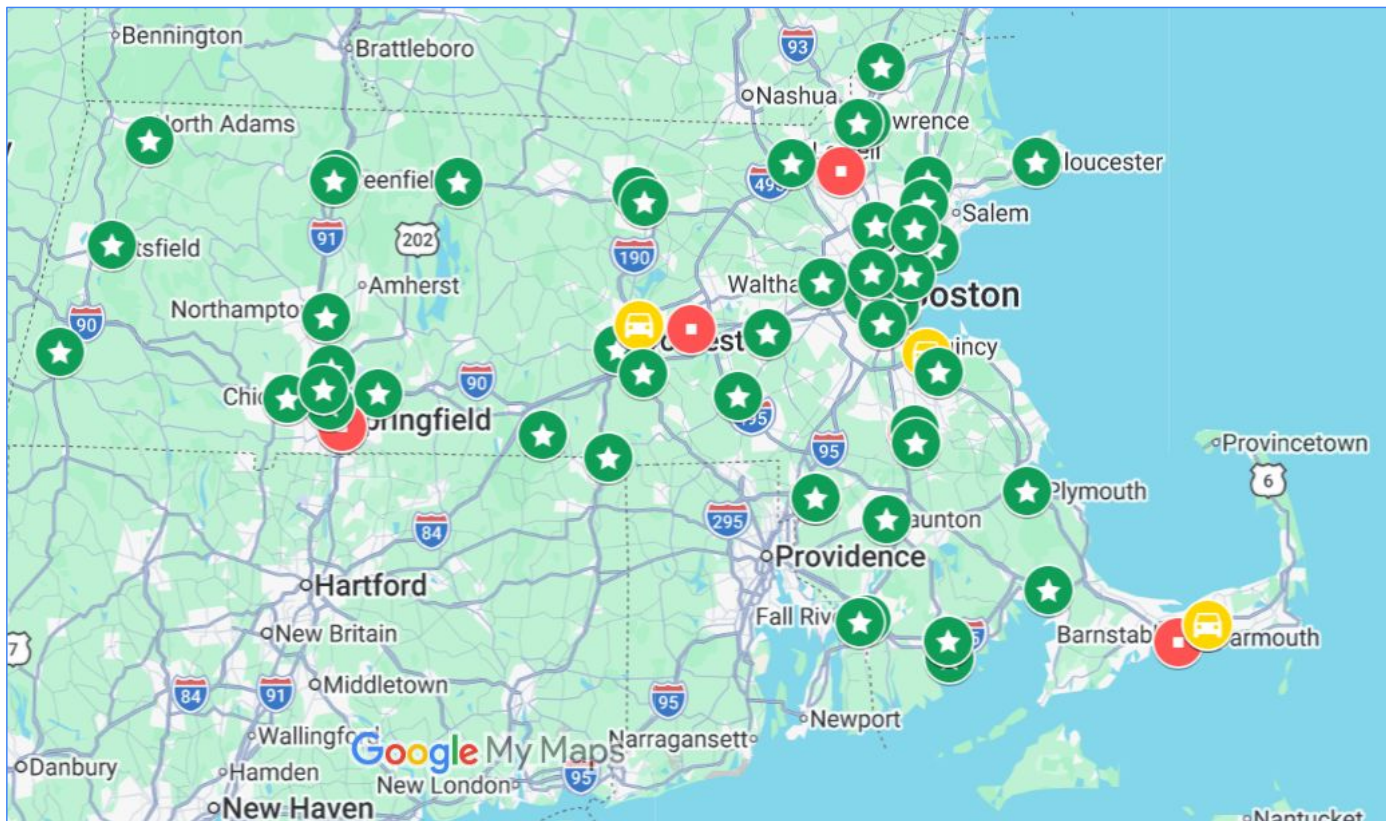


OUR Landscape in Massachusetts and Opportunities for Partnership

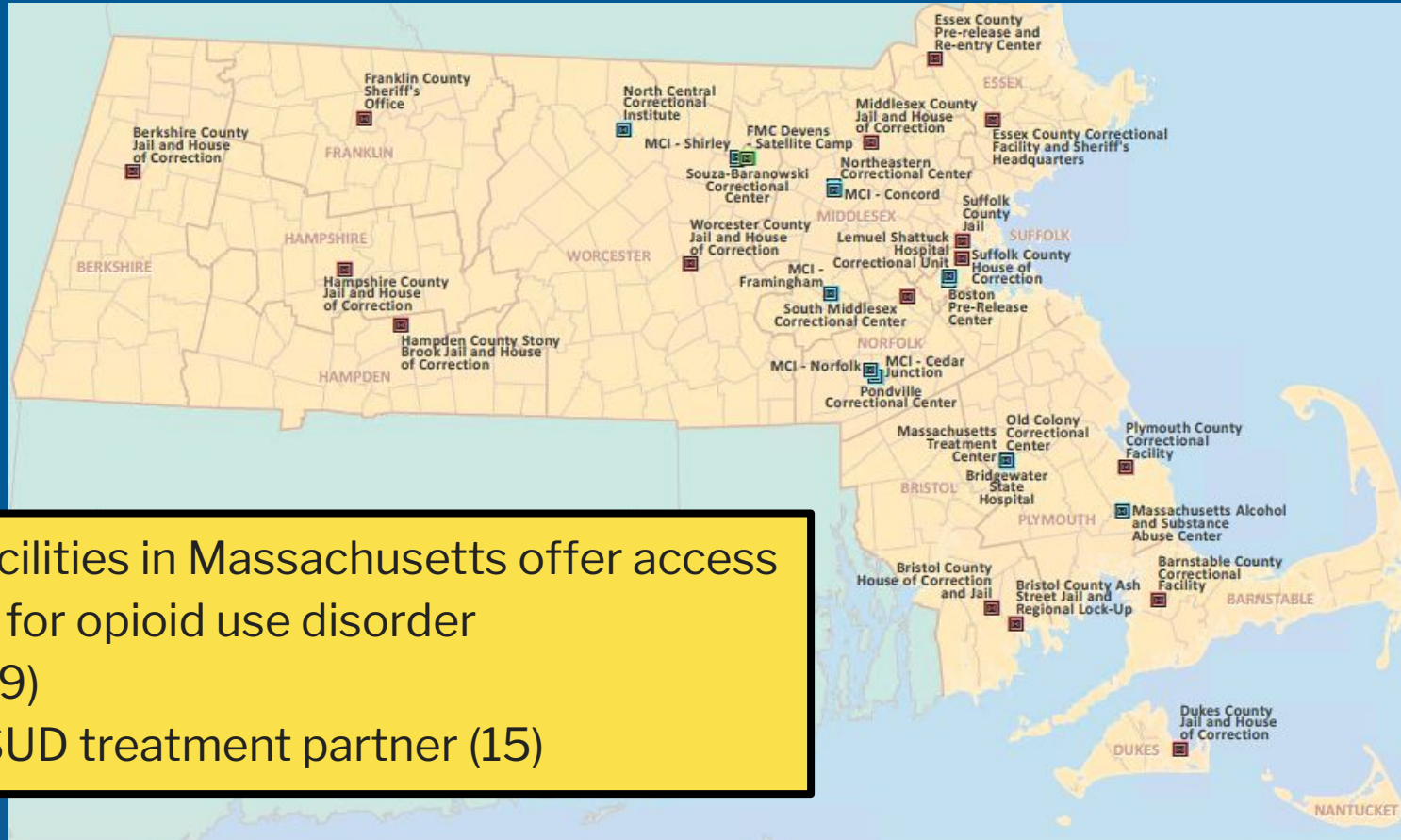


Community-Based OTP Access - Massachusetts

1.27.26



Correctional Facilities in Massachusetts



Correctional facilities in Massachusetts offer access to medications for opioid use disorder either directly (9) or through an SUD treatment partner (15)

Faster Paths to Treatment

@Boston Medical Center

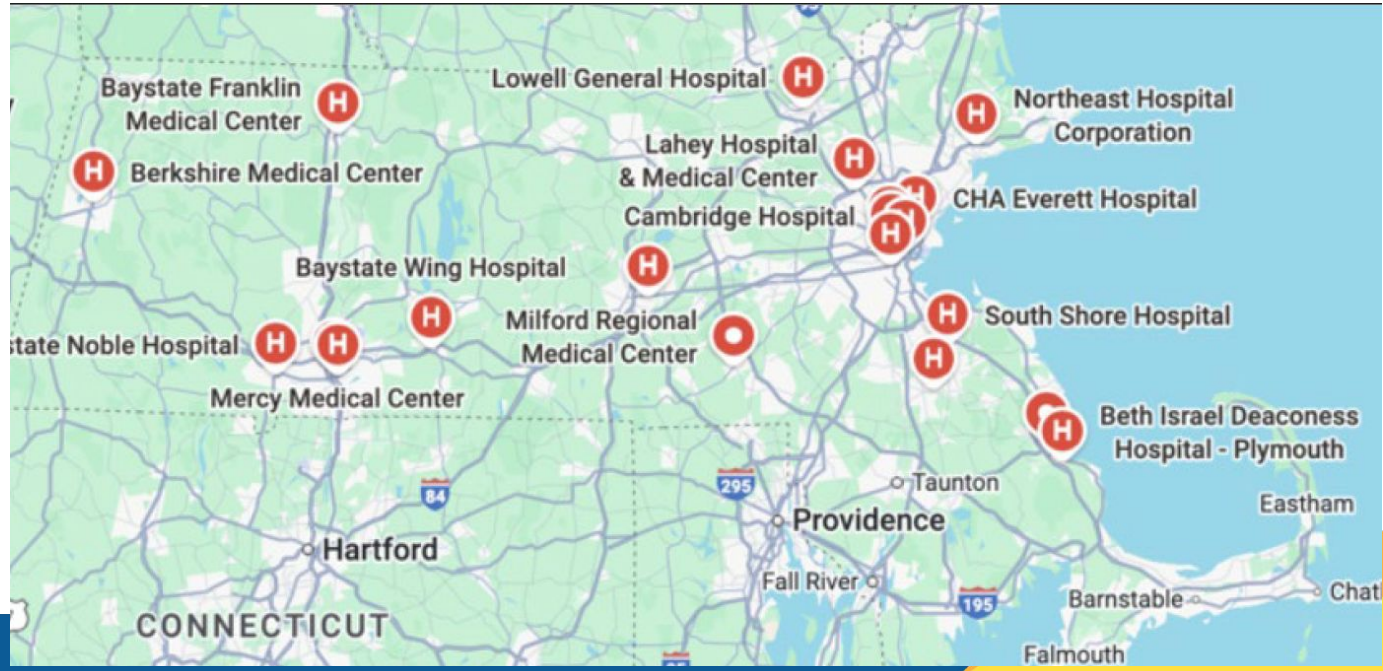


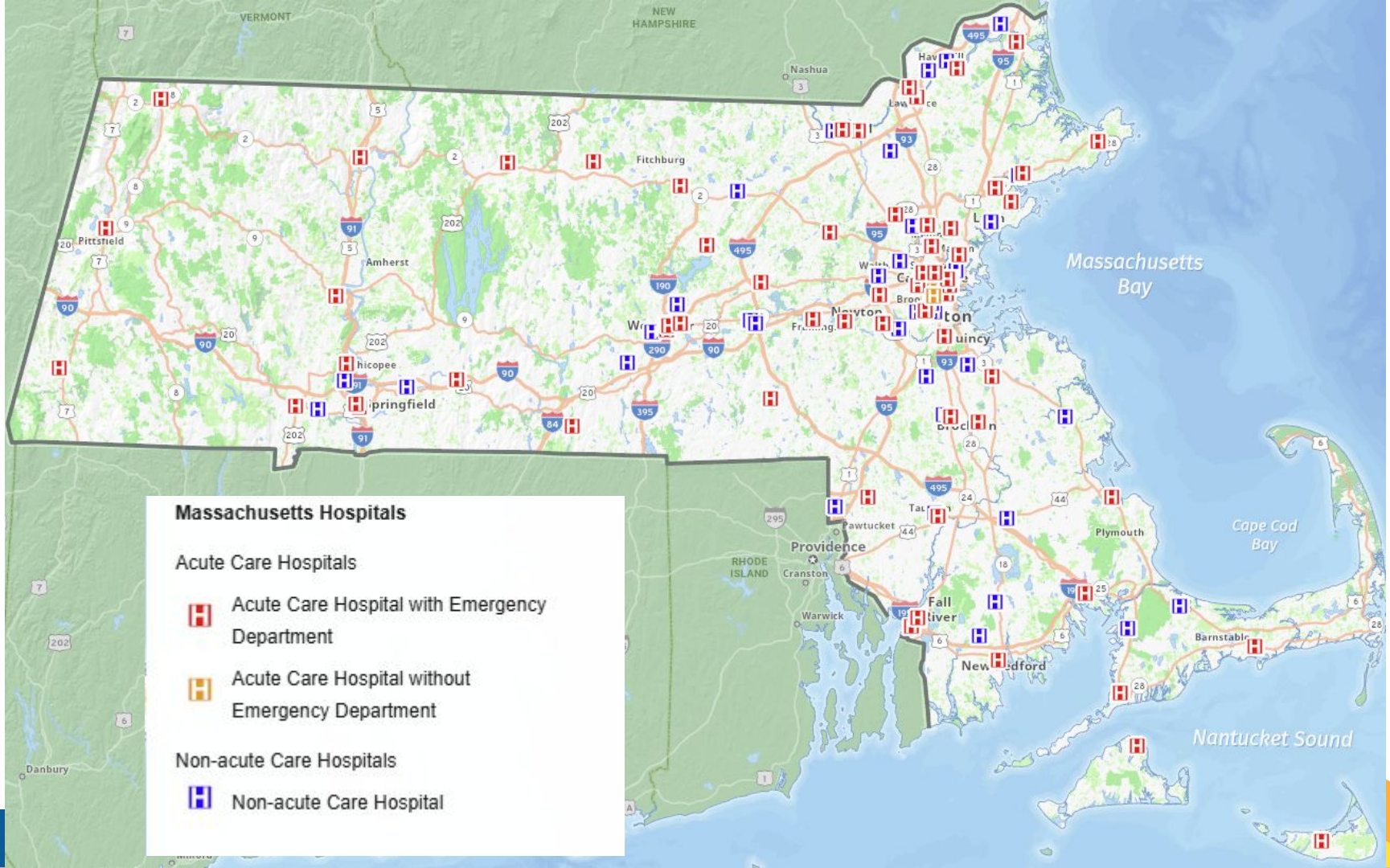
Addiction Consult Services in

Massachusetts

Nurses, therapists, and recovery coaches help support patients and treat underlying substance use disorders



- Increased the number of patients who started MOUD
- Increased referrals to MOUD





Massachusetts Hospitals

Acute Care Hospitals

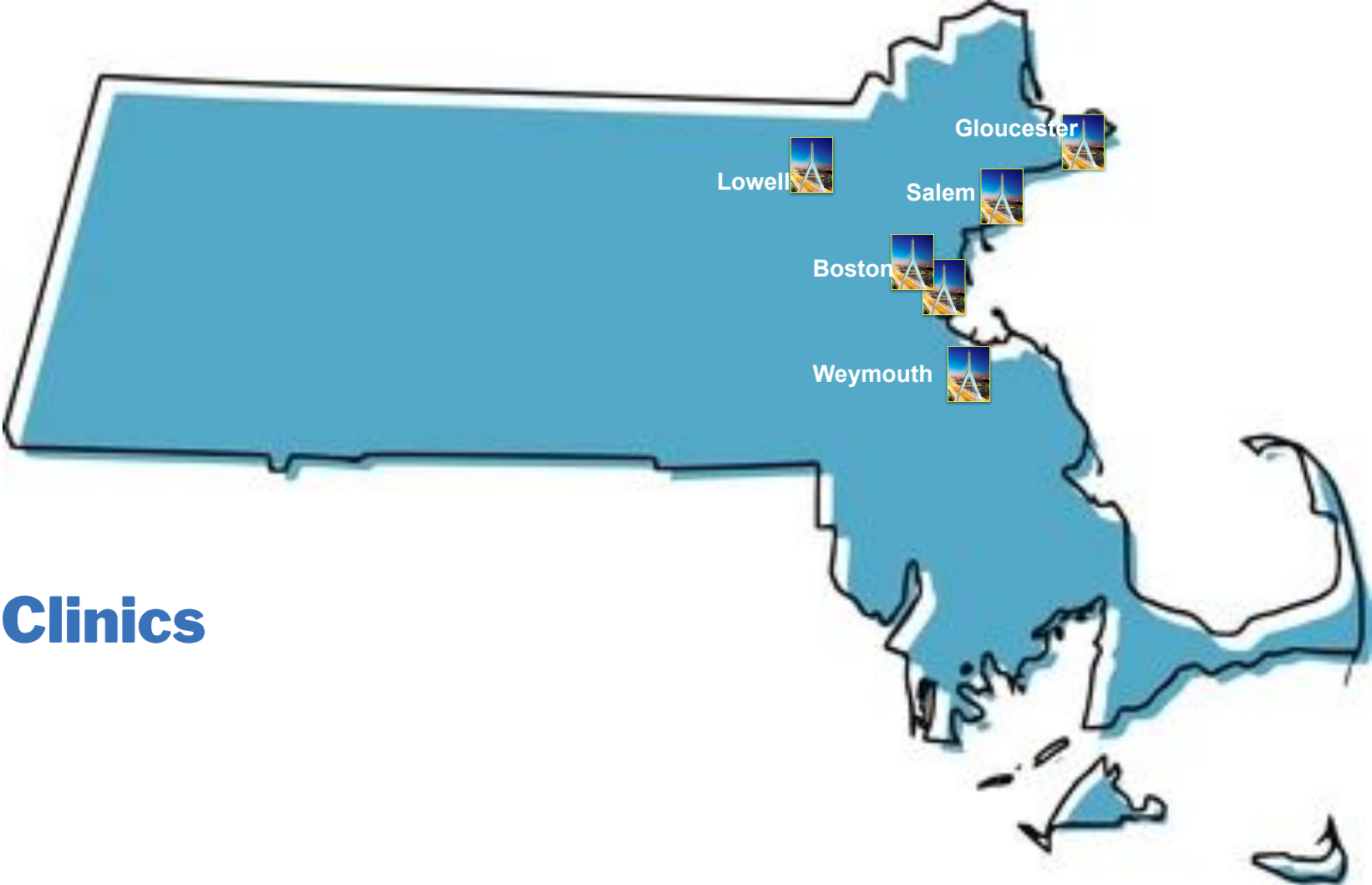
-  Acute Care Hospital with Emergency Department
-  Acute Care Hospital without Emergency Department

Non-acute Care Hospitals

-  Non-acute Care Hospital



**Admissions Process Documentation,
Direct Admissions, Bridge Clinics &
Warm Handoffs**



Lowell

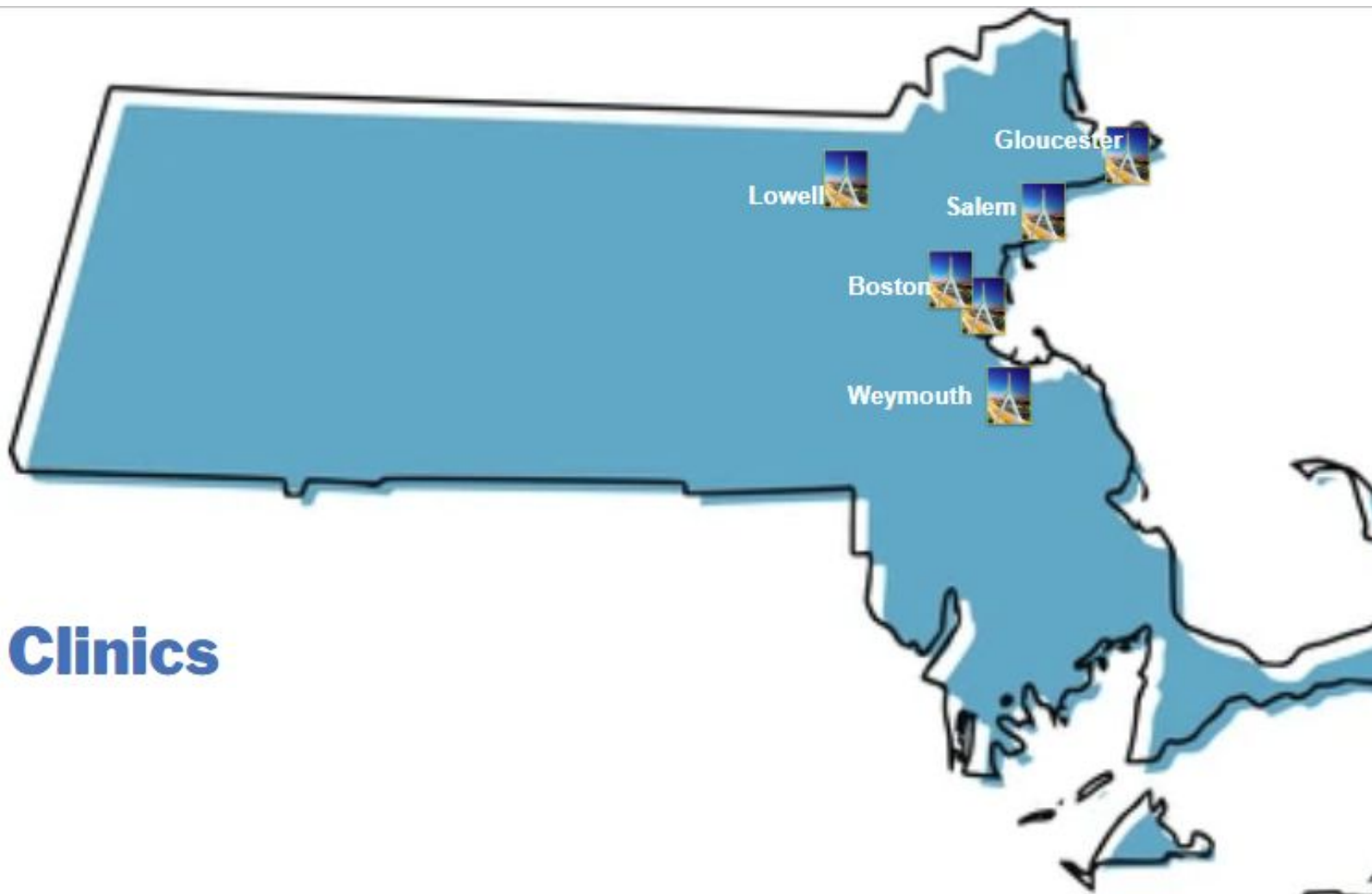
Gloucester

Salem

Boston

Weymouth

Bridge Clinics



Bridge Clinics

Bridge Clinic Language

Adapted from Mass General Bridge Clinic

Patient has severe OUD as indicated by above DSM-5 criteria and is interested in initiating methadone to treat OUD. Due to risk of fatal overdose without appropriate medical management of OUD, patient meets criteria for emergency management of acute withdrawal symptoms or initiating maintenance treatment (or both) under the provisions of Title 21, Code of Federal Regulations, Part 1306.07(b), “the 72 hour rule.”

Patient expresses understanding that methadone can only be provided for a maximum of 72 hours, and is able to be linked to an OTP with an *[organization name]* affiliation agreement within 72 hours. We reviewed that *[organization name]* has affiliation agreements with the following methadone clinics: “OTP A”, “OTP B”, “OTP C”. Patient tentatively expresses interest in connecting with “OTP A”. This may change after meeting with the Resource Specialist.

Admissions Process (example)

- Screening
- Paperwork, which may include:
 - Informed consent to treatment
 - Demographic details
 - Release of information
 - Clinic rules
 - Expectations
 - Central Registry consents
- Biopsychosocial assessment to develop Initial Care Plan
- Physical evaluation and lab testing
 - Drug screening
 - TB screening
 - Screening test for syphilis, HCV, HIV
 - Other laboratory tests required by state regulatory/licensing agencies
 - Urine pregnancy tests



Requirements for initial medical examination

42 CFR 8.12(f)(2)

(ii)

Assuming no contraindications, a patient may commence treatment with MOUD after the screening examination has been completed. Both the screening examination and full examination must be completed by an appropriately licensed practitioner.

- **If the licensed practitioner is not an OTP practitioner, the screening examination must be completed no more than seven days prior to OTP admission.**
- **Where the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner.**

Requirements for initial medical examination

42 CFR 8.12(f)(2)

(iii)

A full in-person physical examination, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP.

The full exam can be completed by a non-OTP practitioner, if the exam is verified by a licensed OTP practitioner as being true and accurate and transmitted in accordance with applicable privacy laws.

(iv)

Serology testing and other testing as deemed medically appropriate by the licensed OTP practitioner based on the screening or full history and examination, drawn not more than 30 days prior to admission to the OTP, may form part of the full history and examination.

Keys to Partnership.

Medical Directors

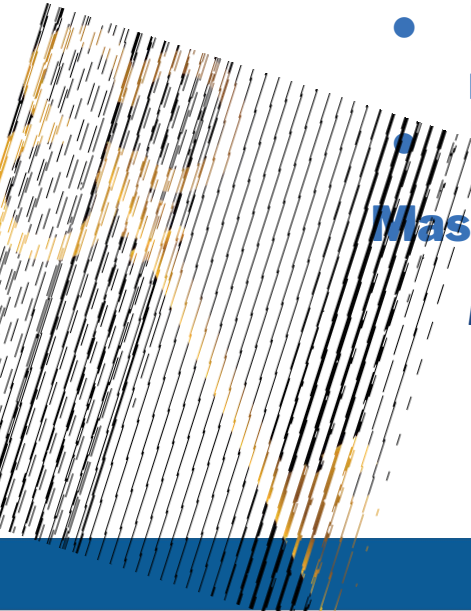
- Responsible for oversight of all medical treatment services
- Play a key leadership role at an OTP

Qualified Service Organization Agreement (QSOA)

- Bridge gaps in confidentiality rules for substance use disorder records (42 CFR, part Part 2)
- Not required. Useful to support coordinated, integrated care

Massachusetts HelpLine -

<https://helplinema.org/otp-dose-verification/>



Contact information and resources
for providers seeking a dose verification for an OTP patient

- Community-Based OTP Dose Verification
(Updated January 2026)
- [Massachusetts Community-Based OTP Map](#)
- OTP Services at Correctional Facilities Dose Verification
(Updated November 2025)

Direct admissions

Direct admissions from hospitals, emergency rooms, primary care clinics, bridge clinics, jails and other medical facilities **lower barriers to attending an OTP.**



What is Needed for Direct Admissions

- **Communication** between OTP and non-OTP programs
- **Signed release of information** from patient between the two facilities that is in accordance with 42 CFR Part 2
- Transmitted documents must show an active OUD based on clinical presentation, history, physical, or toxicology.
This could be a discharge summary, an addiction consult note, a primary care visit, etc.
- Last dose letter
- Confirmation if patient is enrolled in an OTP or not
- Discuss clinical concerns related to induction and split dosing
- An EKG and any labs
(especially if there is any cardiac indication)

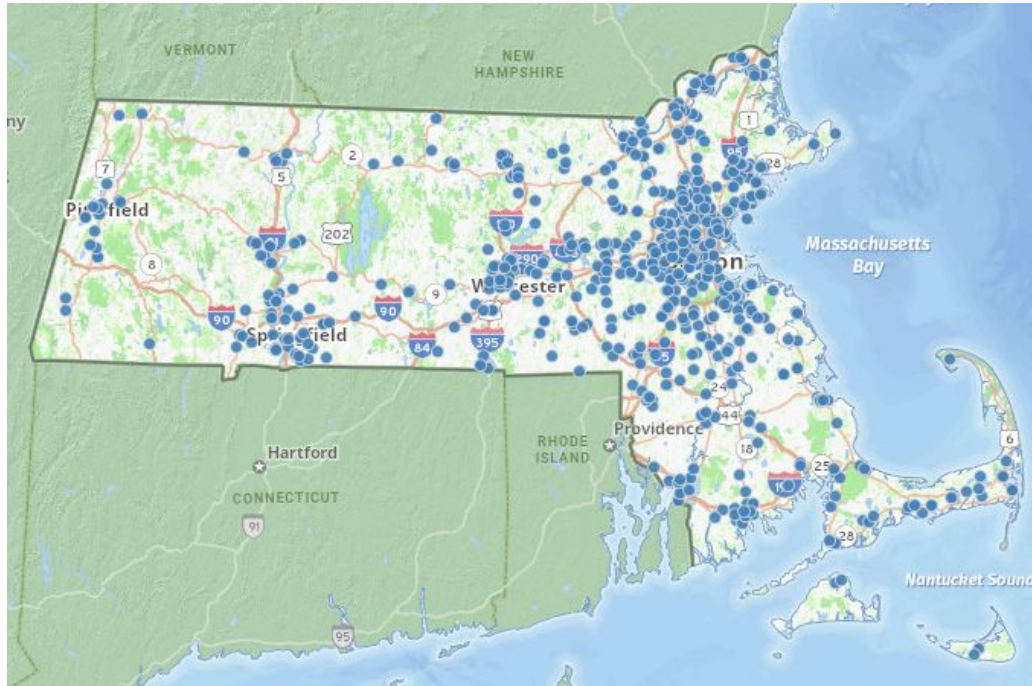


Responsibilities of the OTP Practitioner during Direct admissions

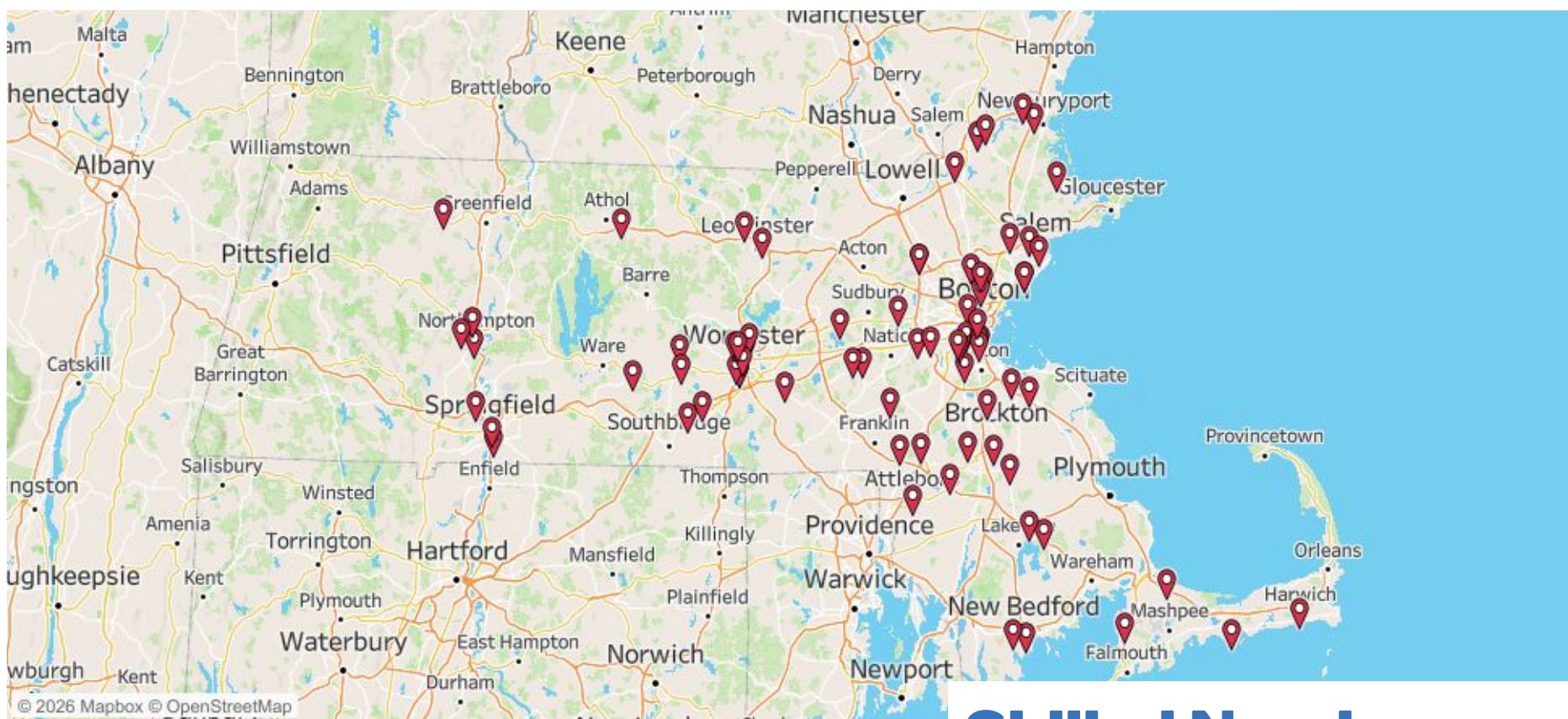
- Review the documentation received about the patient
- Determine if more information is needed prior to the patient enrollment
- Ensure that a complete medical intake is done within a timely manner



Long Term Care Facilities



- MassHealth add-on to bill for substance use disorder services
- Check out the [LTC TTA Center](#) to learn more about SUD in Long Term Care!



Skilled Nursing Facilities

Practice Guidance for Hospital and Opioid Treatment Program (OTP) Coordination of Care



- Effectively treat and manage acute opioid withdrawal
- Ensure patients continue their medication without disruption while hospitalized
- Facilitate the initiation
- Linkage to care in the community upon discharge

Piloting a Hospital-Based Rapid Methadone Initiation Protocol for Fentanyl

Liu, Patricia MD; Chan, Brian MD; Sokolski, Eleasa MD; Patten, Alisa MA; Englander, Honora MD

Author Information 

Journal of Addiction Medicine 18(4):p 458-462, 7/8 2024. | DOI: 10.1097/ADM.0000000000001324

BUY

CE TEST

EARN CREDIT

Objectives

Treating acute opioid withdrawal and offering medications for opioid use disorder (OUD) is critical. Hospitalization offers a unique opportunity to rapidly initiate methadone for OUD; however, little clinical guidance exists. This report describes our experience during the first 9 months following introduction of a hospital-based rapid methadone initiation protocol.

Methods

We conducted a retrospective chart review of hospitalized patients with OUD seen by our interprofessional addiction medicine consult service at an urban academic center between December 2022 and August 2023. We identified patients who initiated methadone using the rapid methadone initiation protocol, which includes dose recommendations (maximum 60 mg day 1, 70 mg day 2, 80 mg day 3, 100 mg days 4-7) and strict inclusion and exclusion criteria (end organ failure, arrhythmia, concurrent benzodiazepine or alcohol use, age >65).

Results

There were 171 patients that received methadone for OUD during the study period. Of those, 25 patients (15%) received rapid methadone initiation. The average total daily dose of methadone on days 1-7 was 53.0 mg, 69.2 mg, 75.4 mg, 79.5 mg, 87.1 mg, 92.2 mg, and 96.6 mg, respectively. There were no adverse events requiring holding a dose of scheduled methadone, naloxone administration, or transfer to higher level of care.

Conclusions

A rapid methadone initiation protocol for OUD can be implemented in the inpatient setting. Patients up-titrated their methadone doses quicker than with traditional induction methods, and there were no serious adverse events. Appropriate patient selection may be important to avoid harms.

Questions?



Thank you!

Share your thoughts & get CEUs!

Your feedback on this session will help us improve our content based on your needs.

