OTP Accreditation: A Progress Report
An Interview with Megan Marx of The Joint Commission

In 2001, federal regulatory oversight for opioid treatment programs (OTPs) shifted from the Food and Drug Administration (FDA) to a national accreditation model under the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT).

SAMHSA-approved accreditation bodies make site visits to each clinic certified by SAMHSA/CSAT to verify that it meets specific, nationally accepted standards of organizational functioning, and provides quality patient care. These accreditation organizations help OTPs enhance their person-focused care, using an individualized approach to services and treatment outcomes (see Sidebar).

Currently there are six SAMHSA-approved accrediting bodies:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- The Joint Commission
- Council on Accreditation (COA)
- Division of Alcohol and Drug Abuse, State of Missouri Department of Mental Health
- Division of Alcohol and Substance Abuse, Washington Department of Social and Health Services
- National Commission on Correctional Health Care (NCCHC)

CARF and The Joint Commission represent most OTPs.

A decade has passed since the accreditation model was enacted. Addiction Treatment Forum discussed the progress OTPs have made during that time with Megan Marx, MPA, Assistant Director of Special Contracts at The Joint Commission.

**AT Forum: In your view, what has accreditation accomplished for OTPs and their patients?**

**MARX.** Part of the purpose of accreditation was to improve standards, and that has happened. More programs are focusing on patient safety and on consistent, higher quality care.

**ATF: How are OTPs progressing in the area of continuous quality improvement (CQI)?**

**MARX.** CQI is one of the best ways to describe what accreditation is all about. There’s CQI related to patients, to staff, and to community. The best programs we have are always looking at ways to improve the services they offer.

Continuous quality improvement isn’t just an end; it’s a cultural approach to how you offer treatment. That’s probably the most significant thing that accreditation...
Improving OTP Media Relations & Outreach in Your Community

In our Fall 2009 issue, we interviewed Stacey Pearce about Georgia’s first state Methadone Treatment Awareness Day. While the day was deemed a success, one of the lessons learned was that there was no press coverage of the event. Many opioid treatment programs (OTPs) just “don’t have a good mechanism for press outreach,” she noted.

Value of Media Relations & Outreach

Outreach to the media can be an invaluable tool to OTPs. It can help demystify treatment, counteract stigma, and enhance your program’s image. It can improve the potential for a more balanced reaction when negative incidents or views threaten to undermine patients, the clinic, or medication-assisted treatment (MAT).

Ed Johnson, OTP Administrator at Charleston Center (Charleston County Department of Alcohol and other Drug Abuse Services) in South Carolina, makes it a point to seek out good publicity for MAT and his program. Not only does it help his 250 patients by removing stigma coming from the community, but it helps promote MAT in general. In 2008, in the midst of negative news coverage about methadone overdoses, Johnson talked to a reporter for the Charleston Post and Courier, and the result was “a very good article about methadone treatment.” When that kind of article gets picked up by other news outlets, facts, not myths, get passed along.

Johnson’s advice: keep track of local reporters to ascertain which ones are supportive of recovery, and contact them about opioid treatment. But you don’t need to do it on your own: find media-savvy officials or connections who can help. If your program is connected to a state or county, there will be a press officer who will be glad to market your program to media contacts. Make sure you tell the press officer that you can talk about addiction issues in general, not just about methadone.

OTPs should also connect with their local affiliate of Faces and Voices of Recovery (FAVOR), a national organization with strong grassroots and press operations. Don’t reinvent the wheel, when FAVOR may have already identified media people who are friendly, says Johnson. In many cases, FAVOR is very supportive of MAT.

Numbers Tell A Story

You will need specific numbers when talking to the media. For example, show how many of your patients are working, leading stable lives, and paying taxes—facts that resonate with the public, says Johnson. Cite the number of patients at admission who had any legal involvement in the previous six months, and then show the decrease in that number as the patients stay in treatment.

One of the best statistics you can share—one that impresses even other drug and alcohol treatment programs—is the percentage of patients on some level of take-homes, which means they have negative drug screens, are involved in treatment, and are making therapeutic progress, says Johnson. His numbers: between 60 and 65 percent of his patients are on some level of take-homes, and fewer than 15 percent test positive for more than one drug. On average, on a monthly basis, only 6 percent test positive for opioids other than methadone after initial stabilization.

In addition to numbers, give reporters some guidance in terminology. Reporters may insist on calling your program a “methadone program” unless you can explain why it’s more accurate to say “opioid treatment for Press Releases

- Unique research findings or treatment outcomes
- Human interest story about a patient’s treatment success or accomplishment
- Introduction of new services, dedication of a new facility
- Announcement of new director or high-level staff appointments
- Announcement of seminars, fairs, or workshops open to the community
- Promotion of the local impact of a national event (eg, Recovery Month)
program.” Tell the reporter that it’s not a euphemism: in fact, your OTP is not a place where people come to get medication only. It’s a place where they come to get treatment.

Other Suggestions for Press Coverage
A community education kit from the Substance Abuse and Mental Health Services Administration (SAMHSA), called “Medication Assisted Treatment for the 21st Century,” provides a good framework for media outreach. It includes fact sheets and a press release with blanks for you to fill in about your own program (see Sidebar for ideas on press releases).

It’s important to be proactive—don’t wait until you have to do damage control. For example, host a community liaison event for program staff, patients, and family to interact with the public. Then invite the press to cover that event (that’s the piece that the Georgia OTPs forgot).

Another way to get press coverage is to participate in forums that involve elected representatives, government officials, and law enforcement organizations, including local police. Local reporters usually cover these meetings, and your presence as an active and responsible member of the community will help get you entry when it’s time to actually pitch a story. Give the reporter your business card and some literature about your program, and invite him or her to stop by.

Encourage Patients to Speak Out
SAMHSA’s community education kit suggests that you “involve recovery patients in the agency’s community and media relations to counteract stigma.”

But Johnson says his patients don’t feel ready to identify themselves to the press, using their real names. In the Northeast—especially New York—where there is a heavier concentration of OTPs, the patient advocacy movement is stronger. But in other parts of the country, the stigma may be too great. For example, some of his program’s patients have formed a team to enter a local AIDS walk, but are not choosing to identify themselves as patients. “I hope we’ll get to a point, someday, when they do feel comfortable doing that,” Johnson says.

Resources available online at ATForum.com.

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New Stigma-Related Resources

New Video: “In My Backyard: Dispelling Myths About Methadone”

The International Center for Advancement of Addiction Treatment (ICAAT) has produced a 15-minute video addressing the “not-in-my-backyard” (NIMBY) phenomenon—probably the greatest barrier to meaningful expansion of methadone treatment availability in the U.S. This film highlights the patients, staff, and services of a methadone maintenance treatment clinic operating since 1974. The clinic is in a church building in the heart of residential and commercial Greenwich Village, NYC.

The video can be accessed online at: http://www.icaatnimbyvideo.info/ or, for a free copy of the DVD, contact Hindy Bernstein at hbernstein@icaat.org.

New White Paper: Strategies to Reduce Stigma Attached to Addiction, Treatment, and Recovery

A new white paper focusing on stigma reduction for medication-assisted treatment (MAT) provides valuable insights into why society views MAT the way it does, and how to combat myths, to benefit your program and your patients. This thorough analysis, prepared for the City of Philadelphia by William L. White, MA, also addresses street myths and stigma.

The 48-page white paper is available for download at the Faces and Voices of Recovery website: http://www.facesandvoicesofrecovery.org/pdf/White/StigmaMedicationTreat ment.pdf.

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does for an organization. We follow our own CQI process within The Joint Commission, just like we ask our accredited organizations to do.

**ATF:** What about patient satisfaction related to CQI?

**MARX.** Patient satisfaction is key. If patients are satisfied, you’re doing something right. That’s part of why individualized treatment is so important.

Talking with patients is built into the accreditation survey. The surveyor traces the patient’s care from the first point of contact, and talks with all care providers, and the patient, in detail. This confirms that patients and providers agree on treatment planning and progress. The surveyors talk with more than one patient, to get different opinions, ideas, and experiences, to create a holistic picture.

**ATF:** Are OTPs providing, or linking to, the comprehensive services patients require?

**MARX.** Things are improving all the time. In training, we focus on how OTPs can link to community services. CSAT’s revised guidelines have helped by providing some guidance on linkage and the variety of services and programs available in the community. Perhaps the resources are not even related to addiction or medical or mental health; they may be ways to access clothing, food, or employment. Programs are working to prioritize each patient’s needs and find appropriate resources.

**ATF:** What are some primary challenges OTPs face?

**MARX.** First would be individualization of treatment. This is where we focus a lot of our educational efforts; how you devise treatment plans that are not the same for everyone. Counselors and staff are often pulled between paperwork and individualization. The more streamlined the paperwork, the less individualized the treatment. Finding a happy medium is a challenge for the staff.

Another important area is documentation. When we survey a program, documentation is the only reliable evidence of treatment progress. If OTP staff say, “But we just don’t have a way to capture that information in our forms,” we help them find a way.

The third challenge is improving staff retention. If the leadership makes an investment to train staff and address their concerns, staff are more likely to remain. But you need resources to do that, and that is always a problem, especially in today’s economy.

**ATF:** When you survey an OTP for accreditation or reaccreditation, what aspects of risk management do you focus on as areas that need help?

**MARX.** Anything that is a risk to patient safety. If we see practices in methadone dosing that could risk patient safety, we respond immediately. For example, any pre-written standing order for methadone dose induction. Or consistent problems with the calibration of computerized dosing equipment.

If a patient enters a program intoxicated, and an OTP will not medicate the patient, we will review the patient’s records to make sure the staff are offering counseling, and working with the patient on issues related to this intoxication episode.

If we see diversion of methadone, and the program isn’t addressing the situation appropriately, we will speak with the OTP administration. We’ll ask about their relationships within the community, and whether they are networking with community and neighborhood associations, and with the law enforcement community. All play a part in diversion control.

**ATF:** What is The Joint Commission’s position on monitoring patients for abnormal QTcs, and issues related to risk management?

**MARX.** Some time ago we wrote into our standards a recommendation about doing a risk assessment related to cardiac concerns. Our accredited programs have gone much further with this than we expected they would.

Larger programs affiliated with medical centers can perform admission and follow-up ECGs, with possible computer linkage to the cardiology department. Smaller programs generally don’t have those options. It makes sense to ask all patients about personal and family cardiac history, and any medications that, combined with methadone, may increase the risk of QTc. Beyond that, we don’t know enough to make specific recommendations. The Joint Commission is hopeful that a future study will more definitively measure the cardiac risk related to methadone for OTPs.

**ATF:** What would you recommend about take-home medication?

**MARX.** When we survey, we make sure that all patients are assessed for appropriateness for take-homes—initially and at change points—but not for every take-home dose. The OTP physician must sign off on every assessment. The Joint Commission wants to make sure that programs have developed and follow appropriate protocols that ensure safety for patients receiving any take-homes. For instance, this may be a protocol that requires new admissions only on Monday and Tuesday, so that new patients have been observed taking their methadone medication in the clinic for at least three or four days before they receive a Sunday take-home dose.
ATF: Are you finding many new OTPs seeking accreditation for the first time?

MARX. Just a handful each year. We’ve seen more activity in the South and West than in the East. And some of this increase is related to the increased use of prescription opioids, not heroin.

Since the accreditation model was adopted, most new OTPs have come from corporate structures. The single-owner programs have found it difficult to remain open, especially now that less federal and state funding is available. Corporate entities have purchased many of those small programs, and have become large and influential providers.

ATF: How have the corporate providers impacted the quality of care?

MARX. It depends on each company’s commitment to the field and to its patients. Making the program work well for patients, staff, and investors is difficult. Corporate ownership typically increases the cost to the patient, and may decrease the individualization of treatment—although we’re constantly working with programs on that aspect.

On a positive note, corporate ownership has greatly increased the availability of treatment. About 100,000 more people are in treatment now than ten years ago, and many of these people wouldn’t be in therapy if it weren’t for corporate investors. So there’s a definite benefit with corporate entities, if quality is equal.

ATF: Has accreditation had any impact on reducing the stigma associated with methadone maintenance treatment?

MARX. Perhaps to some extent, but we’re talking about stigma against medication-assisted treatment itself, and against the people who need treatment, regardless of whether the program is accredited. Accreditation has, however, helped the medical community understand that addiction is a disease, not a moral failure. We encourage OTPs to market their accreditation. It raises the public’s awareness of its significance, and could help reduce stigma as well.

ATF: Prescription drug abuse has become a big problem in many small communities and rural areas. Do you know of any models of care that might make treatment in these areas more accessible?

CSAT Rescinds “Dear Colleague” Letter on Methadone Take-Homes

Last October, the Center for Substance Abuse Treatment (CSAT) rescinded the January 24, 2008 “Dear Colleague” letter on methadone take-home doses. The letter had raised serious concerns among OTPs, patient advocates, state opioid treatment authorities, and accrediting bodies, detailed in a letter to HHS Secretary Kathy Sebelius from The American Association for the Treatment of Opioid Dependence (AATOD). The retraction means that those OTPs that closed Sundays and holidays where state regulations allow, may continue to remain closed without fear of citations from CSAT or accrediting bodies.

CSAT still intends to consider options for promoting patient safety, particularly during the first 30 days of treatment, Robert Lubran, Director of the Division of Pharmacologic Therapies at CSAT, told AT Forum in mid-December. Options include proposing a federal rule; convening a meeting with stakeholders, including OTPs and states; and rewriting the “Dear Colleague” letter.

See ATForum.com for links related to the “Dear Colleague” letter.
Managing Alcohol Use Disorders in OTP Patients
Part I: Overview and Screening

Alcohol use disorders (AUDs) are always a concern with patients in methadone maintenance treatment for opioid addiction. Mixing alcohol with methadone can adversely affect patient compliance and treatment outcomes.

Staff members in opioid treatment programs (OTPs) need to be aware that screening and treating methadone patients for AUDs is an important part of patient care, and cannot be overlooked.

Why Some People Develop AUDs

Heredity and other genetic factors that cannot be modified play an important role in AUDs. But health care practitioners can help patients modify other factors that trigger alcohol disorders.

Triggering factors were examined in a recent study in England involving a small cohort of 50 OTP patients, 27 (54 percent) of whom were alcohol dependent. More than half said they used alcohol to relax, relieve boredom, improve mood, forget problems, or fall asleep more easily. Almost one-third said they drank to increase the psychoactive effects of methadone or other drugs, and one-fourth drank to calm themselves after using other drugs.

Effects of Alcohol on the Body

Alcohol depresses the central nervous system. The exuberant behavior often associated with drinking does not result from a stimulant effect, but from loss of inhibition. People who lose inhibitions are more likely to drink too much or use other harmful drugs while under the influence of alcohol.

Like methadone and other opioids, alcohol increases dopamine levels in the pleasure center of the brain. But an excessive amount of alcohol can lead to depression and other distressing feelings. It induces sedation and impairs judgment and mental and motor skills. It increases the chance of traffic or work-related accidents and other mishaps, and raises the risk of death from injury. Over the long term, excessive alcohol intake can damage organ systems; the results—such as cirrhosis of the liver—are well known.

Some people develop tolerance to alcohol after consuming large amounts over a long period. Even greater amounts are then needed to achieve the same effects. Tolerance does not occur at the same rate for all effects; it develops more quickly for mental functions, such as taking a test, than for activities needing eye-hand coordination, such as driving. Thus, someone who doesn’t appear to be impaired may in fact be in no condition to drive.

Effects of AUDs on Opioid Treatment Outcomes

Patients on methadone maintenance who chronically misuse alcohol face a less favorable and more complex course of treatment:

- Higher death rates during and after methadone maintenance treatment
- More medical problems, eg, accelerated progression of hepatitis C infection to cirrhosis and liver failure
- More psychological problems, including depression, antisocial personality disorder, obsessive-compulsive behavior, phobic anxiety, psychosis, and suicide
- More behavioral problems, often a reason for premature discharge from treatment; problems may include lack of cooperation, intoxication that makes safe dosing impossible, and threats of violent acts towards staff, other patients, or both
- Increased use of illicit drugs during treatment
- Poorer social and family function and peer relations
- Increased criminal activity, and escalating legal problems

Screening for Alcohol Use

Because drinking alcohol is an individual treatment issue, and AUDs impact treatment outcomes, all patients should be screened for alcohol use before methadone maintenance treatment begins, and monitored for use throughout therapy. Screening allows OTP staff to record data for diagnostic use, advise patients about potential alcohol/drug interactions, educate patients about risks of alcohol use, and suggest ways to reduce alcohol intake.

Screening also enables OTPs to determine the level and frequency of alcohol use, and to assess the possibility of related health risks.

Two self-scoring tests commonly used in screening OTP patients are the Alcohol Use Disorders Identification Test (AUDIT) and the

Patients on methadone maintenance who chronically misuse alcohol face a less favorable and more complex course of treatment.
Men may be at risk of alcohol-related problems if consuming more than 14 standard drinks/week* or 4/day; women, more than 7/week or 3/day.

*Standard drink: one 12-ounce bottle of beer or 5-ounce glass of wine, or 1.5 ounces of distilled spirits.


Audit – Alcohol Consumption Patterns

Hazardous Drinking
– increases risk for user or others

Harmful Drinking
– has consequences for physical and mental health

Alcohol Dependence
– behavioral, cognitive, and physiological effects from repeated alcohol use:
  – strong desire for alcohol
  – impaired control over alcohol use
  – persistent drinking, despite harmful consequences
  – higher priority for drinking than for other activities/obligations
  – increased tolerance
  – physical withdrawal reaction when discontinuing use

Source: The Alcohol Use Disorders Identification Test, World Health Organization

Newburgh, NY Family Health Center Integrates OTP Services

Many patients who are in medication-assisted treatment (MAT) have neglected their health care as a result of their opioid addiction. Access to comprehensive medical care can be directly related to improved outcomes in opioid treatment program (OTP) patients. And one program in New York, the Greater Hudson Valley Health Center’s Center for Recovery, has now integrated its primary health care services within the chemical dependency outpatient programs, making it even easier for patients to get primary medical and dental care.

The Center for Recovery, headed by MaryAnn Elberth, DSW, is part of the Greater Hudson Valley Family Health Center (GHVFHC), which took over the methadone program in 2008. Dr. Elberth is excited about being able to use this connection to get comprehensive medical care for her patients, including primary care, dental care, and treatment for infectious diseases and for conditions involving obstetrics and gynecology.

One patient, for example, gets her primary care at the family health center, and has a host of issues, including behavioral health, HIV, and dental, that require attention. All clinical professionals who work with her meet for case conferences so that they are all “on the same page and working toward the same goals,” says Dr. Elberth.

One of Dr Elberth’s goals is to establish a staff liaison position and to appoint someone who would work for both the family health center and the Center for Recovery. This person would facilitate the admission of patients from the family health center to the OTP, and would also
coordinate comprehensive medical services for patients at the Center for Recovery. A sizeable prescription opioid problem exists in the surrounding area, about an hour north of New York City, and Dr. Elberth feels that many of these patients could be referred by the GHVFHC to the Center for Recovery.

Those referrals will be streamlined starting this spring, when the family health center will move into a new building one block from the Center for Recovery. Currently, the family health center is a mile away.

Co-location of the services is very important for patients in treatment and in recovery, says Karen Carpenter-Palumbo, commissioner of the New York Office of Alcoholism and Substance Abuse Services (OASAS). “We’re trying to make sure people get a warm handoff to the care they need, not just a referral,” she says. “Somebody who has food stamps, who has kids, and who is addicted, isn’t going to take a bus to get to medical care.” But if that care is nearby and easy to get to, the patient will have better medical health and be more likely to stay in treatment.

Methadone Transformation

Dr. Elberth already has experience integrating MAT with drug-free treatment for addiction. When she first arrived at the Center for Recovery in 2008, there was one program for treating all drug and alcohol addictions, and an OTP, which was located on the other side of the building. “Never the twain shall meet” was the guiding philosophy, Dr. Elberth recalls. “There was little collaboration and little coordination of services.”

But that was soon to change. The Center for Recovery was moving to a “no wrong door” concept even before OASAS announced its plans to incorporate OTPs into general recovery systems of care, as part of methadone transformation. The OASAS announcement came at the AATOD annual conference in April 2009 (see AT Forum, Spring 2009).

The “no wrong door” central intake will be operational by spring—around the time the family health center will move next door. The stigma of going into a “methadone” program will be removed, because patients will be going to get just health care—and health care, says Dr. Elberth, is a right, not a privilege.