OTP 101 For Community Partners:

Collaboration and Connecting Systems of Care - April 30, 2026 Transcript

Melissa Schoemmell:

I think we can start.

Shaivi Herur:

All set.

Melissa Schoemmell:

Thank you. All right, good afternoon. Welcome. This is the Second out of three sessions of OTP 101 for community providers. Collaboration and connecting systems of care. Sorry, I don't know what happened here. There we go. A reminder about the OTP TTA Center. We are hosting this today, and we are here to support OTP practitioners and, OTP programs in Massachusetts, to deliver patient-centered care, address treatment barriers and to improve health outcomes. Our content is usually targeted to OTP providers. And we are so excited to expand our audience today to a larger, cohort of people working with people who use drugs.

A reminder for everybody about, the words that we use, and how much they matter. And so, our team is hoping to infuse these reminders in our presentations, in an ongoing way. And so, really, trying to be more person-centered in our approaches to talking with folks. Using language such as, for people who use drugs, A person at high risk. Instead of a relapse, a return to use, things like that. Thank you for your attention to that, we appreciate that.

Some housekeeping items. There will be opportunity at the end for questions and answers, so if you do have a question, please feel free to raise your hand. We can submit questions through the chat, so I see folks are using the chat. Thank you for doing that. We love your engagement. And today's session is recorded, and we do have ASL interpretation, so, thank you. For that.

If you are able to, we'd love to know who you are, so if you can update your Zoom name, if your name says a phone number, or has a colleague's name, if you shared a link, let us… if you can't rename yourself, please let us know, and we'll help you. We, are putting out an evaluation today. Those are tied to your CEUs, so please be sure to fill that evaluation out. And, in the chat, we have our MassOTPtraining.org website with all of our events and how to join our contact list. So please stay involved. The CEU options for today's session are the NADAC CEUs available through the Center. And fortunately, we have been able to partner with the Grayken Center for Addiction to provide the other CEUs today for LMHC, CME, CNE, and social work. To receive credits for attendance through either option, please complete the evaluation after today's session. If you didn't register with, Grayken, but you want to receive those credits, please email otptta-ma@jsi.com, and we will be sure to make sure you get those CE credits for today. Thanks for the introductions in the chat, too. I love to see it. We have some fun events coming up. We'll have, they're not in order, but that's okay. Ruth will be back in June, later in June for… for the same content as today, so if you leave here today wanting to hear this again, please come back in June, but if you want to share this with your partners, with your peers, it's a great opportunity to have, have your, partners and peers, or people that you work with understand this information, and so please share it and spread the word.

The TTA Center has some more traditional webinars coming up in May and June. The first one is, insights for the mobile opioid Treatment Clinics and that will be on May. And then we have implementation of MOUD in the correctional framework in June. All of the registrations for these are on the OTP TTTA website. Which, this is a beautiful picture of our OTP TTTA website, so please check that out. So here we are. Today, I'm pleased to welcome, Dr. Ruth Potee, the Medical Director for Behavioral Health Network. Dr. Potee is also a board-certified family physician and addiction medicine physician, and currently working in Western Mass. Our objectives for today, are listed here, and we hope by the end of this webinar. Participants will be able to identify the basic treatment elements of an OTP Opioid treatment program assess how biases and other barriers affect patient care, summarize changes in OTP patient care, and also identify opportunities to partner with OTPs, And our route to these OTP 101 topics. We'll first… we'll have a timeline and history of methadone, We'll walk through Opioid treatment programs, the 2024 regulatory changes, and what that means for the OTP treatment setting And then we will see the OUD landscape in Massachusetts, and how connected it is, and, and other ways addiction care is being performed in Massachusetts, and how methadone is a part of that system of care and opportunities to partner, and that's why we're so excited to have you all here. As partners in this work. I am going to hand it over to Ruth. So thank you for being here, thank you to Dr. Potee, I will pass it over. Thank you so much.

Ruth Potee:

Thanks, Melissa, and Shaivi, and the folks at JSI. Melissa's going to be advancing my slides, so you'll hear me say next slide, and there may be a pause, but because we have ASL interpreters, we're waiting for them to complete their interpreting before we move the slide, so that is intentional. I'm also going to try to not speak as fast as I normally speak, because I can be appalling in how fast I go. Having said that, I'm going to want to make sure we have time for questions. I don't expect, actually, most of you on this call to know a lot about methadone rules and regulations. Having said that, there are a lot of you on this call who I know, who actually work in methadone clinics, and you know a ton. But, you know, methadone's been around for a really long time. It was discovered in Germany during World War II. When Germany ran out of morphine in the late 1930s, they needed a new medicine to help with pain. And after World War II, as part of reparations, the United States received the methadone molecule as part of its own arsenal of meds to utilize. They used it for pain for a little bit of time, but really in the 1960s people began to use methadone in studies, specifically in New York City, and then later on in Chicago, treating people who had a heroin addiction. And there were dozens, if not nearly 100, excellent papers written on the use of methadone for helping people get better with their addiction to heroin and it was an unregulated time with methadone in the 1960s. These were all off-label studies, and it began to be a little bit of the Wild West. And having said that, they all of a sudden had a new, incredibly effective treatment. And it was pretty exciting. They, you know, one of the first places they used methadone was actually at Rikers Jail in New York City, and people felt a lot better. But it ran into the Nixon administration in the early 1970s and the very beginning days of the war on drugs, and in 1973, was the public declaration of the war on drugs, and it was a time when, in 1973, the DEA was founded to control the way that controlled substances were prescribed, but also to begin the control of illicit substances. And the DEA prior to 1973, didn't exist.

It is a time in 1973 when the schedules 1 through 5 were created, and for those of us who are prescribers, we know the schedules of the drugs. We know what each category is, where they fall and at that moment, a decision was made to remove methadone from the rest of medical care. And put it all by itself, in 42 CFR, so the Code of Federal Regulation 42, Chapter 8.12 is where methadone lived, and it was a very unusual thing to do this. It's the only medication other than buprenorphine that's controlled out of an OTP that came later that exists in this way. And for people like me and others. This is a major sort of historical point that then takes methadone away from normal treatment of people who have substance use disorder, and for the last 50 years, it's lived in this space, separate and really unequal from the rest of treatment. And it is no small thing that this happened, and it's really had a big impact on the lives of people who have

struggled with opiate use. And we're going to spend a little bit more time talking about, then, what does it look like to have a medication living in an opiate treatment program, siloed away from everything else. As somebody who's been a prescriber now for 27 years, I knew nothing about methadone. I was never taught about it. I used it for pain management, which is where my knowledge base came from. And the first time I walked into a methadone clinic, I was the medical director, and that's not great. And it's not great how frequently I speak to providers who know nothing about methadone as well. I literally spoke to two providers, two doctors today, who said, I really don't know anything about methadone, can you help me? So that is a real failure of a system that, continues today and then, we're gonna now move to the next slide and talk about what has happened, more recently in the last 6 years that has really changed the regulations on methadone.

So, in 2020, I think we all remember 2020 pretty vividly. We all remember where we were working, and where we were traveling, and where our kids were when the world seemed to shut down in the middle of March of 2020 a letter was sent to the medical directors of every methadone clinic in the country, and the letter was very short. And letters don't get sent out to OTPs all that often from SAMHSA or the federal regulators. And it basically said three things. Methadone clinics are not going to be a good place for people to gather because of the risk of COVID-19. If people are somewhat stable on methadone, give them 2 weeks of bottles. If they're very stable, give them a month's worth of bottles and it blew the lid off of methadone clinics.

First of all, none of us were prepared for this, none of us had the… a lot of us didn't have staff at the time because things were falling apart with COVID-19, and nobody had the bottles, the policies, and it was a radical change from what the rules had been since 1973. And it was during this time of great change where we had an unplanned experiment, and what does it look like when you free methadone? And what we found is that there weren't more risks of methadone in society, there was not an increased rate of overdose, the DEA did not see any risk or increased rates of diversion of methadone. And instead, what happened is that people said, holy smokes, methadone all of a sudden has become a more freeing medication in the fentanyl era, and part of what happened also in 2020 is fentanyl became the chief drug in the drug supply across the entire country. We had had it in the Northeast since 2016, but it became the main opiate in the nation's drug supply. So you had a more potent drug supply that killed more people, and you also had a very effective treatment for that, which was methadone, that had a lot more flexibility with it. So, surprisingly, methadone enrollments increased starting in 2020, 21, and 22, which is not what you would have predicted during a COVID era and more methadone clinics were licensed and opened, which was also a great thing. Next slide.

During this time, we had an administration that was strong and excellent. We had incredibly smart people working at SAMHSA, including people who trained in Massachusetts and ran methadone clinics. And, in 2023, they wrote some new rules that they put out into the public space for comment. And in 2024, February of 2024, the final rule was announced and put into place in April of 2024 and they revised the entire document. They read every word and considered every word of this original document, and they changed it in ways that were much more patient or patient-centered in the care. They advocated strongly that there should be shared decision-making between providers and patients, and it actually began to say we should rely on practitioners' clinical judgment when making decisions about how to treat patients. It allowed for more responsive and flexible methadone treatment services, it had much more evidence-based practice, and it used, for the first time, non-stigmatizing language. It was a really beautiful document, and for those of you who don't mind reading Code of Federal Regulation. It's a great… it's actually a great read. I recommend it. If you could go back to the last slide very specifically, in this document. They changed a few things. And Melissa, will you just go back one? There we go.

So, they codified or made more permanent access to take-home doses, and so the old rules said that you had to be in a clinic for 90 days, perfect. No urine toxicology that had any unanticipated drugs in it. You had you couldn't have missed a clinic day. And you really had to be deemed perfect from the OTP's perspective to get one take-home bottle. 90 days, 3 months of perfection. Which may you have to go to a methadone clinic, no matter how far away it was, 6 or 7 days a week. The next thing that was changed is that the diagnosis of substance use disorder was not defined by toxicology, and that may seem like a small thing, but it's an enormous thing. It said you could use toxicology, whether it's an oral swab or a urine toxicology test, to help, help you get a better sense of if somebody has an active substance use disorder, but that the decision about what is a true active substance use disorder was now a clinical decision, not based on a single test. It allowed, for the first time, truly individualized decisions about how to dose somebody. One of the recommendations for those of us that submitted language in 2023 that we thought would be better for the final rule. A lot of us said, please don't tell us how to dose methadone. We are licensed practitioners, we've trained for a long time, and we know what we're doing. The original CFR42 said that you could start at 30 milligrams of methadone. And this new document, some of us had argued, don't tell us what to do. And they did better. They said you could start at 50 milligrams, but they continued with very clear language, saying that a medical decision could be made if a patient may need more than that the medical decisions were left to the medical team, and I know that seems like a small thing and an obvious thing, but it wasn't originally in there, and it allowed those of us who know this world to be able to do our jobs better. You would still need, it was still required to have an in-person admission,

but all of a sudden, there was a lot more spelled-out flexibility. You could admit somebody on a screen, meaning that you could be sitting in Springfield, but a patient just walked into your clinic in Holyoke. There isn't a provider in Holyoke, but you could admit them on a screen. And that has actually, sort of opened up the door in an unanticipated way, where it's really very easy these days to do admissions 5 days a week, or even 6 days a week, because you can do it remotely, which is great. And it very clearly spelled out how to do a direct admission between, between hospitals, jails, and other places, and we're going to do a deeper dive on that.

It had always been written in 42 CFR that hospitals and skilled nursing facilities could use methadone for treatment as long as there was an admitting diagnosis other than opiate use disorder and to get a hospital admission, very few people are admitted for opiate use disorder alone. They're admitted because they have one of the sequelae of acute, disease on top of an opiate use disorder. They added 3 words to that sentence, which is that jails and correctional facilities could also use methadone under their DEA clinic license, to treat. This really could open the door for jails and prisons across the country to have better access to methadone. It hasn't blown the lid off of it yet. It certainly hasn't in Massachusetts, because we had already solved for this. We're going to talk a little bit more about that. But in other states, this really could open up treatment more easily. And a really important thing is that it allowed any provider with a DEA license who had knowledge of methadone to be able to work in a methadone clinic and make decisions. It is still the case that a medical director of a methadone clinic needs to be a doctor with either MD or DO after their name, but otherwise, providers that are PAs, nurse practitioners, a nurse midwife, they could all work at a methadone clinic. Next slide. Actually, two slides ahead.

Methadone clinics are required by statute to do certain things. They must provide adequate medical counseling, vocational, educational services to meet patients' needs. But the new rules made it also very clear that the services that are provided needed to be in combination and frequency that was tailored to each individual patient. And very specifically, it says, counseling is not a requirement. You cannot kick somebody out of the methadone clinic because they refuse to participate in counseling. And always in the past, it felt as though that was a way that you could get kicked out of a methadone clinic. And for those of us who've been around for a long time, we all heard you needed to do your five annual groups, you needed to meet with the counselor every week or every month. And this really says you need to meet the patient where they are. You need to get through the requirements that are set at a baseline, but above and beyond that, you're going to have to tailor what you provide to the patient's needs. Next slide.

I'm a family doctor, and I've prescribed medication across literally, I think, every class of medication in the pharmacopoeia and I'd only used methadone for the management of

pain. Coming to a methadone clinic or doing treatment at an acute treatment service, a detox facility. I've really come to love methadone. I think it's a remarkably effective medication that is stabilizes people's lives and makes them so much healthier. It helps them meet their goals, whether it's to stop using illicit opiates, or to decrease their use of illicit opiates. It allows people to get their lives back in a way that really, very few other medications I've ever prescribed have worked. Buprenorphine, also a very effective treatment as well that I've prescribed since 2003, but in the fentanyl era, methadone just seemed to work better. People were having a harder time getting on buprenorphine. And again, for those of you who haven't used methadone for treatment of opiate use, I think it's hard to know until you really start to do the work how effective it is. The studies are very clear on methadone. It reduces overdose rates by at least 50%, although that data is old, and for those of us in the field, what we'll say is methadone is very effective in treatment of fentanyl use disorder. And because fentanyl has such a high overdose rate, it's likely that overdose rates have been cut by way more than just 50%. Next slide.

Going to a methadone clinic is really hard, and one of the things we might say to a patient is that it took a lot of courage to walk in, because methadone clinics don't feel great to people. There's an admission, I think, that people have that some of them feel their own internal shame, or their own internal stigma, that they should just get over this addiction of their own accord, that you're just trading one drug for another, that maybe there's somebody in the family who thinks that they're weak, or there's somebody in their peer-to-peer 12-step recovery community that says you're not really sober if you're on methadone. There's a lot of, barriers, internal and external, to walking into a methadone clinic. So one of the things we say to people is, "We're proud that you're here, we think you're courageous, that you walked in, we're glad you're here for treatment, and walking into a methadone clinic, you're choosing… you want to get better, you're choosing life." I would argue that many other people who do the research on it would argue that the stigma and the harm associated with substance use in people of Black and brown-skinned people in Indigenous communities is even higher. Access to clinics may even be worse. Methadone clinics are, quite honestly, few and far between nationwide. Our numbers in Massachusetts are actually pretty good, but I live in a rural part of the state, and people can still drive 45 minutes or longer to get to a methadone clinic. And, you know, in our great state, the originator of the Affordable Care Act, where almost everybody has insurance, the Affordable Care Act mandated that substance use treatment was paid for by insurance, so our access in our state is excellent. But if you're in a state that hasn't expanded the Affordable Care Act, then the coverage or insurance coverage for methadone is quite poor, and it's often a cash-based system. That is not true in Massachusetts, all insurance covers methadone treatment. Next slide and then, next slide.

This is my favorite part of any talk, is when we get to show maps. I grew up in a house where literally the walls were wallpapered with geologic map, so it's, I'm a map girl. You'll never see me give a talk that doesn't have a map, is what I now know about myself. So these are the OTPs throughout the state of Massachusetts. And honestly, it looks pretty good. In our bigger cities, there's often more than one methadone clinic. They're spread out pretty evenly around the state. And yet, there's some places where there's some big holes, I think everybody can see that. In the West, it doesn't look like we have many clinics, but remember, the population in the West is obviously a lot less. When BSAS and Tufts has looked at the availability of methadone clinics by density. Really, it's actually many neighborhoods in Boston that have the lowest access to methadone clinics. And even though it looks like there's a bunch of clinics piled on top of each other. But when it comes to access, if you're in Mattapan, or Roxbury, or Dorchester, there's no methadone clinic there. If you're anywhere on the southern side of Boston, the access is less. I also want to point out Middlesex County, which is that county that really surrounds a lot of Boston. It's sort of the 128 and 495 area. That's actually the greatest population of counties; the county in Massachusetts, and you can see how few methadone clinics are there. Next slide.

This may feel like I'm head-jerking you, because I'm now showing you a map of correctional facilities, but I think that when you think about where people end up who struggle with a substance use disorder they end up in two places very predictably. They end up in an emergency room or hospital and they end up in jail. And if your jail or prison is not good at taking care of people with significant mental health disorder or substance use disorder, then you are failing at your job and one of the many reasons I'm proud to be a homegrown Bay Stater is in 2018, when there was a rewrite of criminal justice legislation at the state level. The original mandate from the legislature was that all prisons and jails in Massachusetts, not the federal, because state doesn't control federal, but every one of them would need to provide all levels of treatment for opiate use disorder. Methadone, buprenorphine, and naltrexone. And at the time, in 2018, the county sheriffs kind of freaked out, because they were like, we can't do that at least some of them said we couldn't do that, and some of them said, oh, we'll do that. And so we… it was sort of beta tested with 6, and then actually seven, facilities, including the Department of Corrections, to start the treatment. And then by 2021, it was mandated that every jail or prison, both state and county, needs to provide this. What did it really mandate? It said you had to maintain people on treatment, so if somebody walked in on methadone, it had to be maintained, and there should not be an interruption in care. it did not mandate that you were started on one of these treatments because you had opiate use disorder. And there remains a spectrum of care in the state as to what each jail or prison does. I wish that weren't true. I wish that if you had an opiate use disorder and you ended up at Bristol County, that you just knew you were going to be started

right away. But that doesn't happen.

There are some that are known to do it well, and start people within hours of arriving, and there's other places that specifically will not start you. They may consider you prior to release. But people, really suffer when they are forced to detox in a jail or prison. It's very painful physically, it's very painful emotionally, people tell me that if they had a way to kill themselves, they would. And, you know, we know that there's certain very large facilities, I'm going to say Worcester County is one of them, that is pretty rigid about even continuing people. If you have any, if you haven't been perfect at your methadone clinic in the last 7 days, they consider you not stable in treatment, and they won't maintain you on treatment. So again, there's a wide spectrum of care. The reason this matters to people on this call is that whether you're a recovery coach or you work at an OBOT, a community health center, you take care of patients who are in and out of our correctional system. And you knowing that getting them stable on treatment is going to allow them to maintain their treatment if they end up getting arrested on a warrant tomorrow morning. It's really important that people get admitted to treatment so that if they end up in jail, it can be continued. 9 of the facilities in the state actually became their own… oh, no, that's not quite correct. There's, yeah, 9 became their own opiate treatment program, directly, and then the other ones partner with another outside OTP. The federal government, and we have actually several federal facilities in the state of Massachusetts, is actually considered the largest fully licensed OTP in the country. They are mandated to do the treatment, and they do it pretty universally. Next slide.

We have some really brilliant partners in the state of Massachusetts, people who have been doing this work for a long time, who sort of grew it organically from Holyoke, or from Lawrence, or Lowell, and there's just great providers doing really creative work out there, who are already partnered with us, so I'm gonna just shout out a few of them. These are people I've gotten to work with over the last, last six years. But, you know, Holyoke Medical Center, a small community hospital in Holyoke, has an excellent addiction consult service that was you know, founded by a nurse practitioner, and still staffed by that same nurse practitioner, and a recovery coach, and nurses, and discharge planners, they do a great job. They're at Lowell General and Lawrence General, they have superb inpatient addiction consult services. At Boston Medical Center and Mass General Hospital, they have really high-functioning bridge clinics that can get you onto buprenorphine, or injectable buprenorphine, or methadone in a really effective way. With a well-oiled handoff to the community. So, there are systems that work really well. And would I love to replicate those systems everywhere? 100%. Next slide.

These are the addiction consult services based at hospitals in the state, and there's a lot of them. I think if we looked at maps of other states, they wouldn't look this good, partly

because BSAS has really worked hard to encourage these. I know Jen Miller is on this call from BSAS, and these are excellent care providers that are specialists in addiction, they know all there is to know about alcohol use disorder, opiate use disorder, and they can be consulted by an inpatient hospitalist, the surgical team, the ER, an outpatient clinician, to say, "Look, I don't know what to do with this person now, will you help me?" It's impressive how many there are, and I know how good they are. I work with all of these people across this system, and I watch what they do, and I'm constantly struck or astonished some days at how good they are at doing their jobs, how advanced they are. So for those of you who work these, these addiction consult service, Mazel Tov, you do a great job. The next slide is going to show us, however. How many hospitals there are in the state, and how many are missing an addiction consult service.

So, H is for hospital here, and lots of hospitals. I know you didn't memorize that last, slide, and I'm gonna actually have Melissa go back to it. But you'll see that, really, the entire southeastern part of Massachusetts, the entire Cape and the islands a lot of Worcester County. Worcester County, for those of you that don't live there, is a huge county. It goes from New Hampshire to Rhode Island and Connecticut, it really has one addiction consult service, and at UMass, all of Route 2, there's really nothing until you hit Greenfield, so there's a lot of work to be done at hospital levels. My experience working in regions that don't have highly knowledgeable addiction people at the hospital is that people who have substance use don't want to go there. I've had people on the Cape say to me, "I would rather lose my leg than go to this hospital. Because I feel like I'm… I'm treated badly, I tend to withdraw, and then I walk out after a day and a half, because it… I can't… I can't not use when I'm there." And you shouldn't have to travel to Boston or Greenfield or Springfield to get addiction care. You should be able to walk into any local hospital and have people be able to take care of you. Next slide. And then one more. Now, one more.

So, bridge clinics: Is there a formal definition of a bridge clinic? I don't really think so, but a bridge clinic in general is a place where you could go acutely to say, I need help. And you can imagine a bridge clinic doing a short-term prescription and then warm hand offing you to somewhere that can take you on permanently. This happens with the Community Behavioral Health Centers (CBHCs) for psychiatric care. They will start you on things and then hand you off. We have, I think, 27 CBHCs in the entire state. My number may be wrong there. But the bridge clinics I'm speaking of here are… are, focused on people with substance use disorder. It's a low barrier entry point. They mostly work 5 days a week, not 7 days a week, and they mostly work normal business hours. But you could walk into the Lowell Bridge Clinic and be started on buprenorphine. You could maybe get an injectable buprenorphine. You could do the same thing in Gloucester or at South Shore Hospital. These are really great clinics.

There's only two clinics that I'm aware of, and I would love somebody to correct me in the chat on this, that are using the 72-hour rule for methadone very routinely, like, literally every day. And that is Boston Medical Center's Faster Paths and MGH's Bridge Clinic. The 72-hour rule has been in place, maybe since 2022, I might have that year wrong, but it means that for 3 days, a hospital pharmacy or a community health center, a federally qualified community health center with a pharmacy, could dispense methadone to somebody with opiate use disorder. I don't know any of the Federally Qualified Health Centers (FQHCs) with a pharmacy that are doing this yet. I think it's a place we should be working towards. And I can only name two hospitals that are doing Methadone, 72 hours. And again, I want to hear in the chat that more people are doing it. I know that Cambridge Health Alliance is opening their bridge clinic. The open house is this Thursday. My team is going there with the question of: "Will you be doing methadone?" And in my experience, it's the fastest, easiest way to get on methadone in the city of Boston, and the patients know this. They'll show up at MGH or at Boston Medical Center, they get started on methadone, and then those clinics are superb at handing them off to a provider in the community. If all you're doing is giving people a day or two or three of methadone, you're not solving their problems. You have to be able to link them to the next clinic. One of the things I also think is not really happening at hospitals yet, and it really should be, is that if a person is really sick and they're on methadone in the hospital, and then you are discharging them, you are allowed to dispense 3 days of methadone. If they're sick, getting to a methadone clinic the day after they leave your hospital is really challenging to do, but you are allowed to dispense, hand to a patient 3 days worth of methadone. I know that Boston Medical Center has a process for this. They have a protocol, because Donna Beers shared it with us, but they… I think she made it clear they haven't actually put it into action. I could tell you, as the receiving person from a hospitalized patient, I often look at that poor patient and think to myself and say to them, "Oh my goodness, I wish you hadn't had to come here today. You look terrible. You could barely walk, it would have been better for you to show up in 3 days." So this is still something we can improve upon. Next slide.

This is language that I literally took out of the Bridge Clinic paperwork that came… comes from MGH, it's really clear. They have to be able to diagnose somebody with opiate use disorder, and they make that language very clear in the paperwork and they make it clear to the patient, look, we're not your methadone clinic. You can't be coming back here on day 5 and 8 looking for methadone. We're… our job is to start you, maybe get you towards a little stability, and then hand you off to a clinic and they have all this language in there, and then they send it to us. Next slide.

When you walk into a methadone clinic from a patient perspective, there's a lot of stuff

that has to get done. Does it all have to happen on day one? No, but a lot of it could happen on day one. We usually get… try to get people get it done in the first few days, because the sooner they get it done, the sooner they can advance to take-home bottles. But there's a screening to make sure they really have an opiate use disorder that's both asking questions, but also drug toxicology. They have to have been seen by a medical provider to admit them to the clinic. That can be done on a screen, or it can be done in person. We make decisions about what labs to get for patients based on their history. We screen them for tuberculosis and other things. We also… there's a ton of paperwork that is required. It's a lot. It's very overwhelming for a patient to walk into a methadone clinic and tackle all of this. Next slide.

The initial medical exam, that can be done by anybody. It can be done by a medical provider at a federally qualified community health center or primary care doctor. But the person who doesn't work at the methadone clinic could see a patient and could evaluate them and document that they have an opiate use disorder. It could be that they're a patient of yours who goes to your Office Based Addiction Treatment (OBAT) at the Lowell Community Health Center, and they're just not doing well on buprenorphine. They just… they come to you, they say, "It isn't working for me anymore, I tried it all, I tried this shot, I can't do it." That is a person who you might think it might be better for you to go to a methadone clinic, and let me start the paperwork so I can get you admitted there in a lower barrier way. So, documenting that they have an opiate use disorder, maybe by using the DSM-5 11-point criteria. And then, to actually get admitted, you need to have, the physical, could be documented, that makes the admission even easier for everybody. If you happen to have some lab results, that would be awesome, too. But this could be then sent to your local OTP, and then based on your relationship with that OTP, it could be considered an admission. Next slide.

If the exam was done by the non-OTP provider, it needs to have been done within 7 days. So let's pretend that you're discharging a patient from Holyoke Medical Center to the local methadone clinic. That you would send along your documentation that says they have an opiate use disorder, you started them on methadone, here's my physical exam from either admission or my last physical exam from the last day they were in the hospital. By the way, we do an EKG every day on them. Here's an EKG, because if you send an EKG, you'll save the patient a headache later, you'll create less work for the patient, which is kind. If you happen to have done a bunch of lab work, send that as well, because it could mean that we don't have to do any more lab work. The lab work should have been done in the last 30 days, but the physical needs to have been done in the last 7 days to count as the full physical. Next slide.

You know, my hope is that all of you on this call who either work in a methadone clinic or work outside of a methadone clinic will feel empowered to make a relationship. We

showed you the map of every methadone clinic in the state. My hope is you know who runs your local methadone clinics, that you have partners there, you have connections there, and if you don't, then call them up and make that connection. Talk to the program director, talk to the medical director, talk to the head clinician, and say, "I want to introduce myself to you. I run the OBAT at the local community health center, and I think we should develop a relationship." Having a Qualified Service Organizational agreement, a QSOA, is helpful. We all have to show those things to our BSAS friends and to our other credentials that we have developed these relationships. They're not required, but it does help in exchange of information. And, you know, if you're calling us about a specific patient with specific questions, obviously we need a release of information before we talk to you about that patient. But I… what bothers me about methadone clinics is, firstly, that they were ever siloed away in 1973. And, now, it's really… people feel like, I don't even know who they are or how to access them. We want everybody to feel like the same way I can call in and expect to my local ER and talk to an emergency room physician at any point, you should be able to call your methadone clinic and say, "I need help. We have… we have a shared patient", or, like, I got called this morning from a skilled nursing facility saying, "I think I have one of your patients, but I don't know what to do with them, can you help me?" So it's great to have those, that relationship with your local methadone clinic. Next slide.

People ask this question all the time, hey, a person just came in on methadone, how do I call for a dose confirmation? So BSAS is excellent. They're extremely well organized, they are a very smart group, they know what they're doing, and they have a great website, the OTP dose verification website. It has the telephone number, the 24-hour contact number for every one of the methadone clinics in the state, and they have one just for the jails as well. So let's pretend you are seeing somebody from a jail at your site, and you just need to call and confirm what they're on. You go to this website to get it, and the JSI team is going to drop those links in the chat so you can maybe save them somewhere. 24 hours, 7 days a week, people should be able to get dose verification. And what Mike Gurney will tell me is this still is probably the number one complaint: is sometimes it's really frustrating to get the dose confirmed, because you end up in some phone tree, and it's sending you other places, you get disconnected. It can be a very frustrating process, but my hope is it's gotten easier over the last few years. Next slide.

We've covered a little bit about direct admissions already, but I really think this is one of the most important things we can do. So even if you don't run an addiction consult service at a hospital, let's pretend you're one of the hospitals that doesn't… you're at Haywood Hospital in Gardner, and you don't have any of this, and yet you know your patient who just delivered a baby would be best on methadone. Figure out who your local methadone clinic is, contact them if they haven't already contacted you, and figure

out how to develop a direct admission process. Again paperwork, first of all, the thing that matters the most is that you've had the patient sign a release of information so that you can share that information with the methadone clinic. And then that is the lowest barrier way for a patient to have delivered a baby. Be sent home, still bleeding and exhausting… exhausted with a brand-new baby, to have her get into the clinic so we can see her so fast, we can get her take-home bottles right away, so that she doesn't have to put a baby that she doesn't even feel comfortable holding at this point, into a car seat and haul them into a methadone clinic. Next slide.

We've covered a lot of this as well. We've said the signed release of information. The document must show that the patient has an active opiate use disorder. I would say 10% of the time, I look at the paperwork somebody sends me, and I'm like, yep, this isn't gonna work, because it doesn't have any of that. It has a last dose letter, it has, like, the meds the patient is on. That's not enough. It has to show that they have an active substance use disorder based on somebody's evaluation, whether it's their history that you took. Something you found on a physical exam or drug toxicology. A last dose letter is awesome if it comes, because you may hand it to a patient, but I could tell you very few patients can find their last dose letter in that giant stack they left the hospital with. It's the OTP's job to confirm if a patient is already enrolled in another methadone clinic. And you should be prepared if you do a direct admission, that the methadone clinic providers might call you and say: "Hey, can you help me understand your thinking on how you did this?" or "Why you did it this way? Just so I can make sure I'm understanding our process and how we can help the patient the best." Next slide.

The methadone clinic provider is responsible for the receipt of this, and to review the documentation, and then we further document on top of this documentation to say that this patient has been enrolled in our clinic, and that if the in-person physical did not happen in the last 7 days, that the OTP provider needs to have done an in-person physical within 14 days of the patient arriving. Next slide.

Long-term care facilities are numerous. I think many of us who work in this world know that our patients are getting older. They're getting more complicated. They have cancer and hip replacements and other joint replacements, and they end up going to a long-term care facility. It is the rule that long-term care facilities are not supposed to discriminate against people who have opiate use disorder or substance use disorder, and yet our experience from people who discharge from hospitals is they do discriminate. That is, they are not supposed to, and it's a violation the Americans with Disability Act.

And in the past, the Department of Justice would go after them. I don't know what the Department of Justice is doing these days, but likely not going after skilled nursing

facilities. There's a..., it will be dropped in the chat, but there's a long-term care TTA center that you could go to and learn a little bit more about this. MassHealth has additional billing that can be added on top of long-term care billing. In order to, maybe get a little bit more money. And there's some really positive relationships that OTPs in the state have with certain skilled nursing facilities where they come and deliver the methadone. But remember, if you have a DEA clinic license as a skilled nursing facility, 42 CFR says you can use methadone. You're treated like a hospital is. I still think most of these facilities don't seem to understand that, and it's the lowest barrier way to manage people on methadone in a skilled nursing facility. Next slide.

This is an absolute great document, and we're going to send this link in the chat as well, but Department of Public Health came out with practice guidance that maybe came out, I don't know, 6 or 8 weeks ago. And it talks about practice guidance on hospital and opiate treatment program coordination of care. It literally spells out what we're just covering here. So if you are thinking, "Oh, this is kind of interesting, I want to learn more", you need to get this document. So that will be dropped in the chat so people can easily get to it. Next slide.

I'm actually not going to spend any time on this, but I'm… one of the things we've learned in this process is this is a 101 conversation we're having with folks. There's a 201 and 301 conversation. I was out in San Diego this past weekend at ASAM doing a 201 or 301 talk with a bunch of addiction providers. And I do want to remind everybody that in the fentanyl era, how we have dosed methadone in the past isn't working, and patients are really suffering. And the sooner we can get people both safely but quickly onto a stable dose of methadone, the better it is for patients. The old days of it taking 3 months to get to a stable dose of methadone, that's unacceptable. And I definitely have improved my own private personal practice on how to get people stable, and with great efficacy. For patients, it's a life changer. For when people really want to stop using, we should not give them such a low dose that they have to keep using for weeks or months on end. Next slide.

I think, well, we're at questions, and we have time for questions, and the way we're going to do questions is, I think. Melissa's gonna sort of look at them, in the chat. Probably will rely on the chat for questions.

Melissa Schoemmell:

Yes, thank you, Ruth, so much. I so appreciate every time I hear that talk. There were some questions in the chat. Let me scroll up. The first question, just about how to start the conversation with a hospital, to… in setting up an addiction consult service, especially if they were advised against even talking to that hospital.

Ruth Potee:

Hmm, okay. Yeah, I'm not gonna lie, I think it's actually hard because, so, first of all, you need to sort of know people on the inside. You need to know who the people are in that hospital that already have sympathy towards folks who struggle with substance use. Maybe there's an ER doctor who's been doing bup[renorphine] prescriptions after an overdose for a while, or a hospitalist that you know also happens to work at an OTP part-time. So you… it is hard if you know nobody in the hospital to break in. I'm working on the Cape right now, and I have a methadone clinic there, and I actually… I don't know people on the Cape. I've never worked in the hospital system there, and I'm having to sort of, take a deep breath and just basically cold call people to get myself in there. And I do think… so, but if you have… if you have some ins, then I think that's the place to start. If you have real ins, I think saying, "Look, I'm a local methadone clinic doctor, I'm an addiction specialist, and I'd like to give grand rounds to the medicine and the emergency medicine services on treatment of opiate use disorder. I'm a specialist, I want to teach you about it." That would be the best thing to do. And then, you know, do I think that you have to have an addiction consult service? Nope. I think if you had well-trained hospitalists and ER doctors, you could… you could get them going pretty fast, especially if you were willing to say, "Call me if you have trouble, call me if you can't figure something out, I'm happy to provide guidance to you." And nobody should be recreating the wheel on starting people in the emergency room. This is done across the country not universally, but I'm thinking about my own Bay State Hospital in Springfield, where Bill Sores has a protocol that every ER doctor in the Bay State system, they have 4 hospitals, a big hospital, and 3 community hospitals, they all use it in the ER, and they start people on methadone, and they hand them off to the community OTP provider. So don't start from scratch, somebody's already done the work for you, just get their information. And Bill Soares is on the OTP TTA website. He presents pretty frequently in that setting.

Melissa Schoemmell:

Thank you. Thanks for that question. And, I'm seeing in the chat there's also a hospital TTA learning collaborative, that is available, so we're connecting that question asker with that learning collaborative. So…Another question, what is the soonest time frame that someone can receive, and I think this is supposed to say, receive take-homes?

Ruth Potee:

Day one, the federal rules say that on day one, you can have a week's worth of bottles. By the time you hit day 14, you can have two weeks of bottles. By the time you hit day 30, you can have a month's worth of bottles. So that's what's written in the federal regs, and the state of Massachusetts said, we will do what the federal regs said. We will not add any more barriers on top. And in fact, the state is so good. That they asked for some exceptions to be even a little lower than what the federal regs are. So, on day one, you can get a week's worth of bottles. Now, having said that, many people who walk in a methadone clinic are just starting, they're not on a stable dose they're kind of a mess, and handing them a week's worth of the wrong dose of bottles isn't great, so it's not common I have people walk out of my clinic on day one with a week's worth of bottles. Sometimes they do, though. Sometimes they're a transfer, they've done well at another clinic, they jump through the bare minimum of requirements, and we can start. The places where I think it really matters is when you're taking care of somebody who's sick. Somebody who's disabled, who getting to the clinic is too hard. Then, not only, if they're on a stable dose, should they have a week's worth of bottles, but any methadone clinic can file for an exception at both the federal and state level, and for medical reasons, can ask for more bottles on day one. So it's pretty fast.

Melissa Schoemmell:

Thank you. I see Robin has her hand raised. Would you like to come off?… I don't know if guests can come off mute.

Shaivi Herur:

Yep, I can bring Robyn off mute.

Melissa Schoemmell:

What is your question, Robyn?

Shaivi Herur:

May also just be a technical… oh, there we go, I see Robyn off mute.

Robyn Donati:

I don't know… I don't think my hand was raised, unless there's more than one Robyn.

Melissa Schoemmell:

Okay.

Shaivi Herur:

Just to…

Melissa Schoemmell:

Let me… we can remove the hand raised. There was another question in the chat, from a residential program. So, as a residential aftercare program… as a residential program, aftercare is important for clients to continue their treatment. We have reached out to long-term care facilities and have been turned away because our clients receive methadone. Thank you for confirming clients should not be turned away. So that was more of a comment.

Ruth Potee:

Yeah, they should not be turned away, and yet we know that they are, and… I mean, for me, it's a time to call DPH and make a complaint. In the old days, when the Department of Justice was a little more functional than it is right now, we literally would call the Department of Justice Assistant Attorney, and he would send letters to them that were threatening, and it was super effective. But again, I haven't myself been to the, long-term care TTA site. My hope is that there's some ideas there about what exactly you should do, but personally, remember, DPH is the one that licenses most long-term care facilities. The more you complain to DPH, the more DPH is going to be able to make people do their jobs better.

Melissa Schoemmell:

Thank you. And we did put that link in the long-term… to the long-term care TTA Center in the chat, and there was, from our virtual convening, there was a session on, long-

term care in the TTA Center, so definitely another resource for folks who are interested in that. So there's two other questions I'm seeing in the chat. Thank you all for throwing those in there, but why… Ruth, why do you think that methadone isn't included on the Massachusetts Prescription Drug Monitoring Program (PDMP)?

Ruth Potee:

Why do I think? I… I mean, I think it all has to do with 42 CFR, even though that's not rational, because buprenorphine is on the Prescription Monitoring Program (PMP) it isn't included on the PMP, and the only state where it could be included on the PMP at this point is Illinois, and it's still not even there. So, there's no state in the country where it's on the PMP. And, you know, again, how… why bup[renorphine] and not methadone? Because the 42 CFR applies there, too. I don't… I don't have an answer for that. Having said that, it both isn't, and it's not about to be. And I really wish it… it's such a problem that it's not. It's so hard for people to know that somebody takes methadone if a patient doesn't let you know that. And it could be really harmful to somebody if you're… if they are on methadone, and you've continued to prescribe them buprenorphine, or you're about to give them a long-acting injectable of because the patient didn't tell you. So, somebody just asked a second question, which is a little bit of a part of this. So, Lighthouse is the central registry clearinghouse that's used, I think, in almost every state. It's what we use, where the OTPs can see who's on methadone. And you could theoretically see their dose, you should be able to see what their take-homes, and the problem is hospitals and ERs don't have access to that. And honestly, I think… I hate to throw it at BSAS to answer that question. If there's ever a time when hospitals might have access to Lighthouse, I don't know the answer. It would help.

Melissa Schoemmell:

Thank you and a comment here, there's still a huge stigma around methadone, and buprenorphine is more acceptable in the public view. And then, Steven, I know you're popping off, but Ruth, any, insight into the impact of the very recent SAMHSA change? I'm not sure if I am aware.

Ruth Potee:

You mean the letter that… the Dear Colleague letter that came out 5 days ago? Are you that… are you that up-to-date on things, or is there something I'm missing there?

Melissa Schoemmell:

I think this individual is, yes.

Ruth Potee:

Wow. Mmm… Well, again, the Dear Colleague letter came out… two letters came out on Friday, for those of you who are really deep in the weeds. I mean, there's a whole bunch of things that are about to change that are causing us a lot of anxiety. I think the fact that in 2027, patients could get kicked off MassHealth, you all know that having the diagnosis of substance use disorder, or in fact, a mental health disorder, makes you a vulnerable patient, so you shouldn't be kicked off. But, you know, we're gonna all need to document pretty well all the time to make sure our patients are protected. The Dear Colleague letter, I'd have to dive back in my head fast on this, but one of the things it said to OTPs and OBOTS is that we're going to be required to talk to our patients every year about tapering off. I mean, I don't even know what to say about that. I… again, I don't love it when the government tells us how to practice medicine. I'm trying to think of what else he's referencing that would nothing else lit up for me other than whenever we get a Dear Colleague letter from SAMHSA, that what was most concerning about that letter was that federal monies couldn't be used.

Melissa Schoemmell:

For…

Ruth Potee:

Safe supply, like syringes and fentanyl test strips. That was really concerning to those of us who work in harm reduction. In general, you know, if we're going back in time, the final rule that came out in 2024 has been a game changer for patients, and I hear what people say, that methadone is more stigmatized. What I say to patients is methadone clinic rules stink. Methadone, the drug, really works. And if clinic rules are easier, it makes coming to a methadone clinic much more reasonable. And, I think more people are liking being on methadone because the rules have changed. I know I'm over time. And thank you to our ASL interpreters. You are amazing. I've been watching your hands fly.

Melissa Schoemmell:

I agree, I agree, and we are at time, and I do see there's a couple other questions, so we will make sure we get those, and if Ruth is able to provide a response to those, we will be sure to share that. There's some claps going out, and thank you again, Dr. Podi and, everyone here, just to… to be learning and asking these really important questions. This presentation has been recorded, and our website will be a place where you can access this information, but we will be sending it out over the email system when… as… that you registered with. So, thank you all so much for being here. We will see you at our next event, hopefully soon. Take care of yourselves.