

FINAL REPORT

OPIOID TREATMENT PROGRAM (OTP) ACCREDITATION EVALUATION

May 31, 2006

Task Order Number 277-00-6507

Submitted to:

Arlene Stanton, Ph.D., N.C.C., Government Project Officer
Division for Pharmacologic Therapies (DPT)
Center for Substance Abuse Treatment (CSAT)
Substance Abuse and Mental Health Services Administration (SAMHSA)
1 Choke Cherry Road, Room 2-1069
Rockville, Maryland 20857

Submitted by:

Northrop Grumman Information Technology
Health Solutions
Public Health Division
2101 Gaither Road, Suite 600
Rockville, Maryland 20850

ACKNOWLEDGMENTS

This report was prepared for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, by Northrop Grumman Health Solutions and its subcontractors under contract number 277-00-6507. Arlene Stanton, Ph.D., N.C.C., served as the Government Project Officer, and Ray Hylton, R.N., M.S.N., as Alternate GPO. Numerous other colleagues at CSAT contributed in various ways to the implementation of this study. These included Robert Lubran, Division Director, and Nicholas Reuter and others within the Division of Pharmacologic Therapies. Herman Diesenhaus, Ph.D., no longer with us, generously shared files, instruments, and wisdom garnered from conducting an earlier, pioneering study with volunteer opioid treatment programs that was begun before the decision to move to an accreditation system had been made. Kevin Mulvey, Ph.D., now with the Center for Substance Abuse Prevention, researched and wrote the statement of work that provided the foundation for the present study. Additional thanks go to Carolyn Lichtenstein, Ph.D., the original Northrop Grumman Project Director, and Namratha Swamy, Ph.D., who subsequently headed the evaluation team through a challenging and complex data collection. Numerous other people who contributed to the development of this document, including other Northrop Grumman staff members and subcontractors, are listed below. Not listed here are the staff members, program administrators, and patients of several hundred opioid treatment programs who so generously contributed to the successful completion of this study—and for whom ‘thank you’ does not seem enough.

NORTHROP GRUMMAN

Callie Gass
Sharon Williams
Sameria Rasheed
Charles Li
Kristin Zempolich
Danyelle Mannix
Victoria Herrera-Kozisek

HEALTH SYSTEMS RESEARCH, INC.

Karen Aschaffenburg, Ph.D.
Eric Gelman

REDA INTERNATIONAL, INC. OTHER CONSULTANTS

Elham-Eid Alldredge, Ph.D.
Joan Wang, Ph.D.
Amy L. Djangali
Jackie Miller
Jeanette Martin
Roula Sweis

Kevin Knight, Ph.D.
David Farabee, Ph. D.
Brian Yates, Ph.D.
Diane Grieder (Alipar Inc.)
Johnson, Bassin & Shaw, Inc.

CONTENTS

I. Executive Summary	1
I.A Background	1
I.B Overview of the Evaluation Design	1
I.C Administrative Impact of OTP Accreditation	2
I.D Clinical Impact of OTP Accreditation	2
I.E Overall Implementation Impact of OTP Accreditation	4
I.F Conclusions and Recommendations	4
II. Introduction	6
II.A Brief Background.....	6
II.A.1 Study Background.....	6
II.A.2 Overview of the Current Literature.....	7
II.B Purpose of the OTP Accreditation Evaluation Study.....	8
II.C Evaluation Design	9
III. Methods	11
III.A Instrument Development	11
III.A.1 Overview of the Instruments.....	11
III.A.2 Field Review	12
III.A.3 Pilot Study.....	13
III.A.4 Office of Management and Budget Approval.....	13
III.A.5 Assurance of Confidentiality	13
III.A.6 Establishing Communication Methods	15
III.B Questionnaire Administration (PAQ and FQ)	15
III.B.1 Description of Procedures	15
III.B.2 Use of Financial Incentives.....	18
III.B.3 Data Collected.....	18
III.C Indepth Study Sample.....	18
III.C.1 Sampling and Recruitment.....	19
III.C.2 Use of Financial Incentives.....	21
III.C.3 Field Protocol.....	22
III.C.4 Data Collected.....	23
III.D Other Data Sources.....	24
III.D.1 CSAT OTP Certification Database.....	24
III.D.2 State Methadone Authority Phone Interviews	24
III.D.3 National Survey of Substance Abuse Treatment Services (N-SSATS).....	24

III.D.4 Opioid Treatment Program Accreditation Impact Study (MAP I)	24
III.E Dataset Preparation	25
III.E.1 Data Cleaning	25
III.E.2 Definition of Covariates	25
IV. Analysis and Results	27
IV.1 Representativeness of Data	27
IV.2 CPPOA Analytic Framework	28
IV.3 Explanation of Administrative, Clinical, and Full Implementation Evaluations	29
IV.A Study Population	31
IV.A.1 Introduction	31
IV.A.2 Descriptive Characteristics of OTPs That Responded to the PAQ	31
IV.A.3 Descriptive Characteristics of OTPs Participating in the Indepth Study Sample	35
IV.A.4 Summary	37
IV.B Administrative Evaluation	38
IV.B.1 Introduction	38
IV.B.2 Activities and Costs Associated With <i>Achieving Compliance With Accreditation Standards</i>	38
IV.B.3 Activities and Costs Associated With <i>the Accreditation Process</i>	40
IV.B.4 OTP Staff Perceptions of Accreditation-Related Activities	41
IV.B.5 Characteristics of Applicant OTPs and Accreditation Bodies Related to Accreditation Survey Outcomes	44
IV.B.6 Activities and Costs Associated With Operating as an Accredited OTP	45
IV.B.7 Summary	50
IV.C Clinical Evaluation	51
IV.C.1 Introduction	51
IV.C.2 Clinical Policies and Practices Associated With Operating as an Accredited OTP	51
IV.C.3 Effects Associated With Operating as an Accredited OTP on Service and Delivery	58
IV.C.4 Effects Associated With Operating as an Accredited OTP on Service and Delivery Outcomes	62
IV.C.5 Effects on Patient Outcomes Associated With Operating as an Accredited OTP	62
IV.C.6 Summary	66
IV.D Full Implementation Evaluation	67
IV.D.1 Introduction	67
IV.D.2 Suggested Improvements to Accreditation Process	67
IV.D.3 Suggested Changes to Accreditation Bodies' Standards	67

IV.D.4 Cost to Government of National Implementation of OTP Accreditation.....	67
IV.D.5 Cost-Effectiveness of National Implementation of OTP Accreditation.....	68
IV.D.6 Projected Costs to Individual OTPs of Undergoing and Continuing Accreditation	72
IV.D.7 Summary.....	76
V. Conclusions and Recommendations	77
Appendix A: OTP Post-Accreditation Questionnaire.....	A-1
Appendix B: OTP Followup Questionnaire	B-1
Appendix C: Patient Questionnaire.....	C-1
Appendix D: Chart Abstraction Form	D-1
Appendix E: Discharge Record Abstraction Form	E-1
Appendix F: Staff Activity Log	F-1
Appendix G: Staff Questionnaires	G-1
Appendix H: Cost-Effectiveness Questions.....	H-1
Appendix I: Analytic Framework for OTP Accreditation Evaluation	I-1
Appendix J: References	J-1

LIST OF EXHIBITS

Exhibit III.A-1. Consultant Field Reviewers	12
Exhibit III.B-1. Planned OTP Questionnaire Administration Schedule.....	15
Exhibit III.B-2. Summary of Data Collection Timeline for All OTPs	16
Exhibit III.B-3. Examples of Challenges and Solutions in PAQ and FQ Data Collection.....	17
Exhibit III.C-1. Summary of Data Collection Timeline for Indepth Study Sample.....	19
Exhibit III.C-2. Examples of Challenges and Solutions in Indepth Study Site Recruitment	20
Exhibit IV-1. Representativeness of Results from the PAQ.....	27
Exhibit IV-2. Representativeness of Results of Indepth Study Sample.....	28
Exhibit IV-3. Original OTP AE CPPOA Model.....	29
Exhibit IV.A-1. Accreditation Source for OTP Program Sample (N=478).....	31
Exhibit IV.A-2. Organizational Settings for OTP Program Sample (N=470)	32
Exhibit IV.A-3. Treatment Setting by Type of Treatment (N=470).....	32
Exhibit IV.A-4. Treatment Setting by Financial Structure (N=470)	33
Exhibit IV.A-5. Treatment Setting by Accreditation Body (N=467).....	33
Exhibit IV.A-6. OTP Patient Demographics (N=462)	34
Exhibit IV.A-7. Indepth Study OTPs vs. PAQ Respondents Based on Accreditation Body	35

Exhibit IV.A-8. Indepth Study OTPs vs. PAQ Respondents Based on Number of Patients Served..... 36

Exhibit IV.A-9. Indepth Study OTPs vs. PAQ Respondents Based on Treatment Type 36

Exhibit IV.B-1. Time Spent and Labor Cost of All Staff in an *Average Month* To Achieve Compliance With Accreditation Standards Since OTP Started Preparing for *First Accreditation* 39

Exhibit IV.B-2. Time Spent and Labor Cost of All Staff in an *Average Month* To Achieve Compliance With Accreditation Standards Since OTP Started Preparing for *Second or Third Accreditation* 39

Exhibit IV.B-3. Mean Nonpersonnel Costs To Achieve Accreditation Standards, Including Programs That Did Not Indicate Having These Expenditures (*N=478*)..... 40

Exhibit IV.B-4. Mean Nonpersonnel Costs To Achieve Accreditation Standards, Among Only Programs That Indicated Having These Expenditures..... 40

Exhibit IV.B-5. Time Spent and Labor Cost by All Staff in an *Average Month* on the Accreditation Process Since OTP Started Preparing for *First Accreditation* 41

Exhibit IV.B-6. Time Spent and Labor Cost by All Staff in an *Average Month* on the Accreditation Process Since OTP Started Preparing for *Second or Third Accreditation*..... 41

Exhibit IV.B-7. Past-Year Changes in OTPs and Program Impact (*N=456*)..... 42

Exhibit IV.B-8. Perceived Areas of Impact of the Accreditation Process (*N=467*)..... 42

Exhibit IV.B-9. OTP Providers’ Perceived Impact of Accreditation on Their Program (*N=468*)..... 43

Exhibit IV.B-10. Overall Impressions of Accreditation Process, by Job Category..... 44

Exhibit IV.B-11. Patient Outcomes Tracked by OTP Programs (*N=474*)..... 45

Exhibit IV.B-12. Ongoing Quality Assurance Activities Reported by OTPs (*N=470*)..... 46

Exhibit IV.B-13. Mean Hours Per Average Month Spent on *Indirect* Service Activities *Not* Related to Accreditation..... 47

Exhibit IV.B-14. Mean Dollars Per Average Month Spent on *Indirect* Service Activities *Not* Related to Accreditation..... 48

Exhibit IV.B-15. Mean Hours Spent Per Average Month in *Direct* Service Activities *Not* Related to Accreditation..... 49

Exhibit IV.B-16. Mean Dollars Spent Per Average Month in *Direct* Service Activities *Not* Related to Accreditation..... 49

Exhibit IV.C-1. Who Determines a Patient’s Maximum Dose and Length of Treatment? (*N=475*) 52

Exhibit IV.C-2. Likelihood of Revoking Methadone Take-Home Privileges for Suspected Diversion (*N=383*)..... 53

Exhibit IV.C-3. Areas in Which All Patients Are Assessed at Admission (*N=475*)..... 54

Exhibit IV.C-4. Types of Assessment Instruments Used by OTPs (*N=475*) 55

Exhibit IV.C-5. Criteria Used To Evaluate and Place Patients in Treatment (*N=475*)..... 55

Exhibit IV.C-6. OTP Responses to Patients With Two Positive Drug Tests for Opioids or Two Negative Tests for Methadone (*N=428*)..... 56

Exhibit IV.C-7. Number of Missed Doses/Sessions Required To Discharge a Patient (*N=325*) 57

Exhibit IV.C-8. Patient Behaviors Likely To Result in Discharge from OTP (*N=457*)..... 57

Exhibit IV.C-9. Reasons for Discharge Based on Patient Charts (*N=20*) 58

Exhibit IV.C-10. Post-Accreditation Changes in OTP Services Offered (*N=171*) 59

Exhibit IV.C-11. Types of Education Patients in the Indepth Study Sample Reported Receiving From Current OTP (N=590)	60
Exhibit IV.C-12. Services Patients in Indepth Study Sample Report Being Delivered by Current OTP (N=590)	61
Exhibit IV.C-13. Post-Accreditation Changes in OTP Patient Characteristics (N=171)	62
Exhibit IV.D-1. Mean Number of Hours Per Month Spent in Activities Not Related to Accreditation.....	70
Exhibit IV.D-2. After the First Accreditation, Significantly and Substantially Less Time Is Spent in Some Activities Related to Preparing for Accreditation	70
Exhibit IV.D-3. After First Accreditation, Time Spent in Some Activities Not Related to Accreditation Decreases Significantly	71
Exhibit IV.D-4. Time Spent in Some Direct Patient Services Is Significantly Reduced After First Accreditation	71
Exhibit IV.D-5. Time OTPs Spent on Accreditation Activities Is a Function of Program Size ..	72
Exhibit IV.D-6. Average Monthly Nonpersonnel Costs for Past 3 Months	73
Exhibit IV.D-7. OTPs Report of Whether Nonpersonnel Costs Increased, Decreased, or Stayed the Same Since Accreditation.....	73
Exhibit IV.D-8. Mean Nonpersonnel Costs To Achieve Accreditation Standards, <i>Among Only Programs That Indicated Having These Expenditures</i> , Broken Down by Program Size	74
Exhibit IV.D-9. Mean Nonpersonnel Costs To Achieve Accreditation Standards, <i>Including Programs That Did Not Indicate Having These Expenditures</i> , Broken Down by Program Size.	74
Exhibit IV.D-10. Costs of Accreditation, Distinguishing Between Nonpersonnel and Personnel Costs.....	75

I. EXECUTIVE SUMMARY

I.A BACKGROUND

On March 19, 2001, Federal oversight of opioid treatment programs (OTPs) shifted from direct inspection by the Food and Drug Administration (FDA) to a system administered by the Center for Substance Abuse Treatment (CSAT), a part of the Substance Abuse and Mental Health Services Administration (SAMHSA). This new system of opioid treatment program regulation relies on accreditation by independent organizations (accreditation bodies [ABs]) and States, whose standards are based on the *CSAT Guidelines for the Accreditation of Opioid Treatment Programs*. These standards emphasize improving the quality of care through such activities as individualized treatment planning, increased medical supervision, and assessment of patient outcomes.

SAMHSA/CSAT awarded a contract to Northrop Grumman to assess the accreditation process and its cost, and to provide input into how the process might be improved. The results of this evaluation are categorized into three thematic areas regarding the impact of the OTP accreditation process on the administrative, clinical, and overall implementation aspects of OTP program functioning.

I.B OVERVIEW OF THE EVALUATION DESIGN

The OTP Accreditation Evaluation was composed of two principal primary data collection efforts. One involved questionnaires directed to the universe of some 1,100 opioid treatment programs. Due to the timing of approval by the Office of Management and Budget (OMB), the study could not commence until accreditation already had gone into effect and thus pure “pre-accreditation” results could not be obtained. For this reason and because at this point accreditation was mandatory, emphasis shifted to issues related to maintaining versus initially obtaining accreditation. The first questionnaire, the Post-Accreditation Questionnaire (PAQ), was sent to programs as soon as possible upon accreditation and contained retrospective items in an attempt to garner “near-pre” information. Data from this first survey are termed “baseline” data for purposes of our analyses. Ultimately, given the difficulty of surveying these programs, 478 programs (47 percent) completed the PAQ. These programs were then later asked to complete the Followup Questionnaire (FQ); time constraints related to ensuring sufficient time to analyze the data meant that 171 of these could be included in the analysis. Policy variables used (e.g., program size, ownership status) echo those identified in an earlier study among a subset of programs that underwent accreditation on a voluntary basis before it became mandatory.

Results from the PAQ indicate the majority of these programs (55.4 percent) offer both detoxification and maintenance therapy, with the second most common category being maintenance only (35.4 percent). Only 9.2 percent of the sample provide detoxification services only. The percentage of programs that are for-profit and nonprofit are fairly similar (41.0 percent and 44.6 percent, respectively); only 14.4 percent of the programs self-reported being Government funded.

The OTP programs in this sample reported an average current caseload of 238 patients (median of 250). On average, these programs were operating at 81 percent of capacity at the time of the survey. Most are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), but 4 in 10 have the Commission on Accreditation of Rehabilitation

Facilities (CARF) as their AB, and 1 in 8 are accredited by other approved accreditation bodies, including State organizations.

The second data collection effort involved an indepth study of 22 OTPs that volunteered to participate in 2- to 3-day site visits. These site visits included interviews with staff and patients, extraction of limited data from patient charts, and review of recent discharge charts; key staff at these programs also were asked to complete Staff Activity Logs on a weekly basis for a period of up to 6 months following their site visit. As much as possible, the recruitment process was structured to obtain a range of programs that represent key subgroups.

I.C ADMINISTRATIVE IMPACT OF OTP ACCREDITATION

When program directors were asked in the PAQ to estimate how much time their staff spent in an average month on a number of accreditation-related activities since their OTP started preparing for accreditation, they reported that the total personnel-related cost associated with *achieving compliance with standards* and *the accreditation process* was \$9,501.07 per month. The mean nonpersonnel expenditures also were calculated for those programs that said they had incurred these expenses. The mean nonpersonnel cost for this group was \$27,655. This amount represents the upper end of the range. If the analysis includes those programs that did not report incurring these expenses as having spent \$0, then the average nonpersonnel cost related to preparing for accreditation for all programs was \$9,501.03, which would represent the lower end of the range. The expenditure related to achieving accreditation on which the OTPs reported spending the most was renovating a program's physical structure.

To better understand the level of effort and cost associated with the *accreditation process*, the personnel activities in this area were analyzed separately. These activities included preparing the accreditation application, communicating with the accreditation body, conducting a mock survey, interacting with an external consultant, and answering the accreditation survey. Programs preparing for either their first or subsequent accreditation generally reported spending about the same amount of time on the accreditation process. The average monthly personnel cost related to the accreditation process across all programs was \$1,473.

Although 4 in 10 providers indicated in the PAQ that the accreditation process hindered their staff from performing their daily activities, the majority of respondents reported specific program improvements associated with accreditation. For instance, at least 70 percent of the programs reported that the accreditation process had a positive impact on documenting patient progress, enhancing treatment efficiency, improving coordination of care, improving the OTP's treatment practices, developing new quality assurance procedures, and increased monitoring of patient outcomes. Overall, 86.1 percent of the respondents believed that the OTP accreditation process improved their program either "significantly" or "somewhat."

I.D CLINICAL IMPACT OF OTP ACCREDITATION

OTP providers were asked in the PAQ to describe their existing treatment services along several dimensions, including dosing, treatment planning, drug testing, and discharge policies. The average dose of methadone that OTP physicians prescribe patients at admission is 36.9 mg/day (median=30.0 mg/day.) On average, the largest dose that OTPs prescribe patients during maintenance is 205.0 mg/day (median=180.0 mg/day).

At the majority of OTPs, decisions regarding dosing and treatment length are made by medical staff, rather than State or local policies or even payer/reimbursement guidelines. However, more than 1 in 5 providers indicated that State Government regulations also play a role

in determining their program's maximum methadone dose. Although payer/reimbursement guidelines have virtually no impact on the maximum dose prescribed, about 1 in 10 OTPs indicated that these guidelines do affect treatment length.

Ninety-two percent of the programs that responded to the PAQ offer methadone take-home privileges (usually in liquid form). More than half of the OTPs reported always revoking take-home privileges when a patient is suspected of diverting methadone; another 17 percent reported that they "frequently" revoke take-home privileges under these conditions.

Data captured from the staff interviews conducted during the 22 OTP site visits show that the most important issue to the medical directors and nurses is clearly that of take-home privileges. There was an almost even split between those who said that take-home privileges are stricter since accreditation and those who felt that they have not changed. Significantly, only 4 of the 16 medical directors and nurses indicated that any changes to take-home privileges had been implemented specifically due to the accreditation.

Regarding assessments, most OTPs (55.0 percent) reported using an instrument developed by their own program. Larger programs (current enrollment of more than 100 patients) are more likely than are smaller programs (100 or fewer patients) to use standardized intake assessments. Responses also vary by financial structure, with Government-run OTPs being the most likely to use standardized intake assessments (31.8 percent), followed by for-profit OTPs (25.4 percent). Only 18.8 percent of the nonprofit OTPs reported using standardized assessments.

Virtually all the OTP programs surveyed collect urine samples from patients for drug testing, typically about once per month. When asked how patients are selected for testing, more than half (55.1 percent) of the respondents indicated that patients are selected at random; 34.9 percent reported that some patients are selected at random while others are specifically identified; 10.1 percent reported that all tested subjects are specifically identified.

The behaviors most likely to result in discharging a patient before he or she completes treatment are engaging in violence and diverting (or attempting to divert) methadone. More than 90 percent of the OTPs also rated onsite sexual activity as likely to result in early discharge. As might be expected, providers view missed dosing appointments as being much more serious than missed counseling/therapy sessions. The actions least likely to result in early discharge are substance abuse and nondrug criminal justice involvement.

As part of the 22 site visits, data were abstracted at each program from records of approximately 20 recently discharged patients. The data collected included the length of time in treatment at that OTP and the reason for discharge. The length of time that the recently discharged patients remained in treatment ranged from a single day to 34.2 years. The mean length of treatment episode was 25.6 months or 2.1 years.

Based on the results of the FQ, no evidence indicates significant changes in the composition of the OTP patient population with regard to gender, race/ethnicity, or socioeconomic status during the 6 months following the PAQ. These results were supported by the results of the site visits. None of the medical directors or nurses interviewed said that the characteristics of the patients they serve had changed with program accreditation. The demographics of the patients interviewed in the indepth study also mirror those from the PAQ.

By and large, there were few substantial changes in the way OTPs provided services during the 6 months following the PAQ. Perhaps the most dramatic change occurred with regard to the level of influence OTP patients have in determining their methadone dose levels, with the

percent reporting that patients influence their dose “to a great extent” increasing from 17.6 percent at baseline to 76.5 percent 6 months later.

I.E OVERALL IMPLEMENTATION IMPACT OF OTP ACCREDITATION

During the site visits to the indepth study sample, medical directors, nurses, and counselors were asked for suggestions about how to improve the accreditation process by making future survey preparation easier. Among the medical directors and nurses ($N=16$) and among the counselors ($N=37$), the majority either had no suggestions, said they do not know, or thought the process is already efficient and had no positive suggestions for change. The most frequently cited concrete area for both groups was improving the interaction with the AB before, during, and after the survey (medical directors/nurses [$N=4$] and counselors [$N=5$]). Counselors voiced additional suggestions, including reducing the costs of accreditation, reducing the duplication between the State and Federal authorities, and reducing paperwork.

Program directors were asked a slightly different question during the site visits. They were asked to give suggestions to improve the survey process (as opposed to the accreditation process). The most frequently cited suggestion was to improve interaction with the AB, followed by reducing the cost of accreditation and standardizing the process across ABs.

In absolute terms, a total of \$1,678,719 was spent on technical assistance (TA) efforts by the Federal Government, according to information collected by JBS International, Inc., on behalf of CSAT. Based on this information, the cost per TA effort was a mean \$2,012 and a median \$2,109, ranging from \$197 to \$11,921.

The PAQ found that the amount of time spent in activities related to accreditation is highly correlated with program size, reflecting the additional effort that larger programs, with more patients, staff, and records, often need to or are able to spend in accreditation-related activities. These correlations also may reflect relationships between other program characteristics, such as financial organization of the program and the time the program was willing to allocate to accreditation preparation.

It was not possible to quantify the cost-effectiveness or cost-benefit of the national accreditation effort. Importantly, however, it does appear that those OTPs undergoing a subsequent accreditation have lower costs in preparing for accreditation, for both personnel activities and nonpersonnel costs, than do OTPs undergoing accreditation for the first time. Based on an average preparation time of 2 to 4 months, the cost of accreditation for OTPs was between \$28,000 (\$9,501 as the low end of nonpersonnel costs, plus \$9,501 a month for personnel costs times 2 months) and \$66,000 (\$27,655 as the high end of nonpersonnel costs, plus \$9,501 a month for personnel costs times 4 months).

I.F CONCLUSIONS AND RECOMMENDATIONS

The results of this evaluation indicate that the shift from an enforcement model (administered by FDA) to a regulatory model (accredited by SAMHSA) of OTP oversight has had a positive overall impact on OTPs and on the field of opioid treatment more generally—particularly with regard to tracking patient outcomes, increased patient involvement in determining appropriate dosing levels, and ensuring more uniform standards of care across States. Perceptions of the accreditation process are generally favorable, though most providers (particularly clinic directors) acknowledge that achieving accreditation can be a burdensome process. In spite of the challenges associated with achieving accreditation, approximately 8 in 10 OTP providers

indicated that—if given the choice—they would prefer to work in a program that is accredited than one that is not.

Based on the findings summarized in this report, the evaluation team offers the following recommendations to further improve the OTP accreditation process:

- Continue to emphasize the need for OTPs to use standardized intake assessments and patient placement criteria
- Strongly encourage OTPs to use computerized records to track patient performance and outcomes (only about half of the programs currently use computers for this purpose)
- Increase interaction/communication between OTPs and ABs before, during, and after administering the accreditation surveys
- Encourage OTPs to expand efforts to educate patients about overdose signs and potential drug interactions with methadone
- Continue to recognize the importance of achieving and maintaining OTP satisfaction with the accreditation process.
- In training, increase staff's sensitivity to patients' differences related to their time in treatment, primary drug, etc.

These recommended changes should further enhance the positive changes already seen in the transition from an FDA enforcement model to a SAMHSA-administered accreditation model.

II. INTRODUCTION

SAMHSA/CSAT, in conjunction with the Food and Drug Administration (FDA) and other Federal agencies, issued final regulations for the use of narcotic drugs in maintenance and detoxification treatment of opioid addiction, 42 CFR Part 8, which went into effect on March 19, 2001. Opioid treatment programs (OTPs) are programs that are authorized to dispense methadone, buprenorphine, and/or levo-alpha-acetyl-methadol (LAAM) for the treatment of opiate addiction.¹ Because the new approach to oversight relies on CSAT's best practice guidelines, the shift to an accreditation approach is expected to improve the quality of and access to OTPs. Under the new regulations, OTPs were required to achieve accreditation by May 19, 2003: the deadline was extended by 1 year in some cases.

SAMHSA initially approved five organizations to provide accreditation to OTPs that use methadone and similar medications to treat opiate addiction: (1) CARF, (2) JCAHO, (3) the Council on Accreditation for Children and Family Services (COA), (4) the State of Washington Department of Social and Health Services, Division of Alcohol and Substance Abuse, and (5) the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse. A sixth organization, the National Commission on Correctional Health Care (NCCHC), was approved later during the course of the study, though no OTPs accredited by this organization were included in this study.

II.A BRIEF BACKGROUND

A brief literature search and review were completed to examine the research concerning the immediate and long-term impact of the SAMSHA/CSAT OTP accreditation process. This review of the literature focuses on the rationale for the current study by looking at a previous evaluation of the OTP accreditation process and recent reports about OTP accreditation.

II.A.1 Study Background

SAMHSA/CSAT conducted an earlier study, variously called the Opioid Treatment Program Accreditation Impact Study or the Methadone Accreditation Project (MAP I) from 1998 to 2002 (CSAT, in draft). The study began prior to the new regulations and focused on a pilot group of OTPs undergoing the accreditation process for the first time on a voluntary basis, with technical and financial assistance provided by SAMHSA/CSAT.

Because the new regulations were likely to go into effect before the study could be completed, the evaluation was designed as an impact rather than a feasibility study. The MAP I evaluation team was charged with assessing the impact of the processes, barriers, and costs associated with the change to an accreditation-based opioid treatment oversight system. The study sample comprised 172 programs in 15 States. Because the new regulations were not in effect at the beginning of the study, the OTPs that participated took part in the study on a voluntary basis. The evaluation team applied statistical weights in an effort to ensure that the OTPs in the study were reasonably representative of U.S. opioid treatment programs in terms of key policy variables (e.g., size of the OTP).

A pre- and post-accreditation study design used a stratified random sample of programs that included sites undergoing accreditation (experimental) and sites delaying accreditation until after study data were collected (control). This design allowed for comparisons before and after

¹ Note: In early 2004, LAAM was discontinued as a medication-assisted treatment (MAT) due to associated cardiac disturbances.

undergoing accreditation, as well as between programs. This evaluation was not a longitudinal study that could capture the long-term impact of accreditation on treatment quality or the costs of maintaining accreditation once achieved.

Study findings suggested that there was a need for all parties to come to consensus concerning protocols and tools used to carry out routine but critical functions. Examples include, at a minimum, assessment tools and treatment planning protocols, dosing and monitoring tools, diversion control policies and procedures, and indicators of quality service delivery. The MAP I evaluation team recommended that consideration of these issues be incorporated into planned revisions of the SAMHSA accreditation guidelines. Findings also indicated that the ongoing development of new accreditation guidelines and best practices may promote the continued delivery of quality treatment. The results of the study also revealed that for-profit programs were playing an increasing role in the field of opioid treatment and that the costs associated with accreditation were higher than originally projected.

As expected, 42 CFR Part 8 went into effect before the completion of the MAP I study; the Secretary of the Department of Health and Human Services (DHHS) determined that accreditation was a “valid and reliable system for providing external monitoring of the quality of health care—including substance abuse and methadone treatment” (SAMHSA/DHHS, 2001). Even with the usual study limitations, the results of MAP I supported the conclusions reached independently by the Secretary of DHHS to implement the regulatory change to ensure that OTPs provide quality treatment and are accountable for results (CSAT, in draft).

Under the new regulations, each of the approximately 1,100 OTPs was required to be accredited under the oversight of CSAT. Thus, accreditation was no longer voluntary, but was mandated by the Federal Government in order to do business as an OTP.

II.A.2 Overview of the Current Literature

Recent research is generally favorable to OTP accreditation. A national panel study examined the extent to which OTPs incorporated changes in methadone treatment practices to meet established standards for best practice care over a 12-year period from 1988 to 2000 (D’Aunno & Pollack, 2002). Treatment dose levels were used as an indicator of standards of care. The study found that progress was made over time, with two-thirds of patients receiving methadone doses of at least 60 mg/day in 2000, compared to 80 percent receiving doses below that level in 1988. However, despite that trend, it was reported that only 32.4 percent received the increased dosage level of 80mg/day in 2000.

The D’Aunno & Pollack study results also showed that programs with JCAHO accreditation were more likely to provide adequate methadone doses. Although JCAHO does not set specific dose standards, the study results indicated that units with JCAHO accreditation had better overall resources, including staff and funds for training. The study also concluded that many methadone treatment patients were still receiving substandard care in 2000.

Another study examined the movement toward outcome-based performance measurement in substance abuse treatment (Phillips et al., 1995). The study relied on in-treatment outcomes to measure program performance in methadone treatment. The study concluded that JCAHO’s activities in the area of quality assurance epitomized the movement toward the use of outcome measurements in methadone treatment.

Pelletier and Hoffman (2002) proposed that OTPs could “leapfrog” the development of accreditation performance measures they were required to develop by using lessons learned from

the health care quality industry. Performance measures were developed based on the quality management strategy. The study results indicated that a comprehensive performance management system specific to the population being treated in an OTP potentially could make a difference in the care and services provided to clients.

A recent article on the MAP I study included an evaluation review on the costs of the accreditation process and found that the organizational structure of the OTP made a difference in technical assistance costs and survey fees, with sites that were part of a larger parent organization having lower costs compared to sites that were not (Zarkin, Dunlap, and Homsí, 2006). In terms of the total cost of accreditation, however, the evaluation showed that sites faced similar costs in pursuing accreditation, regardless of characteristics such as size and location. The study estimated the total cost of preparing for and undergoing accreditation at approximately \$48,005, representing about 5 percent of operating costs for the average clinic, 17 percent for small sites, 19 percent for rural sites, and 7 to 8 percent for urban sites. These rates represent a substantial expenditure. The average cost per patient of pursuing accreditation was \$289. However, it is expected that if sites remain in compliance, subsequent accreditation renewal costs would be much lower than the original outlay of funds.

II.B PURPOSE OF THE OTP ACCREDITATION EVALUATION STUDY

In July 2002, SAMHSA/CSAT awarded the contract to conduct the *Opioid Treatment Program Accreditation Evaluation*, described in this final report, to Northrop Grumman. Two main components of the SAMHSA/CSAT OTP Accreditation Evaluation were to assess the accreditation process and its cost, and to obtain input into how the process might be improved. The evaluation examined the processes, barriers, and costs associated with achieving and maintaining program changes in clinical and administrative practices, as well as with the long-term impact of accreditation as represented by the effects of the changed clinical and administrative practices on costs and on patients and staff.

The OTP Accreditation Evaluation was designed to measure, analyze, and explain the impacts that accreditation had on:

- The populations served, as reflected in changing demographic characteristics
- Treatment procedures and services
- Treatment costs (i.e., the types, amounts, and monetary values of the major resources used to implement treatment procedures)
- Limited biopsychosocial processes related to treatment
- Nonmonetary outcomes, such as use of licit and illicit drugs, criminal behavior, and risk behaviors for HIV infection
- Monetary outcomes, such as use of health and mental health services and licit employment.

More specifically, the study aimed to answer the following general evaluation questions:

- Implementation
 - What activities and costs are associated with achieving and maintaining compliance with accreditation standards?

- What activities and costs are associated with the accreditation process itself, including undergoing an accreditation survey (the survey conducted by an accreditation body as part of the process of determining an OTP's accreditation status or outcome)?
- What are the perceptions and recommendations of OTP staff regarding the activities and processes necessary to achieve and maintain accreditation?
- Intermediate impact
 - What characteristics of applicant OTPs and accreditation bodies are related to accreditation survey outcomes?
 - What activities and costs are associated with operating as an accredited OTP?
 - What are the clinical policies and practices associated with operating as an accredited OTP?
- Long-term impact
 - What are the effects of operating as an accredited OTP on service accessibility and delivery?
 - What are the effects on patients associated with operating as an accredited OTP?
 - What are the estimated total costs to the Government of national implementation of OTP accreditation?
 - What are the projected costs to the Government of continuing accreditation?

It is hoped that findings from the OTP Accreditation Evaluation will have extensive practical utility for SAMHSA/CSAT and other Federal agencies. The findings presented in this report can inform future policy, funding, and improvements to the accreditation-based oversight system and the general field of opioid treatment.

II.C EVALUATION DESIGN

The evaluation design included two major data collection efforts, one involving questionnaires to be sent to the universe of approximately 1,100 OTPs, and the other, a more intensive study centered on site visits to a small group of programs that represented, to the extent possible, the range of OTPs. OTPs were to be surveyed as soon as possible following their accreditation using a Post-Accreditation Questionnaire (PAQ), and again approximately 6 months later using a Followup Questionnaire (FQ), to describe the post-accreditation operational costs and state of the field. The PAQ also contained retrospective items to capture the level of effort involved in preparing for the accreditation survey and limited information about OTPs' operations before obtaining accreditation.

Data gathered through the questionnaires were supplemented by more detailed information obtained from a more in-depth study of 22 OTPs. Data collected from this small study sample aimed (1) to provide qualitative data to assist in the interpretation of quantitative findings and (2) to contribute patients' perspectives. The evaluation plan included the use of several tools during the 2- to 3-day site visits to gather data from records, staff, and patients. Importantly, OTP staff at these sites reported cost-related data on a weekly basis over the 6-month period following the site visit. The original goal was to recruit 50 programs from a pool of 150 identified through a stratified, randomized sampling process based on key policy variables; in reality, substantial administrative barriers were encountered, including in some cases great difficulty in obtaining permission sometimes from numerous parties. Given the voluntary nature of participation in the

indepth study, which involved substantial demand on its participants, the 22 programs may potentially represent better-functioning and better-organized programs than might be typical.

It should be noted that the original approach to the evaluation was a pre/post design allowing for primary data collection from some of the OTPs both before and after their accreditation site visits. A primary reason for the change was the closing window of time in which to gather data from OTPs before accreditation. As Northrop Grumman prepared for OMB approval, an increasing number of OTPs were being accredited to meet the May 18, 2004, deadline imposed by Federal regulations. By the time data collection could begin, all OTPs would have made at least some preparations for accreditation, making it difficult to draw a true pre-accreditation sample of OTPs. In light of this circumstance, the focus of the data collection effort shifted to include consideration of the costs and processes associated with maintaining accreditation rather than those associated with achieving accreditation for the first time.

III. METHODS

III.A INSTRUMENT DEVELOPMENT

The original evaluation plan aimed to compare some sets of data collected during this study to data collected during the MAP I study from the OTPs that underwent accreditation as part of that earlier pilot project. Some of the tools designed for the OTP Accreditation Evaluation, therefore, were based on MAP I instruments and, with expert input, modified for use in the current study. The PAQ, for example, contained many questions that corresponded with the MAP I questionnaire, and a crosswalk was created to track these overlaps. In addition, the Staff Activity Logs used similar activities, job codes, and definitions as the tools used in MAP I, though the list of activities was later simplified based on input from OTP program staff and consultants. The abstraction forms developed to gather information from patients' charts and discharge records also were extensions of the MAP I forms. This section provides an overview of the tools developed for the OTP Accreditation Evaluation, as well as a description of the process by which the tools were reviewed, pilot tested, and finally approved.

III.A.1 Overview of the Instruments

The tools developed for administration to all OTPs included the PAQ and FQ:

- **Post-Accreditation Questionnaire (PAQ) and Followup Questionnaire (FQ)**—The PAQ and FQ (see Appendixes A and B) were designed to gather information about an OTP's experiences with the accreditation process and changes in its operation and services. Questionnaire topics examined the activities, resources, and costs associated with accreditation preparation (topics addressed in retrospective questions); activities, resources, and costs associated with maintaining accreditation; and the cost and type of services provided by the OTP.

The tools developed to gather data from the indepth study sample included the following:

- **Patient Questionnaire**—The Patient Questionnaire (see Appendix C) was intended to provide a patient perspective to the evaluation and, as feasible, to validate information collected from the OTP questionnaires. Topics that were addressed in the Patient Questionnaire included satisfaction with services received, assessment of treatment received, and patient demographics.
- **Chart Abstraction Form**—The goal of the chart abstraction data collection effort was to assess limited patient outcomes. A Chart Abstraction Form (see Appendix D) was developed in which to enter information on a patient's treatment history at the OTP (including current dose) and data on his or her urinalysis test results and oral fluid test results.
- **Discharge Record Abstraction Form**—A review of the records of recently discharged patients was undertaken to assess the OTPs' discharge practices in terms of length of treatment and reason for discharge. The Discharge Record Abstraction Form (see Appendix E) contained fields to capture the dates of admission and discharge and the reason for the discharge.
- **Staff Activity Log**—The Staff Activity Log (see Appendix F) included lists of personnel activities to be tracked on a weekly basis for up to 6 months. These logs included both patient-level activities related to the provision of services and general activities related to maintaining accreditation (e.g., staff meetings, training seminars,

implementation of clinical procedures). Template spreadsheets for aggregate cost data were created in both paper and electronic formats. The activity logs aimed to enhance the study's cost analyses by permitting costs to be assigned to each of the staff and activities included in the logs.

- **Staff questionnaires**—Interviews were conducted with various staff members to help distinguish between changes in program procedures that were initiated in response to accreditation versus those initiated in response to internally or externally generated desires to improve the program. Interview guides (see Appendix G) were developed containing relevant questions for different staff categories.
 - Program Director/Administrative Staff
 - Medical Director/Nursing Staff
 - Counselor.

III.A.2 Field Review

On an ongoing basis, the OTP Accreditation Evaluation employed a broad base of expert resources in its design and implementation. In August 2002, CSAT convened a project kickoff meeting with staff of the evaluation team. Participants included Arlene Stanton, Ph.D., CSAT Task Order Officer; staff members from CSAT's Division of Pharmacologic Therapies (DPT); and accreditation body grantees from JCAHO, COA, CARF, and the Division of Alcohol and Substance Abuse, Washington State. From December 2002 through March 2003, the evaluation plan and data collection instruments underwent extensive field review by DPT staff; H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director, CSAT; OTP representatives; AB representatives; consultants with expertise in the OTP accreditation process and cost-effectiveness analyses; and academic researchers with expertise in evaluation and OTPs (see Exhibit III.A-1). The evaluation plan and instruments were revised in accordance with feedback received during the field review. Reviewers agreed that data collection for the OTP evaluation project represented an important next step in the OTP accreditation process and that data would be gathered in the least burdensome way possible.

Exhibit III.A-1. Consultant Field Reviewers

Consultant	Affiliation
OTP Representatives	
Karst Besteman	Oasis Clinic
Ron Jackson	Evergreen Treatment Center
Jean Larson	APT Legion Avenue Clinic
Ira Marion	Albert Einstein Center
David Stiles	Montgomery County Recovery Services
Accreditation Body Representatives	
Sharon Dow	JCAHO
Bettye Harrison	CARF
Dennis Malmer	State of Washington
Joanne Page	COA
Expert in OTP Accreditation Process	
Diane Grieder, M.Ed.	Alipar, Inc.
Expert in Cost-Effectiveness Analyses	
Brian Yates, Ph.D.	American University
Experts in Substance Abuse Treatment Program Evaluation	
Robert Schwartz, M.D.	Friends Research Institute, Inc.
David Zanis, Ph.D.	University of Maryland School of Social Work

III.A.3 Pilot Study

In April and May 2003, pilot tests of the evaluation design were implemented at three OTPs in the Washington, DC, metropolitan area (one each in Virginia, Maryland, and Washington, DC, itself). These OTPs were in different stages of preparing for their accreditation. The primary purpose of the pilot test was to determine whether any changes were needed in the design of the evaluation and data collection strategy.

The pilot test included all aspects of the study, including the OTP questionnaires, OTP patient and staff interviews, chart abstractions, and training in Staff Activity Log data collection. There were no more than nine respondents for any data collection instrument. Respondents were asked to note the amount of time they spent reviewing instrument instructions, assembling the necessary information, and completing the instruments. Feedback received from each of the pilot tests was incorporated into the evaluation design and data collection instruments. For example, as a result of the pilot test, the original chart abstraction component was simplified greatly, as was the plan for interviewing patients. Also, some questions were simplified and some were eliminated to shorten the OTP questionnaires and Patient Questionnaire.

Some of the feedback gathered during the pilot study served to confirm that the instruments already were appropriate. The Staff Activity Log, for example, was developed with input from OTP program directors and, as a result, already had been simplified before the pilot study. During the pilot test, OTP staff provided positive feedback about the log, for instance, indicating that recording how much time was spent on activities took approximately 5 minutes to complete each day and was very similar to the process that OTPs already had in place for the completion of timesheets. Participants quickly became familiar with the log and said they did not find the data collection to be burdensome. In fact, some OTP staff considered it to be an ideal way of keeping track of how they spent their time.

The project databases (tracking databases and databases for each instrument) also were tested during the pilot by entering all the data that were collected.

III.A.4 Office of Management and Budget Approval

Staff prepared and revised several drafts of the OMB package in response to comments received from DHHS and SAMHSA. During a conference call on December 15, 2003, with OMB, Nancy Pearce (SAMSHA's OMB Officer at that time), key Northrop Grumman personnel, and Government Project Officer (GPO) Arlene Stanton, the project received OMB approval for the evaluation design and instruments.

III.A.5 Assurance of Confidentiality

The data collection protocol and instruments were reviewed by the Institutional Review Board (IRB) of Chesapeake Research Review, Inc. IRB approval was received on December 26, 2003. Several aspects of the data collection required protecting the confidentiality of OTPs or their patients. In addition, a Certificate of Confidentiality (as provided under Section 301(d) of the Public Health Service Act) was requested as an extra precaution to safeguard the confidentiality of the information collected. The Certification of Confidentiality was received on December 29, 2003.

Assurances of confidentiality and protection of the rights of study participants were provided through a combination of widely accepted survey practices. Data collection for the OTP Accreditation Evaluation complied with applicable Federal (42 CFR Part 2) and State

requirements and with ethical principles in the collection of information from, about, or related to persons enrolled in treatment. Among the rights commonly held for this type of study are as follows:

- The right of informed consent, which requires the study team to provide sufficient information about the study's objectives, level of burden, and uses of participants' information so that individuals may make informed decisions about their participation.
- The right to refuse to participate, which applies to the individual's right to decline to participate at all in the study or to decline to answer specific questions.
- The right to privacy, which guarantees against invasions of privacy as well as the specific protections provided by the Privacy Act of 1974. Individual information in this project was covered by System of Records 09-30-0036, Alcohol, Drug Abuse, and Mental Health Epidemiologic Data.

Several procedures were put into place to ensure confidentiality and privacy were addressed appropriately throughout the study. First, a release form, provided by Northrop Grumman, had to be signed by an OTP staff person before Northrop Grumman could obtain the OTP's detailed accreditation survey report from CSAT. A memorandum of understanding (MOU) was then developed with each OTP that agreed to participate in the OTP Accreditation Evaluation to detail the roles and responsibilities of the contractor and the OTP in implementing the site visits, collecting activity log data, and obtaining limited financial data (annual budget and expenditures).

Second, patients agreeing to be interviewed first signed an informed consent and data release form showing that they understood the purpose and burden of the interview. Their signed form also permitted the contractor to obtain specific data from their patient chart or other OTP records (such as urinalysis results). The informed consent and data release form included a statement to respondents noting (1) that the information collection was sponsored by a Federal agency (SAMHSA/CSAT); (2) the purpose of the evaluation project and the uses to be made of the data being collected; (3) that all responses were voluntary, and that no penalties would be imposed for refusal to participate in the data collection or to provide responses to any particular questions; and (4) that all information collected would be reported in a manner that protects the confidentiality of study participants. The MOU also reminded OTP respondents of the same principles related to ensuring that they also take all steps to safeguard and honor the confidentiality of study participants, such as refraining from comments or behavior that might make patients (or other participants) uncomfortable concerning their participation. The Patient Questionnaire was administered onsite in as discrete a manner as was possible and was conducted in a private area to protect the confidentiality of patient responses.

As stated, patients who agreed to participate in the patient interview also had data abstracted from their charts with their permission. The informed consent and data release form included the patient's name and a computer-generated random patient ID number. Throughout the site visit, the form was held by the site visit team and maintained separately from the data collected. Data collection forms used for patient interviews and chart abstraction were identified by the random patient ID number only. When possible, site visit staff requested that OTP staff pull charts not only for patients who had agreed to participate, but for a few others as well, to ensure confidentiality concerning which patients were interviewed. (The Northrop Grumman team

obtained the patient’s consent before asking staff to pull his or her chart.) Evaluation staff only abstracted data from the charts of patients who agreed to participate in the interviews and who signed the patient questionnaire and chart abstraction informed consent form.

All participating OTPs were assigned a research ID number. Any information delivered to CSAT identified OTPs only by the research ID number and not by name. Only contractor staff had access to the project databases and knew which OTP was associated with which ID number.

Informed consent also was obtained by contractor staff before each interview with OTP staff and State Methadone Authorities (SMAs). The informed consent form included the interview participant’s name and a random ID number that could be used by contractor staff to follow up on interviews and clarify responses. The informed consent forms were stored separately from the data collected. Whenever possible, data were reported in the aggregate, providing further protection of the identities of individuals and programs participating in the evaluation.

III.A.6 Establishing Communication Methods

In preparation for data collection, the project established a toll-free phone number and an e-mail address in an effort to facilitate communication with the OTPs and thereby to maximize response rates.

III.B QUESTIONNAIRE ADMINISTRATION (PAQ AND FQ)

III.B.1 Description of Procedures

Exhibit III.B-1 depicts how the OTPs were categorized for administration of the PAQ and FQ. Exhibit III.B-2 provides a timeline of the processes involved in PAQ and FQ administration, including mailing the questionnaires to OTPs, sending thank-you/reminder postcards, and making followup telephone calls.

Exhibit III.B-1. Planned OTP Questionnaire Administration Schedule

	Accreditation Status at the Start of Data Collection (January 5, 2004)			
	(1) Undergoing First Accreditation Between 1/04 and 4/04*	(2) Undergoing Subsequent Accreditation Before 1/05**	(3) Accredited for Less Than 4 Months	(4) Accredited for More Than 4 Months But Not Planning Next Accreditation Within Study Period
Number of OTPs	300	200	350	250
Mailing of PAQ	As soon as accredited	As soon as accredited	Initial mailing	Initial mailing
Mailing of FQ	6 months after submitting completed PAQ	6 months after submitting completed PAQ	6 months after submitting completed PAQ	6 months after submitting completed PAQ

*Accreditation bodies scheduled accreditation surveys through April 2004 in order for OTPs to receive accreditation by May 18, 2004, the Federal deadline for programs to achieve accreditation.

**This cutoff date was necessary to be able to allow for questionnaire receipt, data entry and cleaning, and analysis within the study period.

Exhibit III.B-2. Summary of Data Collection Timeline for All OTPs

Data Collection Component for All 1,100 OTPs	Target Date
Sent an introductory letter from the CSAT Director to all program directors, medical directors, sponsors, and SMAs	January 5, 2004
Sent packages to sponsors and medical directors of all OTPs: <ul style="list-style-type: none"> • Letter of invitation from Northrop Grumman to participate in the study • Letter of support from the American Association for the Treatment of Opioid Dependence (AATOD) 	January 21, 2004
Sent PAQ packages to program directors: <ul style="list-style-type: none"> • Cover letter (invitation from Northrop Grumman to participate in the study) • Letter of support from AATOD • Post-Accreditation Questionnaire • Stamped, return envelope • Accreditation Report Release Form • Informed Consent Form • Honorarium Reimbursement Form OTPs in categories 3 and 4 were sent this package as soon as possible after the study commenced. Each OTP in categories 1 and 2 were sent the package as soon as notification had been received that the OTP had obtained accreditation.	Started mailing on January 22, 2004, and continued as OTPs received accreditation Ended PAQ administration on December 31, 2004
Sent thank-you/reminder postcards to program directors who were sent the PAQ	Approximately 2 to 3 weeks after mailing of PAQ
Made telephone calls to program directors encouraging the completion and return of the PAQ; sent second PAQ package to program directors who had not responded	Approximately 3 to 4 weeks after mailing of PAQ
Sent FQ packages to program directors: <ul style="list-style-type: none"> • Cover letter (invitation from Northrop Grumman to participate in the study) • Followup Questionnaire • Stamped, return envelope • Informed Consent Form • Honorarium Reimbursement Form 	Started mailing in August 2004 and continued, sending packages to OTPs 6 months after they returned the PAQ Ended FQ administration on February 28, 2005
Sent thank-you/reminder postcards to program directors who were sent the FQ	Approximately 2 to 3 weeks after mailing of FQ
Made telephone calls to program directors encouraging the completion and return of the FQ; sent second FQ package to program directors who had not responded	Approximately 3 to 4 weeks after mailing of FQ

As shown in Exhibit III.B-2, a letter from the Director of CSAT was mailed to all OTPs in January 2004 to inform them of the OTP Accreditation Evaluation and the role that they would be requested to play in the study. This letter also explained the indepth study involving a subset of OTPs to prepare them for a possible invitation to be included in that sample. A few weeks later, a letter from the evaluation team was mailed to all OTPs inviting them to participate in the OTP evaluation. This letter was accompanied by a letter from AATOD, indicating its endorsement of the study.

As soon as possible thereafter, packages containing the PAQ and other items (see Exhibit III.B-2) were mailed to the OTPs in category 3 (OTPs that were newly accredited) and category 4 (OTPs that were already accredited but not planning to seek another accreditation during the study period). As OTPs in category 1 (those seeking their first accreditation) and category 2 (those seeking a subsequent accreditation during the study period) were accredited, they also were sent packages containing the PAQ. Because the evaluation was to include only accredited programs, staff delayed mailing PAQ packages until accreditation was confirmed.

When an AB accredited an OTP, it notified CSAT by letter. CSAT, in turn, uploaded the new status of the OTP into its OTP Certification Database, which the evaluation team accessed regularly to determine which OTPs were newly accredited. JCAHO provided preliminary accreditation results to the OTP onsite during its accreditation site visit, but other ABs sometimes required as many as 8 to 12 weeks to make a final decision regarding an OTP’s accreditation. To ensure that project staff were made aware of new accreditations as soon as possible, CSAT regularly sent them e-mail updates.

OTPs that submitted PAQ data were sent a package containing the FQ and other materials (see Exhibit III.B-2) 6 months after they had submitted the PAQ.

After questionnaires and thank-you/reminder postcards were mailed, regular followup calls to program directors were needed to encourage responses. Staff continued to call nonrespondents until the OTPs that had not responded either (1) submitted a completed questionnaire or (2) indicated they would not send one.

When communicating with OTPs, evaluation staff attempted to identify reasons for any delays and to address them, and often answered the OTPs’ questions about the survey items. OTPs reported to staff that completing the questionnaires required more time than the OTPs had anticipated for several reasons. For example, many OTPs reported that 1 to 2 weeks were needed for the questionnaires to be routed to the correct person within the OTP. In addition, locating required information often involved several staff members, and delays occurred in routing the questionnaires from person to person within the program. Other challenges and solutions involved in the data collection are presented in Exhibit III.B-3.

Exhibit III.B-3. Examples of Challenges and Solutions in PAQ and FQ Data Collection

Challenges	Solutions
Questionnaires that were "returned to sender" due to an inaccurate mailing address.	Calling the program to verify its address and resending the questionnaire by mail or fax.
Questionnaires that were routed to the wrong individual within the OTP.	Contacting the program director multiple times and mailing or faxing the questionnaire package if it was not received.
OTPs that were part of a corporate entity completed some questionnaire items onsite but also sent their questionnaires to the corporate office for review and completion of some items. In some cases, this meant a long delay for a cluster of questionnaires.	Identifying key contact person(s) and maintaining communication; suggesting options to expedite the process.
Level of effort taken to complete the questionnaires because program directors were gathering specific information rather than providing best-effort estimates.	Encouraging the program director to provide estimates and ensuring he or she understood which items were most critical to the evaluation.

Some nonrespondents who were contacted also indicated that they were part of a larger corporation that owned multiple sites. In some cases, the decision about whether to respond was made at the corporate level. These corporations indicated that only a subset of their OTPs could respond due to resource constraints.

Ultimately, evaluation staff initiated a targeted phone followup strategy to obtain PAQ and FQ data from nonrespondents with emphasis on directing the most effort to programs in underrepresented strata (see Section IV.1). This strategy involved offering OTPs the option of completing most of the survey over the phone and faxing in their Informed Consent Form, Accreditation Report Release Form, Honorarium Reimbursement Form, and responses to the remaining, more complex questionnaire items. Ten to 12 call attempts were made to encourage

nonresponding OTPs to participate. Few programs outright refused to complete the questionnaires, which, ironically, sometimes made the process more difficult.

III.B.2 Use of Financial Incentives

Use of incentives was explored as another method to maximize participation. Past experience with similar studies suggested that recruitment would be an issue for this evaluation, particularly for the OTPs invited to participate in the indepth study. The study most similar to this one, MAP I, for example, involved similar data collection methods and study participants. Although MAP I waived accreditation fees amounting to several thousand dollars for OTPs that agreed to participate in the study, collecting accurate and timely data from OTPs still was found to be considerably challenging. Given that accreditation subsequently became mandatory, this OTP evaluation could not waive accreditation fees.

To generate and maintain interest in this study, and to ensure reliable and valid data collection, incentives were essential. Many outside consultants with clinical and research methodological backgrounds provided input concerning the level and type of remuneration appropriate for various participants in this study. In addition, a thorough literature review of the methods used to encourage participation in health services research was conducted. The incentives offered in this study were based on the “reimbursement model,” in which research participants were compensated for time spent away from their work at the rate subjects were typically paid (Saunders et al., 1999).

Specifically, all OTP program directors received a cash incentive of \$25 for completing each OTP questionnaire. A program director at one site, therefore, could receive a sum of up to \$50. Program directors overseeing multiple sites could receive a sum of up to \$50 per center. (Incentives provided to the OTPs in the indepth study sample are described in Section III.C.)

III.B.3 Data Collected

The PAQ was sent to 1,012 OTPs receiving their first or subsequent accreditation from May 18, 2001, to December 31, 2004. Of these, 478 (47 percent) completed the PAQ. Subsequently, the FQ was sent to 310 OTPs that submitted a completed PAQ by December 31, 2004 (in order to ensure time to complete the analyses as the study neared its end). Of these, 171 responded, as follows:

- Of the 248 OTPs that completed the PAQ about their first accreditation, 132 responded, 41 of which completed the PAQ within 6 months of accreditation.
- Of the 62 OTPs that completed the PAQ about a subsequent accreditation, 39 responded, 21 of which completed the PAQ within 6 months of accreditation.

III.C INDEPTH STUDY SAMPLE

Exhibit III.C-1 show the timeline of the processes involved in selecting and gathering data from the indepth study sample.

Exhibit III.C-1. Summary of Data Collection Timeline for Indepth Study Sample

Data Collection Component for Indepth Study Sample	Date
Selected 150 OTPs for the indepth study sample based on stratified process to ensure optimal representation of program types	January 2004
Sent packages to program directors, sponsors, and medical directors of the 150 OTPs selected to be invited into the sample: <ul style="list-style-type: none"> • Letter of invitation from Northrop Grumman to participate in the indepth study • Letter of support for the indepth study from AATOD 	January 27, 2004
Began contacting the selected OTPs by phone and scheduling site visits	February 2004
Conducted site visits	April 2004 to January 2005
Collected Staff Activity Log data	From date of site visit until May 27, 2005

III.C.1 Sampling and Recruitment

III.C.1.1 OTP Sampling

Approximately 150 OTPs were invited to participate in the indepth study. The initial sample was selected on a randomized, stratified basis using information about OTPs stored in CSAT’s OTP Certification Database. The strata represented combinations of the following factors determined to be related to OTP’s accreditation experience:

- **Accreditation status**—Defined by two categories: OTPs that, as of January 8, 2004, were seeking a first accreditation and OTPs that were receiving a subsequent accreditation between September 1, 2004, and December 31, 2004. (OTPs receiving a subsequent accreditation within the study period but outside this window were not eligible for the indepth study due to timing constraints.)
- **Accreditation body used by the OTP**—Refers to the organization to which the OTP applied for accreditation. (For the sampling, lesser-cited ABs were combined into an ‘other’ category.)
- **Financial structure**—Defined by three categories: for-profit, nonprofit, and Government.
- **Treatment type**—Defined by three categories: detoxification only, maintenance only, and detoxification and maintenance.
- **Number of OTPs in the State**—Defined by three categories: small, medium, and large. An OTP was described as being in a State with a small number of OTPs if there were fewer than 35 OTPs in that State. The medium category refers to OTPs that were in States with 35 to 70 OTPs. The large category refers to OTPs that were in States with greater than 70 OTPs; only New York and California were included in this category.

Of the 162 possible combinations of these 5 variables, some did not contain a sufficient number of OTPs to allow proportional sampling of at least 1 OTP. Thus, the categories were combined to form 26 strata. The sample was selected from the resulting strata using proportional allocation:

$$\text{Number of OTPs selected from stratum } h = 50 * \frac{\text{\# OTPs in population in stratum } h}{\text{Total \# OTPs in population}}$$

Three OTPs were randomly selected without replacement for each one OTP desired from a stratum (e.g., if two OTPs were desired from the same stratum on the basis of proportional allocation, six OTPs were selected). This approach allowed for contacting all three OTPs simultaneously and assumed a 2 in 3 refusal rate. Thus, 150 OTPs were selected to achieve a target sample of 50, stratified by policy-relevant factors and selected randomly from each stratum.

As described previously, all the approximately 1,100 OTPs received a letter from CSAT in January 2004 explaining the accreditation evaluation and seeking their participation. This letter also mentioned that some OTPs would be contacted to participate in the indepth study. Shortly thereafter, the 150 OTPs selected to participate in the indepth study were sent an invitation letter from Northrop Grumman, as well as a letter of encouragement to participate from AATOD. Telephone calls followed.

The evaluation team encountered several challenges while recruiting sites to participate in the indepth study sample (see Exhibit III.C-2). The average amount of time from the initial contact to a site’s agreement to participate was 2 months. One reason for this delay, as reported by the OTPs, was that program directors often had to speak with other people or groups (e.g., an executive board that might meet infrequently) before committing the OTP to the indepth study.

Exhibit III.C-2. Examples of Challenges and Solutions in Indepth Study Site Recruitment

Challenges	Solutions
Availability of the program director when contacting the OTP (e.g., often traveling, unavailable).	Contacting the OTP by phone multiple times until the program director was reached.
OTP’s apprehension about Staff Activity Log data collection.	Emphasizing the benefit and ease of data collection; sending a sample activity log to the program director.
Lack of time because OTPs were already overwhelmed with daily operations.	Reiterating the benefits of the evaluation; explaining that the site visit would be scheduled at the OTP’s convenience and that all efforts would be made to cause minimal disruption to operations.

The initial goal was to recruit 50 programs. Ultimately, evaluation staff were able to recruit 23 OTPs; one program, which encountered substantial difficulties and ultimately failed accreditation, dropped out. (Section IV.1 describes the breakdown of the participating OTPs across the strata, which were subsequently again collapsed from 26 into 12 to ensure that each stratum included a sufficient number of OTPs for analysis.) As each site enrolled, it entered into an MOU with Northrop Grumman that delineated the roles and responsibilities of the two parties. Planning for the site visit began after submission of a completed MOU.

III.C.1.2 Patient Sampling

Initially, the evaluation plan called for site visit staff to use a systematic sampling methodology while onsite at each OTP in the indepth study. The goal was to conduct interviews with 30 patients, 10 patients in each of 3 strata: (1) patients who had been in treatment at the OTP for less than 6 months (new patients), (2) patients who had been in treatment at the OTP for 6 months to 1 year (short-term patients), and (3) patients who had been in treatment at the OTP for more than 1 year (long-term patients). Patients were to be approached at random and asked whether they would like to participate in a survey about satisfaction with services at the OTP. Depending on the patient population size of the OTP, every nth patient thereafter would be approached (Thompson, 1992). In addition to gathering interview data from these 30 patients at each site, site visit staff were to collect data from these patients’ charts.

A quota sampling strategy was necessary to ensure that a representative patient sample by length of treatment at the OTP was selected. A true random sample could not be obtained in advance of the visit due to concerns about patient confidentiality. Consultants to the study, however, agreed that it was necessary to obtain the perspective of patients with different lengths of treatment because they were likely to have different experiences at the OTP as it went through the accreditation process. If patients were randomly approached without using length of treatment as a selection criterion, a representative sample would not be obtained because the whole patient population would not be available to be sampled on a daily basis (long-term patients typically visit the OTP less frequently than do other patients).

In practice, site visit staff faced challenges in recruiting every *n*th patient. Many patients were not interested in participating (for a variety of reasons, which often included making sure they got on the right bus after completing treatment), and it was difficult to approach them in an orderly manner as they entered the facility. Because of time constraints (the 2- to 3-day site visit) and the 30-patient target per OTP, site visit staff modified their methods, approaching as many patients as possible in the waiting room before and after they received their methadone. Patients who were willing to participate in the interview were asked about their length of time in treatment, to ensure that site visit staff would interview a maximum of 10 patients in each treatment length. Site visit staff encountered many long-term patients, while new patients generally were more difficult to locate.

In addition to obtaining a sample of 30 current patients at each OTP, the plan called for reviewing the charts of a sample of discharged patients for which discharge data was available. Based on data from the MAP I study, there were, on average, seven patients discharged per month at an OTP. To obtain a full quarter's worth (3 months) of data and to ensure sufficient power for statistical analyses, site visit staff aimed to pull the charts of 20 recently discharged patients.

III.C.1.3 Staff Sampling

Initially, the plan called for a representative sample of OTP staff to be selected before each site visit to complete activity logs and participate in staff interviews. The sample from each OTP was to include people in three categories of OTP staff types—administrative, medical, and counseling. Before each visit, the evaluation team requested the staff roster from the OTP to randomly select OTP staff in each of these categories. In some cases, the evaluation team received a roster and was able to randomly select staff as planned. However, it quickly became apparent in some cases that the staff selected sometimes had no knowledge of the accreditation process or the ways in which it affected the OTP. Furthermore, the evaluation team often encountered difficulty in obtaining rosters before the visits. As a result, site visitors usually approached staff once onsite, asking them to identify OTP staff who were both knowledgeable about accreditation and willing to participate. The program director often provided a list of staff he or she recommended be interviewed because of their knowledge of accreditation. From this list, site visitors selected staff on the basis of their roles at the program. At each site, every effort was made to reach five or more staff members across the three categories of staff types.

III.C.2 Use of Financial Incentives

Each OTP in the indepth study sample was provided an incentive of \$1,100 for its participation in one site visit and all other data collection activities over the course of 6 months. The incentive was dispersed to the program on an incremental basis as different milestones were attained or on a monthly basis, contingent on timely activity log data submission. In effect, this

sum served as incentive to OTPs to participate but essentially was remuneration for services rendered by the OTPs, in part to offset staff time spent in study activities. As appropriate to their situation, these OTPs were encouraged to use part of the incentive to purchase or upgrade computer systems that might enhance their ability to participate more fully in the study.

III.C.3 Field Protocol

The project's site visit manual included a tentative site visit agenda, checklists, data collection instruments, informed consent forms, a project description, and protocols for onsite data collection. Site visit staff received training before the first site visit to learn the protocol and subsequently participated in regular meetings to discuss the challenges of data collection and lessons learned.

With very few exceptions, two staff members visited each site for 3 days. Before each visit, staff made logistical arrangements with the program director, asked the director to identify a patient representative (if the program had one) and a cost liaison (to assemble Staff Activity Logs), and requested a staff roster. After each visit, staff sent a thank-you letter to the program and maintained ongoing contact with the OTP to ensure their continuation in the study. While onsite, data were collected, as described in the following sections. Programs also were expected to complete the study questionnaires.

III.C.3.1 Patient Interview

Before each site visit, the evaluation team inquired about the time and duration of the OTP's dosing periods to determine the usual patterns of patient "flow" through the site. At the few programs with a patient representative, this person was asked to make patients aware of the patient interview before the site visit and to encourage their participation in the study. In addition, project staff sent flyers to indepth study OTPs in advance to advertise the visit to patients.

Once onsite, site visit staff recruited participants for the patient interview. As patients entered the clinic, staff asked them whether they would like to participate in an interview about the services provided at the OTP, and also asked them how long they had been in treatment at the OTP to determine the stratum into which they fell. Juice and donuts were offered to encourage participation. With each patient, staff explained the purpose of the data collection and the voluntary nature of participation, the confidentiality of the information the patient would provide, the patient's rights as a study participant, the estimated response burden, and the use of the data. After obtaining consent from the patient for both the interview and the chart abstraction, the site visitors proceeded to administer the Patient Questionnaire. Which patients participated was not revealed to staff, and patients were assured that neither their participation nor the content of their responses would affect their services.

III.C.3.2 Chart Abstraction

Following the patient interviews, site visit staff conducted chart abstractions using the charts of the interviewed patients who consented. OTP staff pulled the charts. Site visitors collected limited patient data from records and entered the information directly into a laptop computer using the Chart Abstraction Form as a data entry template. In general, OTP charts, as well as the discharge records described next, were found to be organized and legible.

III.C.3.3 Discharge Record Abstraction

While onsite, site visit staff also asked for OTP staff to pull "closed" charts of the last 20 officially discharged patients. Staff collected data from records and entered the information

directly into a laptop computer using the Discharge Record Abstraction Form as a data entry template.

III.C.3.4 Staff Activity Logs

Each OTP in the indepth study sample identified a cost liaison to serve as the point of contact for gathering Staff Activity Log data. This role often was assumed by the program director, with the responsibility sometimes transitioning to the program administrator. Selected staff at each sample OTP were asked to record the total time spent each day on the included activities, in either a hardcopy or electronic version of the log. They were asked to send the cost liaison their logs each week to minimize recall bias. The cost liaison was responsible for aggregating the logs biweekly and sending a summary spreadsheet, indicating the total time spent over 2 weeks on various activities by staff type, to a designated evaluation team member by e-mail or fax. OTPs were asked to continue to submit activity log data for a period of up to 6 months after their site visit.

During the visits, template spreadsheets for gathering and aggregating cost data were given to sites in both paper and electronic formats, and site visit staff trained the cost liaisons in the use of the spreadsheets for data collection. (Cost liaisons later trained the staff selected to participate.) Site visitors also gave each OTP a data collection manual that described, in detail, how the Staff Activity Logs were to be completed and submitted. This manual included a description of the data collection process, as well as definitions of services and activities included in the logs. On an ongoing basis, evaluation team members made calls to each OTP cost liaison to address any problems or concerns and provided technical assistance notes as needed.

One considerable challenge in gathering activity log data over time was substantial staff turnover at the OTPs. For example, by November 2004, 18 sites had been visited. Of these, nine had experienced turnover in the position assigned to serve as the cost liaison. In fact, approximately two-thirds of the OTPs at that time had had at least one or more staff members leave the program.

III.C.3.5 Site Visit Staff Interviews

While onsite, site visitors also conducted interviews with a sample of OTP staff. Site visitors described to the staff the purpose of the interview and its importance to the OTP Accreditation Evaluation. In addition, the interviewer explained to participants that their input was voluntary and that responses would be kept confidential. Informed consent was obtained from each person being interviewed. Site visitors took notes during the interviews, which required no more than 45 minutes each.

III.C.3.6 OTP Budgets

Site visit staff also asked each OTP in the indepth study to provide a copy of the OTP's detailed budget information. This information generally took the form of audited statements or annual reports from the previous year.

III.C.4 Data Collected

Of the 478 OTPs that completed a PAQ, 22 participated in the indepth study. From these, evaluation staff:

- Conducted 84 staff interviews with 37 counselors, 16 medical staff, and 31 program directors/administrative staff (an average of 3.8 staff interviewed per OTP)
- Conducted 590 patient interviews (an average of 26.8 per OTP)

- Conducted 548 chart abstractions out of the 590 possible and obtained (5,703 test result records, an average of 10.4 test results per patient)
- Conducted 461 discharge abstractions (an average of 21 per OTP)
- Collected Staff Activity Logs from 22 sites (specifically, 12 OTPs submitted 26 weeks of data, 6 submitted 17 weeks of data, and 4 submitted 12 to 15 weeks of data)
- Collected budget information from 15 sites.

III.D OTHER DATA SOURCES

III.D.1 CSAT OTP Certification Database

Descriptive information about OTPs, as well as information about their accreditation status and CSAT certification, was obtained from the CSAT OTP Certification Database. This database, maintained by another contractor, provided information necessary to identify the OTPs to be administered questionnaires and to select the sample of OTPs for the indepth study.

During the project, the evaluation team accessed the OTP Certification Database online and downloaded new data to update the OTP Accreditation Evaluation project database. This process required comparing information contained in both databases and establishing rules to determine which information was the most recent before the updates were made. At the beginning of data collection, new data were downloaded weekly because of the volume of OTPs receiving accreditation. As accreditation slowed, the download occurred every 2 to 4 weeks, as needed.

III.D.2 State Methadone Authority Phone Interviews

Between February and April 2004, telephone interviews were conducted with State Methadone Authorities. The SMAs' primary responsibility is to oversee the treatment of narcotic addiction with a narcotic drug. The interviews with SMAs addressed State policies and the environment relating to opioid treatment and OTP regulation. The interviewers limited the discussions to 45 minutes and obtained informed consent via fax. All SMAs in States with at least one OTP were invited to participate, and 30 agreed to do so.

III.D.3 National Survey of Substance Abuse Treatment Services (N-SSATS)

The National Survey of Substance Abuse Treatment Services (N-SSATS) survey, formerly known as the Uniformed Facilities Data Sets (UFDS), is maintained by SAMHSA's Office of Applied Studies (OAS) and contains information collected annually on programs that are funded as part of the Substance Abuse Prevention and Treatment Block Grant. In addition to providing information regarding the location of and services available at existing treatment programs, one of the primary purposes behind the N-SSATS survey is to provide researchers and policymakers with statistical information on the characteristics of substance abuse treatment facilities and the clients served at those facilities.

III.D.4 Opioid Treatment Program Accreditation Impact Study (MAP I)

The MAP I study was conducted by CSAT well before accreditation was federally mandated, to test the processes and costs associated with implementing an accreditation-based system of oversight. The study involved a pre- and post-test design with experimental and control group comparisons. The experimental group underwent an accreditation site visit during the study period, while the control group experienced an accreditation site visit after the study's data collection period. Most data were collected from both groups at two points in time (pre-accreditation and post-accreditation), with some data collection from the experimental group during accreditation preparation. (See Section II.A.1 for more information on the MAP I study.)

III.E DATASET PREPARATION

III.E.1 Data Cleaning

Preliminary data checks were used to ensure data entry accuracy. The rate of errors was examined on a continuous basis to verify that data were being entered as accurately as possible. Once all the data (including data from phone interviews) had been entered into the various Microsoft Access databases and stored in hardcopy, data entry began. Each item in the database was checked twice against the hardcopy version.

Various tests and queries were run to determine whether there were database issues, which were then corrected. The SAS programming was checked to correct any instances in which the database rounded responses or did not correctly capture response types that had not been anticipated (e.g., when the number of employees was given in fractions of a full-time employee).

The responses also were checked for logical agreement by using SPSS and SAS, as appropriate. In most cases in which the responses were not logical (e.g., a response that would indicate that the OTP is located in a hospital but not in a hospital setting), a note was made to contact the OTP. If contact could not be made, the response would be flagged but left as is. In other cases, if the response to a categorical question had a response of “other” but was identical to one of the available choices, a change was made to recode the response to fall into the appropriate category. However, if the response did not match exactly, the response was coded as “other.” The logic checks also included running various univariate and frequency checks in SAS to ascertain a valid range of dates, valid monetary amounts, and valid numbers of people.

III.E.2 Definition of Covariates

Several variables were used in the analysis as covariates. These variables were shown to have an impact on results according to several studies, including MAP I. The majority of the variables originate from the PAQ, FQ, and the Patient Questionnaires, while other covariates were created or gathered independently of the questionnaires. The covariates and dependent variables that had an impact only on specific variables will be discussed further in analysis.

Data describing the financial structure and the treatment type used in the OTP were collected by calling and e-mailing the program directors of each OTP that responded to the PAQ. To ensure uniform responses, the program director was asked to choose the most accurate response out of three choices: for-profit, nonprofit, or Government. Treatment type also was determined during this call by asking, “Which of the following best describes the treatment provided at your OTP: detoxification only, maintenance only, or detoxification and maintenance?”

The organizational setting covariate was created by collapsing response choices in Question 1 of the PAQ: “Which of the following best describes your OTP?” Of the 18 possible choices, the responses were collapsed into 8 more general categories based on the results of logic checks and frequencies.

Other characteristics of the OTPs were generated based on responses to the PAQ, such as the physical location, size, and setting of the OTP. The physical location of the OTP was described as surrounded by other businesses, by itself on its own block, in a residential area, in a rural area, in a mixed business and residential area, or by other type of location. The OTP size was determined by categorizing the number of patients enrolled at each site at the time of the survey. The categories were created based on the results of logic checks, frequencies, and similar to previous studies. The four categories are as follows: 0 to 100, 101 to 200, 201 to 300, and 301 and more. The organizational setting covariate was created by further categorizing the setting

descriptions given in Question 1 of the PAQ into two groups: hospital-based vs. non-hospital-based.

Many of the responses to the PAQ were to be completed in reference to the most recent accreditation. In the analysis, OTPs were categorized as either “first accreditation” or “subsequent accreditation” based on the accreditation date that most closely preceded the date that the site actually completed the PAQ.

The respondents also indicated from which organization they received accreditation (Question 22). The accrediting bodies were categorized as JCAHO, CARF, COA, and “other.”

IV. ANALYSIS AND RESULTS

IV.1 REPRESENTATIVENESS OF DATA

At the completion of data collection, the respondents from the PAQ, FQ, and indepth study sample were assessed for representativeness of the OTP population. Overall, the PAQ response rate was 47 percent; of these, 54 percent also completed the FQ (171 of the 310 OTPs sent the FQ). Site visits were conducted at 22 programs out of the intended sample of 50.

Every effort was made to ensure that the PAQ data were representative of the field, as seen in Exhibit IV-1. The sample was selected on a stratified basis, using information currently stored in CSAT’s OTP Certification Database. The strata represented combinations of factors determined to be related to accreditation, such as financial structure. The strata were developed through discussion with CSAT/DPT staff, AB representatives, and consultants to the OTP Accreditation Evaluation. The sample was selected from the population of OTPs identified as active at the time of the sample selection. The CSAT OTP Certification Database, updated on a regular basis, was used to ensure a complete and accurate sampling frame.

Exhibit IV-1. Representativeness of Results from the PAQ

Accred. Status	AB	Financial Structure	# OTPs in State	Treatment Type	OTP Stratum	# Sites	# Sent	# Returned	% Returned
1	CARF	For-profit, nonprofit, Government	Small, medium	Both, detox only, maint. only	1, 2, 3	223	212	99	47%
1	CARF	For-profit	Medium	Both, maint. only	4, 5	127	110	50	45%
1	CARF	For-profit	Large	Both, detox only, maint. only	6, 7, 8	91	89	47	53%
1	COA, WA State	For-profit, nonprofit	Small	Both, maint. only	9	16	14	5	36%
1	COA	For-profit	Medium	Both, maint. only	10	14	8	4	50%
1	COA	For-profit	Large	Both, maint. only	11	33	27	10	37%
1	JCAHO	For-profit	Small	Both, detox only, maint. only	12, 13, 14	83	81	44	54%
1	JCAHO	For-profit	Medium	Both, detox only, maint. only	15, 16, 17	84	80	41	51%
1	JCAHO	For-profit	Large	Both, detox only, maint. only	18, 19, 20	120	114	60	53%
1	JCAHO	Government	Small, Large	Both, maint. only, detox only	21	9	6	3	50%
1	JCAHO	Nonprofit	Small, Medium, Large	Both, maint. only, detox only	22	11	8	4	50%
2	CARF, JCAHO	For-profit, nonprofit	Small, medium, large	Both, maint. only	23, 24, 25, 26	32	30	22	73%
					Not Stratified	271	233	89	38%
					Total	1,114	1,012	478	47%

Exhibit IV-2. Representativeness of Results of Indepth Study Sample

Accred. Status	AB	Financial Structure	# OTPs in State	Treatment Type	OTP Stratum	# OTPs Intended To Be Included in Sample	# Site Visits Completed	% of Target Sample Visited
1	CARF	For-profit, nonprofit, Government	Small, medium	Both, detox only, maint. only	1, 2, 3	13	4	31%
1	CARF	For-profit	Medium	Both, maint. only	4, 5	7	3	43%
1	CARF	For-profit	Large	Both, detox only, maint. only	6, 7, 8	5	3	60%
1	COA, WA State	For-profit, nonprofit	Small	Both, maint. only	9	1	1	100%
1	COA	For-profit	Medium	Both, maint. only	10	1	0	0%
1	COA	For-profit	Large	Both, maint. only	11	2	1	50%
1	JCAHO	For-profit	Small	Both, detox only, maint. only	12, 13, 14	5	2	40%
1	JCAHO	For-profit	Medium	Both, detox only, maint. only	15, 16, 17	4	1	25%
1	JCAHO	For-profit	Large	Both, detox only, maint. only	18, 19, 20	6	5	83%
1	JCAHO	Government	Small, Large	Both, maint. only, detox only	21	1	1	100%
1	JCAHO	Nonprofit	Small, Medium, Large	Both, maint. only, detox only	22	1	0	0%
2	CARF, JCAHO	For-profit, nonprofit	Small, medium, large	Both, maint. only	23, 24, 25, 26	5	1	20%
					Total	50²	22	44%

IV.2 CPPOA ANALYTIC FRAMEWORK

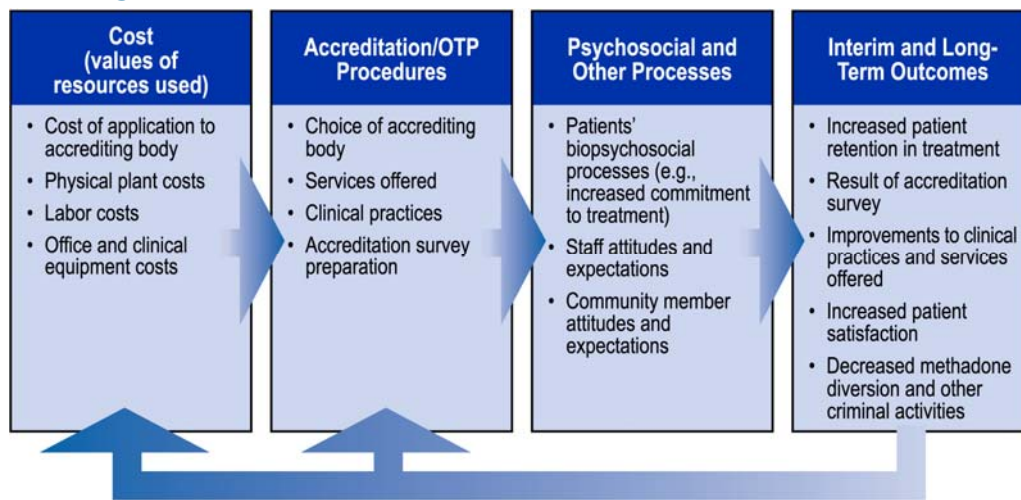
A significant element of this study was an analysis of the costs associated with accreditation. To integrate treatment costs and outcomes into a formative, improvement-oriented evaluation and to apply business procedures to optimizing program performance via accepted methods of operations research, Yates, a consultant for this study, relied on the Cost → Procedure → Process → Outcome Analysis (CPPOA) model developed previously (Yates, 1980a, 1996, 1999). CPPOA encourages the use of operations research procedures to optimize, rather than simply measure, the cost-effectiveness and cost-benefit of human services, including treatment

² 150 OTPs were selected to achieve a target sample of 50, stratified by policy-relevant factors and selected randomly from each stratum.

and prevention of substance abuse. Most CPPOAs to date have applied cost-effectiveness analysis or cost-benefit analysis to the formative rather than summative evaluation of large-scale prevention and treatment programs addressing issues such as substance abuse (Fals-Stewart, Klostermann, Yates, O’Farrell, & Birchler, 2005), mental health (Yates, 1981), and obesity (Yates, 1978, 1987).

In the original proposal, the CPPOA model was to be applied primarily from the perspective of an individual program, as shown in Exhibit IV-3.

Exhibit IV-3. Original OTP AE CPPOA Model



As this evaluation progressed, it became increasingly focused on the questions listed in Appendix H, and so the model evolved into one in which different interest groups would have different perspectives on what the costs, procedures, processes, and hoped-for outcomes were for accreditation, though some of these perspectives could not be fully captured with existing data.

The particular resources, procedures, processes, and outcomes considered from these perspectives are shown in Appendix I. The grayed-out areas indicate variables for which data were not available from this study but suggest a number of topics worth future study. The program perspective is represented best. Relatively little information is available on the time and other resources that consumers devoted, perhaps inadvertently, to activities related to new accreditation and reaccreditation efforts. In light of the need to capture these multiple perspectives, efforts were undertaken to collect additional data (e.g., on the costs of accreditation activities to the accreditation bodies) and not just to measure costs to the programs.³

IV.3 EXPLANATION OF ADMINISTRATIVE, CLINICAL, AND FULL IMPLEMENTATION EVALUATIONS

The results of this evaluation are categorized into three thematic areas: administrative, clinical, and full implementation. Administrative questions addressed the costs associated with the accreditation process, staff perceptions of accreditation-related activities and suggestions for improvement, the relationship between accreditation bodies and the characteristics of the applicant OTPs, and the effects of being an accredited OTP on operating activities and costs.

³ Note: The costs associated with achieving accreditation are based on self-reporting and OTP providers' perceptions of costs.

Clinical questions included those related to policies and practices as an accredited OTP in various areas: dosing, treatment planning, noncompliance with treatment regimen, take-home privileges, drug testing, discharge, and the quality of treatment planning. In addition, they assessed whether there is any effect on service accessibility and delivery associated with operating as an accredited OTP in such areas as number and types of services, the patient population, and number of treatment slots available. Finally, clinical questions looked at the effects on patients associated with operating as an accredited OTP.

The full implementation evaluation questions explored policy questions—improvements that could be made; recommendations for changes to standards by accreditation bodies; effect of regulation on the number of operating clinics; pre/post effects on operations, services accessibility, and patient satisfaction; and State changes in policies and practices as a result of the regulations. Cost-related questions looked at the cost to the Government of national implementation of OTP accreditation, the cost-effectiveness of the national implementation, and projected average costs to the OTPs of undergoing and continuing accreditation.

IV.A STUDY POPULATION

IV.A.1 Introduction

This section of the report describes the OTPs in the PAQ sample with regard to types of treatment offered, financial structure, and accreditation body. For types of treatment, OTPs were categorized based on whether they offer detoxification, maintenance therapy, or both. Also explored is the OTP's financial structure, that is, whether it is a for-profit, nonprofit, or Governmental facility. In the PAQ, OTPs were asked from which organization they received their accreditation. Organizational settings are also analyzed, particularly to understand whether there are any patterns based on organizational setting and accreditation body (AB), type of treatment, and financial structure.

In addition, this section provides an overview of the OTP patient population and staffing patterns. OTPs were asked to report their current caseload and the demographics of that caseload based on gender, race, and age. They also reported the staff levels they maintain to serve their patient population. The PAQ further looked at the types of substances for which these OTP patients were receiving treatment during the past 6 months.

IV.A.2 Descriptive Characteristics of OTPs That Responded to the PAQ

The PAQ respondents consisted of 478 accredited clinics. Although there are many possible characteristics by which these programs could be compared, the subgroup analyses in this section focus on three primary features: (1) type of treatment offered, (2) financial structure, and (3) accreditation body. These program characteristics are summarized as follows.

IV.A.2.1 Type of Treatment Offered

The majority of programs (55.4 percent) who responded to the PAQ reported offering both detoxification and maintenance therapy. The second most common category is maintenance only (35.4 percent). Only 9.2 percent of the sample provides detoxification services only.

IV.A.2.2 Financial Structure

Response categories for this variable were limited to three organizational types: for-profit, nonprofit, and Governmental. The percentage of programs that are for-profit and nonprofit are fairly similar (41.0 percent and 44.6 percent, respectively). Only 14.4 percent of the programs are run by a Government agency.

IV.A.2.3 Accreditation Body

Exhibit IV.A-1 shows the distribution of programs by accreditation body. CARF and JCAHO account for more than 95 percent of the programs, while COA (3.1 percent), Washington Department of Social and Health Services, Division of Alcohol and Substance Abuse (1.1 percent), and the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse (0.2 percent) account for less than 5 percent. Consequently, subsequent contrasts of programs by accrediting source use the following three categories: CARF (54.8 percent), JCAHO (40.8 percent), and "other" (4.4 percent).

Exhibit IV.A-1. Accreditation Source for OTP Program Sample (N=478)

Agency	N	%
CARF	262	54.8
JCAHO	195	40.8
COA	15	3.1
WA State	5	1.1
MO State	1	0.2

IV.A.2.4 Organizational Settings

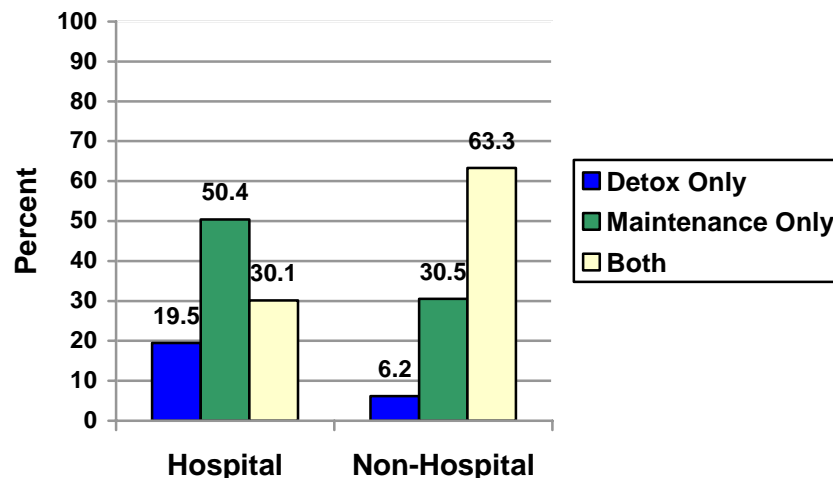
One of the goals of the OTP accreditation survey was to assess the extent to which these three program factors—type of treatment, financial structure, and accreditation body—vary across OTP clinic settings. Responses to the program survey show that these clinics operate in a diverse array of organizational settings. As can be seen in Exhibit IV.A-2, outpatient treatment (whether community- or hospital-based) is by far the most common treatment setting for OTPs—accounting for approximately 85 percent of the programs. It is also interesting to note that the majority of the OTP clinics operate in non-hospital settings.

Exhibit IV.A-2. Organizational Settings for OTP Program Sample (N=470)

Setting	N	%
Outpatient SAP; not affiliated w/ hospital	200	42.6
Outpatient SAP; part of larger corporation	100	21.3
Outpatient SAP; affiliated w/ hospital	56	11.9
Hospital; outpatient SAP on site	42	8.9
Non-SAP; health center	22	4.7
Hospital; inpatient SAP on site	15	3.2
Residential SAP	9	1.9
Other	22	5.5

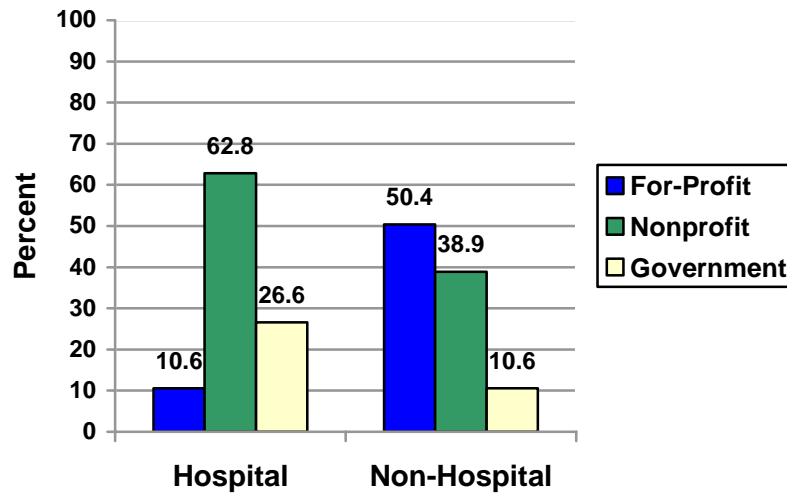
To facilitate comparisons of the three above-mentioned program characteristics by clinic setting, the responses in Exhibit IV.A-2 were collapsed into two categories: (1) hospital-based OTPs (24.0 percent) and (2) non-hospital-based OTPs (76.0 percent). The results of these comparisons are shown in Exhibits IV.A-3 through IV.A-5.

Exhibit IV.A-3. Treatment Setting by Type of Treatment (N=470)



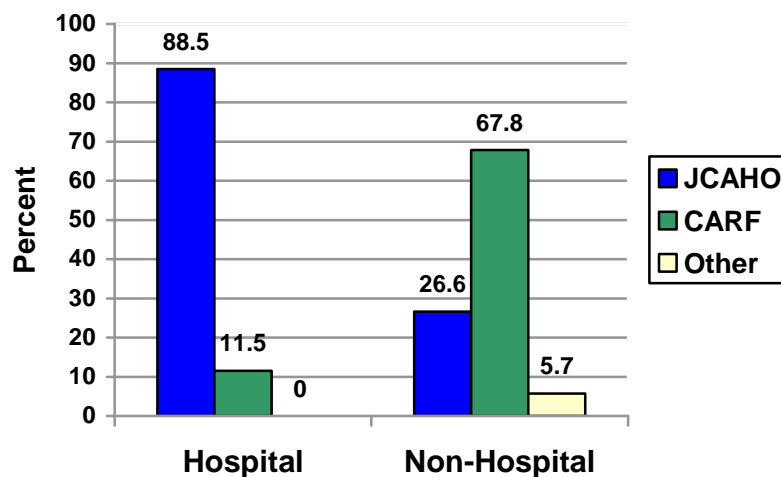
OTP clinics based in hospital settings are more likely than are those in non-hospital settings to offer *either* detoxification or maintenance. In contrast, OTPs in non-hospital settings are more likely to offer both detoxification and maintenance treatment services.

Exhibit IV.A-4. Treatment Setting by Financial Structure (N=470)



With regard to financial structure, hospital-based OTPs are much more likely than are non-hospital-based OTPs to be nonprofit or Government organizations, whereas non-hospital-based OTPs are significantly more likely to be classified as for-profit organizations.

Exhibit IV.A-5. Treatment Setting by Accreditation Body (N=467)



Of the three comparisons of clinic settings made in this section, the sharpest contrasts arose in the source of accreditation. Nearly 9 in 10 hospital-based OTPs were accredited by JCAHO, whereas more than two-thirds of the non-hospital-based OTPs were accredited by CARF. The close association of accreditation source and clinic setting should be taken into account when drawing inferences of cost and program functioning related to accreditation source. At the very least, such comparisons should be made within the setting categories rather than with the combined OTP program sample.⁴

⁴ Note: Often laws and policies required hospitals to seek JCAHO accreditation.

IV.A.2.5 Program Size

Of the 405 OTPs that reported the square footage of their programs, the average size is 5,774 square feet (SD=7,900). Given that the range is from 100 to 7,800 square feet, it is likely that some of the respondents reported the sizes for the larger organization in which the OTP is housed.

IV.A.2.6 General Description of OTP Patient Population

The OTP programs in this sample reported an average current caseload of 238 patients (SD=180.8), ranging from 0 to 1,200. Community-based programs tend to have larger caseloads than do hospital-based programs (mean=255.0 [SD=169.5] versus 216.1 [SD=103.2]). On average, these programs were operating at 81 percent of capacity at the time of the survey. Approximately two-thirds (66.5 percent) of the respondents indicated that their program capacity had increased during the 6 months before the survey. Equal percentages of the remaining programs indicated either no capacity change (16.5 percent) or a decrease in capacity (17.0 percent).

Exhibit IV.A-6 provides an overview of OTP patient characteristics for the combined program sample. Broadly speaking, the “typical” OTP patient is a white male between the ages of 26 and 50.

Exhibit IV.A-6. OTP Patient Demographics (N=462)

Characteristic	%
Male	61.6
Race/Ethnicity	
White, Non-Hispanic	57.5
Hispanic/Latino	20.2
African American	19.4
Other	2.9
Age	
<18 years	0.1
18-25 years	12.7
26-50 years	67.3
>50 years	19.4

Virtually all (95.3 percent) of the patients enrolled at these clinics in the 6 months before the survey were given methadone. The second most commonly dispensed medication was buprenorphine, which accounted for slightly less than 1 percent of the OTP patients.⁵ During this same timeframe, three-quarters (75.2 percent) of the patients were receiving treatment for heroin addiction; 14.6 percent, for oxycodone addiction; and 5.7 percent, for morphine addiction. With regard to treatment length, 38.4 percent of the OTP patients had been receiving treatment for more than 2 years. The next most common category was relatively new patients enrolled in treatment for less than 6 months (22.7 percent), followed by those who received treatment for 1 to 2 years (20.9 percent) and those who received treatment for 6 months to 1 year (18.6 percent).

IV.A.2.7 Description of OTP Staffing Patterns

On average, the OTP clinics have a total of 21.2 (SD=13.6) staff members. Eight (SD=5.7) of these are medical staff (including physicians and nurses), 5.4 (SD=4.5) are counselors, and 1.4

⁵ Note: A rule allowing buprenorphine to be used in OTPs was passed mid-study.

(SD=2.1) are social workers. Programs, on average, have fewer than one psychologist (mean=0.54 [SD=1.2]) or case manager (mean=0.67 [SD=1.7]) on staff.

IV.A.3 Descriptive Characteristics of OTPs Participating in the Indepth Study Sample

IV.A.3.1 Overview of Site Visits and Patient Interviews

As part of the evaluation, site visits were made to 22 OTPs that had already achieved accreditation. (A 23rd site visit was made to a program that had recently failed its accreditation survey; all data from this program were subsequently dropped from the analyses.)

During these visits, patients were interviewed on a number of subjects, including their length of time in opioid treatment, their perceptions of the care provided, types of services received, health and employment status, and current illicit drug use. Data were collected from approximately 30 patients at each site, selected according to the length of time the individual has been in treatment (current episode): less than 6 months (33.5 percent of the patients), 6 months to 1 year (29.9 percent), and more than 1 year (36.6 percent). A total of 590 patients participated in the interviews (an average of 26.8 patients/site visit). The original data collection plan called for 10 patients from each treatment length stratum; one possible explanation for this slightly skewed distribution (i.e., a higher percentage of patients enrolled in the current program for more than 1 year) is that these individuals felt more secure about speaking with the site visitors, as they were more comfortable with their treatment regimen.

IV.A.3.2 OTP Indepth Study Sample vs. OTPs Completing the PAQ

It is important to note that the 22 OTPs that participated in the site visits differ significantly from the OTPs that completed the PAQ along a number of salient dimensions: accreditation body, financial structure, size, and type of services offered.

JCAHO-accredited programs are overrepresented in the site visit population by 6.2 percent and COA-accredited programs are overrepresented by 4.4 percent, while the CARF-accredited programs are underrepresented by more than 9 percent. No programs were visited that were accredited by a State agency.

Exhibit IV.A-7. Indepth Study OTPs vs. PAQ Respondents Based on Accreditation Body

Accreditation Body	Indepth Study	# of OTPs	PAQ Respondents	# of OTPs	Difference
JCAHO	47.3%	10	41.1%	195	6.2%
CARF	45.1%	10	54.7%	260	-9.6%
COA	7.6%	2	3.2%	15	4.4%
Other	0.0%	0	1.1%	5	-1.1%

OTPs with fewer than 100 patients enrolled are significantly underrepresented in the indepth study sample (20.8 percent), compared to the PAQ sample. The data from this size OTP are limited to a single program in the site visits (representing 3.2 percent of the sites, compared to 24.0 percent of the PAQ OTPs). OTPs reporting a patient enrollment of between 201 and 300 are overrepresented by a similar amount (18.4 percent).

Exhibit IV.A-8. Indepth Study OTPs vs. PAQ Respondents Based on Number of Patients Served

Number of Patients	# of OTPs		# of PAQ Respondents		Difference
	Indepth Study				
<100	3.2%	1	24.0%	109	-20.8%
101–200	29.5%	7	26.0%	118	3.5%
201–300	37.3%	8	18.9%	86	18.4%
301–400	15.4%	3	15.4%	70	0.0%
>400	14.6%	3	15.6%	71	-1.0%

No detoxification-only OTPs are included in the indepth study sample, and thus this category is obviously underrepresented. Programs that provide both detoxification and maintenance are overrepresented by 8.2 percent.

Exhibit IV.A-9. Indepth Study OTPs vs. PAQ Respondents Based on Treatment Type

Type of Treatment	Indepth Study	# of OTPs	PAQ Respondents	# of OTPs	Difference
Detox Only	0.0%	0	9.2%	44	-9.2%
Maintenance Only	36.4%	8	35.4%	169	1.0%
Both	63.6%	14	55.4%	265	8.2%

IV.A.3.3 Patient Demographic Data from the Indepth Study Sample OTPs

General demographic information gathered from the patients interviewed at the 22 OTPs that participated in the site visits includes the following:

- Average age is 35, which corresponds to the results from the PAQ, in which the largest age group was 26- to 50-year-olds (67.3 percent).
- 53.6 percent are male, compared to 61.6 percent in the PAQ.
- Of the patients who answered the question about what race/ethnicity they consider themselves to be:
 - 72.1 percent are Caucasian (the smaller the clinic, the more likely that the population is Caucasian).
 - 20.4 percent are African American.
 - 3.5 percent are American Indian/Alaska Native.
 - 2.5 percent are Native Hawaiian/Other Pacific Islander.
- 27.6 percent claim Spanish/Hispanic origin (the larger the clinic, the higher the number of patients with Spanish/Hispanic origins, which may be explained by most larger clinics being located in urban areas).⁶
- As for the reason they are receiving treatment at the OTP:
 - 69 percent reported being treated for heroin addiction.
 - 12 percent reported being addicted to both heroin and pain medications.
 - 19 percent reported being addicted to only pain medications.

⁶ Different methodologies were used to measure race/ethnicity, type of treatment, and other demographic information, so comparisons of these data to those in the PAQ is not possible.

The following information was obtained about patients' experiences receiving treatment at an OTP:

- The mean length of the current treatment episode is 25.9 months.
- The mean number of years in treatment is 6.3 years.
- The mean number of OTPs in which individuals have been enrolled during their various treatment episodes is 2.9 programs.
- 64 percent reported receiving treatment at an OTP prior to their current treatment episode.

Of all the patients surveyed, slightly less than one-third (31.2 percent) reported that they did not have any health insurance. Those with health insurance (68.8 percent) reported the following types of coverage:

- 57.8 percent—only Medicaid.
- 20.1 percent—private health insurance.
- 8.3 percent—only Medicare.
- 7.5 percent—both Medicaid and Medicare.
- 3.3 percent—some other type of coverage.
- 2 percent—a combination of Medicaid/Medicare and other private insurance.
- 1 percent—CHAMPUS, VA, or some other type of military coverage.

Of the patients reporting some type of insurance coverage, almost two-thirds (66.4 percent) reported that their opioid treatment is covered by their insurance policy.

IV.A.4 Summary

The characteristics of OTPs that responded to the PAQ differ substantially by organizational setting. While hospital-based OTPs tend to offer maintenance only, be nonprofit, and have been accredited by JCAHO, most community-based OTPs provide both maintenance and detox services, are for-profit, and have CARF as their AB. As might be expected, the OTPs in settings that fall into the “other” category are diverse when it comes to these three program factors. While half provide both types of treatments, one-quarter offer maintenance only and one-quarter offer detoxification only. These OTPs do tend to be nonprofit organizations, but even so, one-fifth are for-profit, and 3 in 10 are supported by Government agencies. Most are accredited by JCAHO, but 4 in 10 have CARF as their AB and 1 in 8 are not accredited by either JCAHO or CARF. With regard to OTP patient characteristics, the average caseload size is 238 patients, and the “typical” patient is a white male between the ages of 26 and 50.

The program-related demographics among the OTPs chosen for site visits are different from those of the PAQ respondents, with OTPs whose AB is JCAHO overrepresented and those whose AB is CARF underrepresented. Looking at the program size demographics between the two samples, OTPs with fewer than 100 patients are underrepresented in the site visits compared to the PAQ, while programs with between 201 and 300 patients are overrepresented. The final demographic category compared was treatment type. Unfortunately, none of the site visits included detox-only sites.

IV.B ADMINISTRATIVE EVALUATION

IV.B.1 Introduction

This section explores the administrative side of accreditation from the OTPs' perspective. OTPs were asked in the PAQ to report as to whether they had implemented any changes in the past year in order to comply with accreditation standards. The questions were related to changes in staffing and services, as well as salaries and benefits. In addition, OTPs were asked to indicate whether the accreditation process had an impact in any of 14 areas, from requiring more documentation to improving coordination of care and/or treatment practices to increasing patient participation in OTP planning or their individual treatment plan.

To determine general impressions of the accreditation process, the program manager/director, clinicians, counselors, and medical directors at these OTPs were asked whether they agreed or disagreed with 13 statements about areas related to accreditation. These items included questions related to whether accreditation helped or hurt their program, whether treatment was better as a result of accreditation, whether they would prefer to work for an accredited OTP, and whether the paperwork and administration related to being accredited were burdensome.

IV.B.2 Activities and Costs Associated With *Achieving Compliance With Accreditation Standards*

To better understand the level of effort and costs associated with achieving compliance with accreditation standards, program directors were asked to estimate how much time their staff spent in an average month on a number of accreditation-related activities since their OTP started preparing for accreditation. When answering this question, some OTPs were referring to their first accreditation ($N=395$), while others may have been referring to their second or third accreditation ($N=83$). Nearly half of the programs responding about their second or third accreditation participated in the MAP I study, and a very small number may have received a 1-year accreditation from their accreditation body.

In the PAQ, program directors reported staff level of effort using six staff categories: management staff, physician, nurse, counselor, other clinical staff, and administrative staff. Each of these labor categories was assigned an hourly nonloaded wage according to the average 2003 U.S. Department of Labor national estimate for employment wages for occupations within the category. This hourly rate was multiplied by the total number of hours for that labor category for each activity. Finally, each of the labor categories was summed. The total mean personnel-related cost for all these activities (achieving compliance with standards and the accreditation process) was \$9,501.07 per month.

For further analysis, this cost was broken down based on type of activity. The mean cost by program activity for those items related to *achieving compliance with standards* is reported in Exhibits IV.B-1 and IV.B-2 (see Section IV.B.3 for activities related to the *accreditation process*).

Exhibit IV.B-1. Time Spent and Labor Cost of All Staff in an Average Month To Achieve Compliance With Accreditation Standards Since OTP Started Preparing for First Accreditation

	N	Mean Hours	Mean Cost
Staff meetings related to accreditation	273	57.61	\$1,482.13
Staff training related to accreditation	268	36.96	\$919.71
Review/update of records keeping	268	57.73	\$1,413.38
Review/update of treatment plans or continuing care plans and procedures	266	47.19	\$1,209.61
Review/update of admissions procedures	262	21.25	\$539.05
Review/update of storage of controlled substances	261	13.60	\$373.80
Review/update of facilities	254	15.21	\$386.68
Development of quality assurance plan	263	19.65	\$506.92
Preparation of OTP documentation	252	41.77	\$1,066.44
Development/review/update of community relations	260	10.70	\$267.61
Development/review/update of diversion control plan	263	10.35	\$292.50
Other accreditation activities	101	13.72	\$304.72

These cost estimates indicate that programs undergoing a second or third accreditation survey generally reported spending less time preparing for accreditation than did those who were preparing for their first accreditation.

Exhibit IV.B-2. Time Spent and Labor Cost of All Staff in an Average Month To Achieve Compliance With Accreditation Standards Since OTP Started Preparing for Second or Third Accreditation

	N	Mean Hours	Mean Cost
Staff meetings related to accreditation	62	31.17	\$774.39
Staff training related to accreditation	61	24.09	\$586.51
Review/update of records keeping	61	41.44	\$1,060.96
Review/update of treatment plans or continuing care plans and procedures	60	34.93	\$845.64
Review/update of admissions procedures	59	18.00	\$493.62
Review/update of storage of controlled substances	56	12.44	\$323.93
Review/update of facilities	60	10.27	\$250.53
Development of quality assurance plan	59	11.70	\$297.77
Preparation of OTP documentation	61	22.66	\$602.04
Development/review/update of community relations	54	11.14	\$281.06
Development/review/update of diversion control plan	59	10.27	\$273.97
Other accreditation activities	20	2.65	\$66.25

Program directors also were asked to report whether, to achieve accreditation standards, resource expenditures were made in the following areas: renovating the program's physical structure, acquiring additional space, purchasing major equipment, purchasing supplies and materials, purchasing furniture and accessories, and/or purchasing and installing computers and software. Programs that did make these expenditures then were asked to report the cost to the program. Of the 478 programs responding to the PAQ, only 164 reported incurring any of these expenditures. Many providers left the individual items blank.

Because it was not possible to determine whether these items were left blank because the OTP did not incur the expense or whether they were left blank because the OTP did not know the answer to the question, nonpersonnel costs were calculated using two different methods so as to create a range of nonlabor costs associated with achieving compliance with accreditation

standards. With the first method, it was assumed that each blank indicates that the program did not incur an expense related to achieving accreditation for that item. Using this method for OTPs undergoing a *first accreditation survey*, the PAQ found that programs spent, on average, about \$9,801 to achieve compliance with accreditation standards. Programs preparing for their *second or third accreditation* spent about \$8,072 on average. Thus, the average nonpersonnel cost related to preparing for accreditation for *all programs* was \$9,501. Based on the assumption that blanks mean that the program spent zero dollars in a given area, this amount is likely to represent the lower end of the range.

Exhibit IV.B-3. Mean Nonpersonnel Costs To Achieve Accreditation Standards, Including Programs That Did Not Indicate Having These Expenditures (N=478)

	Total (N=478)	First Accreditation (N=395)	Subsequent Accreditation (N=83)
Renovating the program's physical structure	\$5,845.99	\$6,341.48	\$3,487.95
Acquiring additional space	\$476.77	\$571.89	\$24.10
Purchasing major equipment	\$706.03	\$688.56	\$789.16
Purchasing supplies and materials	\$554.39	\$496.33	\$830.72
Purchasing furniture and accessories	\$405.46	\$348.64	\$675.90
Purchasing and installing computers and software	\$1,512.38	\$1,354.43	\$2,264.10
Total	\$9,501.03	\$9,801.32	\$8,071.93

The average nonpersonnel expenditures also were calculated to include only programs that said they had incurred these expenses (i.e., nonresponses were omitted in the analysis). Using this second approach, the average nonpersonnel cost for this group was \$27,655. This amount represents the upper end of the range. Using either method, the largest reported expenditure related to achieving accreditation was renovating a program's physical structure. The most frequently reported nonpersonnel expenditure related to achieving accreditation standards was purchasing supplies.

Exhibit IV.B-4. Mean Nonpersonnel Costs To Achieve Accreditation Standards, Among Only Programs That Indicated Having These Expenditures

	# Reporting Expenditure (N)	Average Expenditure (\$)
Renovating the program's physical structure	93	\$30,047.14
Acquiring additional space	12	\$18,991.25
Purchasing major equipment	39	\$8,653.08
Purchasing supplies and materials	121	\$2,190.08
Purchasing furniture and accessories	62	\$3,126.00
Purchasing and installing computers and software	60	\$12,048.67
Total	164	\$27,655.44

IV.B.3 Activities and Costs Associated With *the Accreditation Process*

To better understand the level of effort and cost associated with the accreditation process, program directors also were asked to estimate how much time their staff had spent in an average month on a number of activities related to the *accreditation process* since their OTP started preparing for accreditation. These activities include preparing the accreditation application, communicating with the accreditation body, conducting a mock survey, interacting with an external consultant, and answering the accreditation survey. Programs preparing for either their

first or a subsequent accreditation generally reported spending relatively about the same amount of time on the accreditation process. The average monthly personnel cost related to the accreditation process across all programs was \$1,473.

Exhibit IV.B-5. Time Spent and Labor Cost by All Staff in an Average Month on the Accreditation Process Since OTP Started Preparing for *First Accreditation*

	N	Mean Hours	Mean Cost
Preparing of accreditation application	260	10.99	\$288.30
Communication with accrediting body	255	7.5	\$192.95
Mock survey from accrediting body	255	19.26	\$507.09
Interaction with external consultant	247	13.27	\$347.42
Accreditation survey	243	28.18	\$723.01

Exhibit IV.B-6. Time Spent and Labor Cost by All Staff in an Average Month on the Accreditation Process Since OTP Started Preparing for *Second or Third Accreditation*

	N	Mean Hours	Mean Cost
Preparing of accreditation application	59	7.75	\$159.50
Communication with accrediting body	60	6.30	\$149.00
Mock survey from accrediting body	46	22.30	\$460.38
Interaction with external consultant	47	10.79	\$246.93
Accreditation survey	50	21.08	\$510.40

IV.B.4 OTP Staff Perceptions of Accreditation-Related Activities

IV.B.4.1 Activities Undertaken To Achieve Accreditation

In a separate set of management-oriented questions related to the activities undertaken to achieve accreditation, OTP providers were asked about certain changes that may have occurred during the past year, whether the changes occurred due to accreditation, and what impact these changes had on the OTP. These results are summarized in Exhibit IV.B-7.

These data suggest three key points. First, by and large, few of the OTPs reported changes in the year before this survey. Second, when changes did occur, they tended to have taken place independently of the accreditation process. Third, among the items listed in Exhibit IV.B-7, “change in documentation activities” is the most commonly reported change—and the most likely to be attributed to accreditation. Among those reporting a change in documentation activities as a result of accreditation, 76.2 percent stated that the impact was positive, 14.6 percent rated the impact as negative, and 9.2 percent reported that the change had neither a positive nor a negative effect on their OTP.

Exhibit IV.B-7. Past-Year Changes in OTPs and Program Impact (N=456)

Change	Did Not Occur (%)	Occurred due to Accreditation (%)	Occurred Indep. of Accreditation (%)
Change in OTP owner	95.8	0.4	3.8
Reduction in OTP services	92.9	1.6	5.6
Salary reductions	92.3	3.3	4.2
Benefit reductions	90.9	1.6	7.5
Decreased staff turnover	90.2	1.6	8.3
Reduction in other staff	89.3	1.3	9.1
Benefit increases	89.2	1.8	8.8
Increase in other staff	86.0	5.8	8.2
Reduction in direct care staff	85.1	1.8	13.1
Extensive staff turnover	79.8	5.3	14.9
Increase in direct care staff	79.0	4.9	16.1
Change in OTP methods	78.7	10.1	10.5
New state/local laws	73.7	8.5	17.8
Change in OTP director	71.1	2.2	26.5
Agency reorganization	70.6	7.5	21.9
Expansion of OTP services	69.6	10.7	19.7
Salary increases	68.4	3.8	27.4
Change in documentation activities	42.5	46.3	10.3

IV.B.4.2 Impact of Accreditation Process

To assess the perceived impact of the accreditation process, OTP providers were asked to rate 14 “impact” items on a 3-point scale ranging from “not at all” to “a great extent,” as shown in Exhibit IV.B-8.

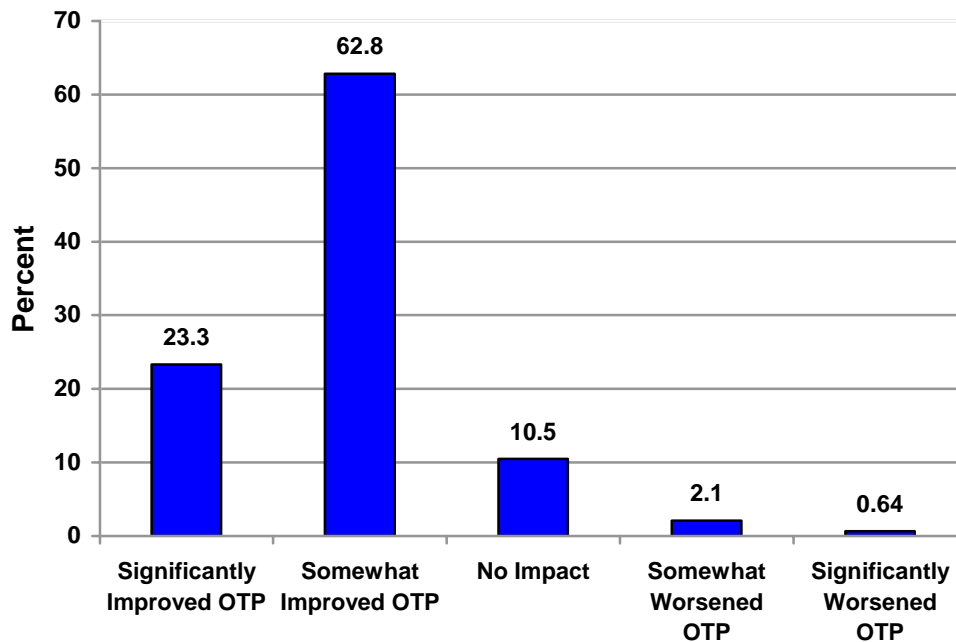
Exhibit IV.B-8. Perceived Areas of Impact of the Accreditation Process (N=467)

Impact Area	Great Extent/Some (%)	Great Extent (%)	Some (%)	Not At All (%)
Require new QA procedures	80.2	26.9	53.3	19.8
Require more documentation of patient progress	79.5	15.2	64.3	20.5
Increase monitoring of patient outcomes	76.4	23.7	52.7	23.7
Improve coordination of care	74.2	14.9	59.3	25.9
Improve treatment practices	73.0	14.6	58.4	27.0
Enhance efficiency of treatment	71.8	18.0	53.8	28.3
Improve ability to monitor patient progress	67.8	11.4	56.4	32.2
Improve safety	63.0	12.0	51.0	37.0
Increase patient participation in OTP planning	62.9	10.3	52.6	37.2
Require doing more with less	58.4	23.5	34.9	41.6
Increase patient participation in individual treatment plan	57.0	11.9	45.1	43.0
Improve links with community resources	52.5	8.3	44.2	47.4
Hinder staff from daily tasks	40.6	7.5	33.1	59.4
Lead to purchasing computer equipment	29.5	6.7	22.8	70.5

Responses to these items are generally positive. Although 4 in 10 providers indicated that the accreditation process hindered their staff from performing their daily activities, the majority of respondents reported specific program improvements associated with accreditation. In fact, at

least 70 percent of the programs reported that the accreditation process had a positive impact on documenting patient progress, enhancing treatment efficiency, improving coordination of care, improving the OTP’s treatment practices, developing new quality assurance procedures, and monitoring patient outcomes. Exhibit IV.B-9 shows how the OTP providers rated the impact of accreditation overall.

Exhibit IV.B-9. OTP Providers’ Perceived Impact of Accreditation on Their Program (N=468)



Collapsing across the two positive rating categories, it can be seen that 86.1 percent of the respondents believed that the OTP accreditation process improved their program to some extent. (Not shown in this exhibit are the three programs that reported that they did not know if the accreditation had an impact or not.) As might be expected, programs that had already been accredited are about twice as likely as those becoming accredited for the first time to report that the accreditation process had no impact on program functioning (11.5 percent versus 6.0 percent, respectively). Also worth noting is the variation in responses by program size, with OTPs serving more than 100 patients (90.0 percent) being significantly more likely than OTPs serving 100 or fewer patients (76.9 percent) to report that the accreditation process had a positive impact. In addition, similar percentages of OTPs getting their first (21.4 percent) or subsequent (23.7 percent) accreditations reported that the process significantly improved the program, suggesting that maintenance or renewal of accreditation status provides an ongoing benefit.

IV.B.4.3 Overall Impressions of the Accreditation Process

The PAQ solicited general impressions of the accreditation process from four sources: (1) the program manager/director, (2) a clinician (nurse or physician), (3) a counselor, and (4) the medical director. These key informants were asked to rate their agreement/disagreement on 13 items associated with the accreditation process. To facilitate comparisons across job category, Exhibit IV.B-10 shows the percentages of all four types of respondents who agree/strongly agree with these statements.

In general, the responses are consistent across job categories. More than half of the respondents (and nearly 62 percent of the counselors) indicated that the information they have now about treatment planning is better than what they had before accreditation. Perceived improvements in the quality of treatment planning show a similar pattern. Only about 1 in 10 respondents agreed with the statement that accreditation caused more problems than it fixed; conversely, the percentage of respondents who believed that accreditation solved more problems than it caused ranges from approximately 37 percent to 42 percent. Approximately half of the respondents indicated that recordkeeping requirements are tougher now than before accreditation. More than half of the respondents reported that preparing for accreditation was burdensome, with the highest percentage (63.0 percent) of agreement reported by clinic directors.

Exhibit IV.B-10. Overall Impressions of Accreditation Process, by Job Category

Statement	% Agree/Strongly Agree			
	Director (N=461)	Clinician (N=378)	Counselor (N=353)	Medical Director (N=326)
The information I have about treatment planning is better now than before accreditation	54.8	51.5	61.8	50.3
The quality of treatment planning is better now than before accreditation	57.3	47.9	60.4	49.7
Accreditation caused more problems than it fixed	10.6	11.7	12.1	8.4
Patients are happier/more satisfied now than before accreditation	22.6	21.1	22.1	19.9
Record keeping requirements are tougher now than before accreditation	59.2	47.1	55.6	50.8
Accreditation improved the treatment environment	59.2	54.8	59.7	54.5
This OTP handles grievances/rules violations more objectively now than before accreditation	28.5	26.9	32.4	27.5
Preparing for accreditation was burdensome	63.0	50.7	53.0	52.6
Coordination of the logistics of the accreditation visit was burdensome	30.9	26.7	23.4	31.8
The effort associated with maintaining accreditation is not as bad as the effort to prepare for the accreditation visit	59.3	56.5	61.2	54.2
The array of services offered is better now than before accreditation	25.8	30.5	35.6	26.2
Accreditation solved more problems than it caused	36.5	37.2	42.2	38.2
If I had a choice, I would rather work in a program that is accredited	80.4	80.5	81.8	79.6

The burden of achieving accreditation notwithstanding, it is worth noting that approximately 8 in 10 respondents indicated that—if given the choice—they would prefer to work in a program that is accredited than one that is not.

IV.B.5 Characteristics of Applicant OTPs and Accreditation Bodies Related to Accreditation Survey Outcomes

Although originally it was thought that OTPs would vary in their accreditation outcomes, all OTPs participating in this study did receive accreditation. The analyses originally proposed to examine the relationship between the applicant OTPs and accreditation bodies and how this

relationship relates to accreditation survey outcomes. Unfortunately, data on the types of accreditation (e.g., 1-year versus 3-year) and conditions placed on OTPs were not available at the time of this report. Future analyses should examine these variables to determine which, if any, are associated with the key OTP characteristics.

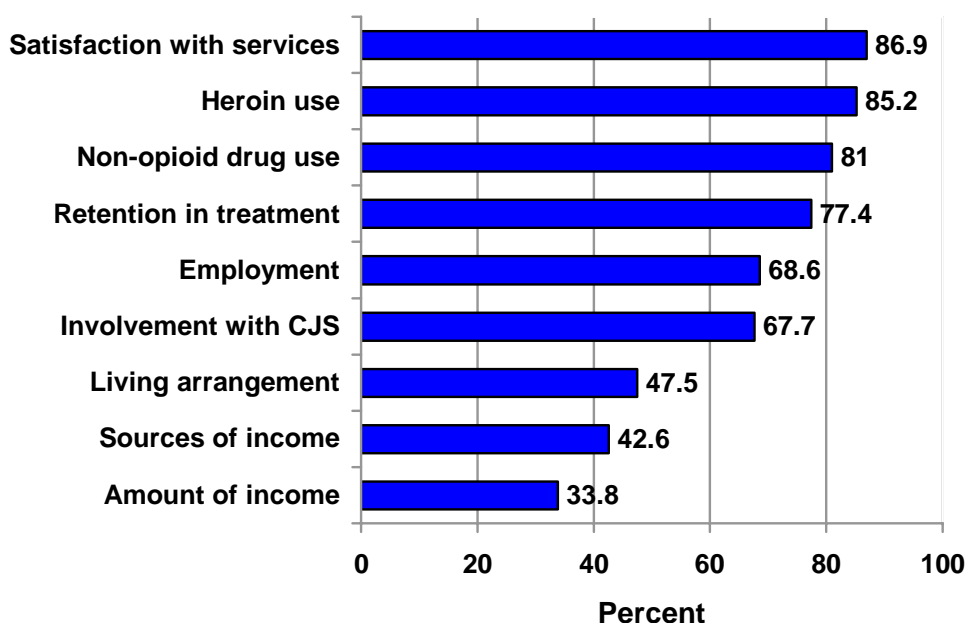
IV.B.6 Activities and Costs Associated With Operating as an Accredited OTP

IV.B.6.1 Activities Associated With Operating as an Accredited OTP

IV.B.6.1.1 Documenting Patient Performance

Because tracking and documenting patient outcomes has consistently emerged as an impact of the accreditation process, analyses were conducted to determine how OTPs measure such outcomes. Providers were asked to report whether they monitor any of nine outcomes, ranging from heroin use to criminal justice involvement. The full list of items and the prevalence by which they are tracked by the OTPs in our survey sample are shown in Exhibit IV.B-11.

Exhibit IV.B-11. Patient Outcomes Tracked by OTP Programs (N=474)



“Satisfaction with services” is the most commonly measured patient outcome, reported by approximately 87 percent of the OTP sample. Heroin use (85.2 percent) closely follows, as does non-opiate use (81.0 percent). At the other end of the continuum are living arrangements, source of income, and amount of income—each of which is tracked by fewer than half of the OTP providers.

It is not clear how systematically any of these outcome measures are in fact collected and stored. Only 48.9 percent of the respondents reported that they use computers to collect and store patient tracking information, suggesting that much of the measurement is done through case notes or paper forms. As might be expected, larger programs are more likely to rely on computers than are smaller programs. In fact, of OTPs with a current enrollment of 100 or fewer, only 37.7 percent reported using computers to track patient outcomes, in contrast to 50.7 percent of programs with enrollments of between 101 and 400 patients, and 70.6 percent of programs

servicing more than 400 patients. The use of computers for patient tracking also is more common among Government-run OTPs (57.6 percent) than non-Government OTPs (47.5 percent).

IV.B.6.1.2 Continuing Program Operation

Maintaining the quality of program services and operations is essential for an OTP to renew its accreditation. Virtually all the OTPs (99.2 percent) reported having a quality assurance (QA) process in place at the time of the survey. Of these, the large majority (89.4 percent) of the respondents indicated having these procedures in place before accreditation. Exhibit IV.B-12 shows the percentage of OTPs reporting having various QA activities in place at the time of the PAQ.

Exhibit IV.B-12. Ongoing Quality Assurance Activities Reported by OTPs (N=470)

QA Activity	% Yes
Hold regular staff meetings to discuss patients	97.2
Presentation of case studies	95.5
Assess effectiveness of actions taken to correct identified problems	94.5
Review records of patients with staff in cases of patient death or other adverse events	94.0
Assess patient satisfaction with treatment services	88.9
Review patient charts selected at random to check for record completeness	87.7
Review records of patients with special serious conditions	87.5
Collect data on indicators of treatment outcomes and monitor trends	84.0
Review patient charts selected at random to compare services received with treatment plans	83.6
Review records of patients who leave the program against medical advice or who are discharged because of rule violations	77.9
Communicate relevant information about QA problems to key staff	73.6
Peer review	70.0
Solicit suggestions on how to improve services	66.8

All the 13 QA activities were reported by the majority of the OTP programs. The only activities reported by fewer than three-quarters of the sample are “communicate relevant information about QA problems to the staff,” “peer review,” and “solicit suggestions on how to improve services.” The latter two items both relate to external input, which may be a theme worth exploring further if existing QA processes prove insufficient.

According to the survey, the most common source of data used to inform QA meetings is verbal information from staff in attendance at these meetings (74.0 percent). Many OTPs also reported relying on patient charts (70.9 percent) and written information prepared specifically for these meetings (65.1 percent). More than half (54.6 percent) of the sample reported using their own data systems. Less common is the use of information from the State’s data system (21.5 percent) or Methadone Treatment Quality Assurance System (MTQAS) quarterly feedback (15.5 percent).

IV.B.6.1.3 Emergency Planning

Almost all (97.8 percent) of the OTPs surveyed reported having a disaster plan or a plan for emergency administration of medication. Providers were asked to describe their emergency plans in terms of (1) what the plan includes, (2) how clients are informed of the plan, and (3) how OTP staff members are informed of the plan.

With regard to the first question, 82.2 percent of those with a plan reported keeping backup copies of up-to-date patient identification and dosing information offsite. Eighty-six percent

reported establishing relationships with other methadone providers to service their patients in cases of emergency.

When asked to indicate how patients at their OTP are informed of the emergency plan, the most commonly reported method (76.6 percent) is to inform patients as part of their new patient orientation. Fifty-four percent of the programs with a plan offer patient handbooks that include their emergency plan. Slightly more than half (52.9 percent) of the OTP programs indicated that they actually hold practice drills with patients.

OTP staff members are most often informed of their program's emergency plan as part of staff orientation (86.5 percent). Approximately three-quarters (75.5 percent) of the programs explain the emergency plan to their staff as part of their training sessions; 71.1 percent of the programs conduct practice drills with their staff.

IV.B.6.2 Costs Associated With Operating as an Accredited OTP

Because all OTPs responding to the PAQ were accredited at least for 1 year, activities not related to accreditation were assumed to be activities associated with operating as an accredited OTP. Data were collected on time spent in both indirect (e.g., admissions, community relations, administrative) and direct (e.g., individual therapy, medication administration) services. Hours spent in a typical month for the indirect treatment activities listed in Exhibit IV.B-13 by the different types of staff were multiplied by their payrates in Exhibit IV.B-14. The resulting total is a mean of \$13,811 per month.

Exhibit IV.B-13. Mean Hours Per Average Month Spent on *Indirect* Service Activities *Not* Related to Accreditation

	Management Staff (N=339)	Physician (N=333)	Nurse (N=344)	Counselor (N=344)	Other Clinical Staff (N=288)	Administrative Staff (N=319)
Staff meetings	9.4	4.8	7.0	8.6	5.0	7.1
Staff training	3.6	2.0	2.9	4.4	2.5	2.8
Records keeping	13.8	11.8	26.1	37.3	15.2	25.9
Implementing treatment plans or continuing care plans and procedures	10.0	11.9	16.9	44.3	10.1	7.8
Implementing admissions procedures	7.1	11.6	13.7	15.6	9.8	8.8
Appropriate storage of controlled substances	2.9	1.7	18.2	0.6	3.7	2.4
Maintenance of facilities	8.8	0.4	2.1	1.7	4.7	7.0
Staff supervision	33.3	9.3	6.4	5.4	4.3	8.2
Quality assurance	10.5	3.4	5.2	6.4	4.3	6.7
Program administration	42.7	3.5	4.4	4.0	2.9	21.9
Community relations	5.7	1.4	1.3	2.8	1.8	4.1
Diversion control	13.9	2.8	24.3	4.5	4.2	3.9
Other nonaccreditation activities	7.9	5.4	9.2	8.7	2.7	11.1
Total	142.0	54.2	109.2	119.7	54.0	89.6

Exhibit IV.B-14. Mean Dollars Per Average Month Spent on *Indirect* Service Activities *Not* Related to Accreditation

	Management Staff (\$32.21 per hour)	Physician (\$57.69 per hour)	Nurse (\$20.83 per hour)	Counselor (\$20.19 per hour)	Other Clinical Staff (\$18.27 per hour)	Administrative Staff (\$12.50 per hour)
Staff meetings	\$301.99	\$274.41	\$146.50	\$173.21	\$90.63	\$88.96
Staff training	\$115.35	\$114.76	\$60.24	\$88.88	\$45.22	\$35.05
Records keeping	\$443.89	\$679.69	\$543.57	\$752.40	\$277.36	\$324.09
Implementing treatment plans or continuing care plans and procedures	\$322.31	\$684.05	\$351.13	\$893.97	\$184.13	\$96.88
Implementing admissions procedures	\$230.08	\$670.46	\$285.03	\$314.09	\$178.52	\$109.77
Appropriate storage of controlled substances	\$92.55	\$100.24	\$379.97	\$12.60	\$66.94	\$29.66
Maintenance of facilities	\$283.78	\$25.46	\$44.06	\$35.31	\$85.18	\$87.91
Staff supervision	\$1,071.65	\$536.09	\$134.05	\$109.01	\$77.65	\$102.88
Quality assurance	\$337.20	\$193.74	\$108.06	\$128.94	\$77.69	\$83.56
Program administration	\$1,374.40	\$204.49	\$92.30	\$81.22	\$52.85	\$274.07
Community relations	\$183.76	\$81.88	\$26.38	\$56.91	\$32.18	\$50.74
Diversion control	\$446.74	\$160.07	\$505.66	\$91.35	\$76.87	\$48.35
Other nonaccreditation activities	\$252.88	\$313.25	\$192.00	\$175.33	\$49.75	\$139.05
Total	\$4,572.77	\$3,128.50	\$2,274.10	\$2,417.08	\$987.47	\$1,120.38

As would be expected, management staff spend the most time and money on program administration and staff supervision. Administrative staff, likewise, spend a great deal of time on program administration, although records keeping is the highest expense for this group. It is interesting to note that physicians spend the greatest amount of time on implementing treatment plans or continuing care plans and procedures, records keeping, and implementing admissions procedures, while nurses are most occupied with records keeping and diversion control. Counselors and other clinical staff spend most of their time on implementing treatment plans and records keeping. Records keeping also occupies the most time for other clinical staff, though implementing treatment plans and admissions procedures also fill a great deal of their time. Perhaps the most interesting finding is that all four categories of clinical staff spend as much (if not more) time keeping records than they spend treating patients.

Data on time spent and monetary cost of *direct* patient services were obtained in a similar manner from the PAQ. Mean hours and corresponding mean dollar values for these professionals' time are shown in Exhibits IV.B-15 and IV.B-16. For these direct service activities not related to accreditation, the average monthly cost is \$14,845.

Exhibit IV.B-15. Mean Hours Spent Per Average Month in *Direct Service Activities Not Related to Accreditation*

	Management Staff (N=283)	Physician (N=319)	Nurse (N=323)	Counselor (N=323)	Other Clinical Staff (N=273)	Administrative Staff (N=281)
Initial patient assessment	6.8	12.4	18.4	22.7	7.6	4.6
Treatment planning	6.1	6.9	11.4	34.0	5.9	2.5
Initial medical services	1.9	18.4	15.6	2.8	4.0	2.6
Methadone dosing	2.1	5.3	98.9	9.5	7.4	2.4
LAAM dosing	0.0	0.1	0.3	0.3	0.4	0.0
Buprenorphine dosing	0.0	0.4	1.0	0.3	0.0	0.0
Ongoing medical services other than methadone/LAAM/buprenorphine dosing	2.2	15.4	22.3	1.7	2.7	0.7
Individual, couples, and family counseling	6.8	4.9	7.8	100.9	9.1	3.2
Group counseling	1.4	0.5	3.7	39.9	6.3	1.0
Case management	5.5	3.0	5.1	35.9	9.7	2.2
Patient administration	16.4	4.0	5.1	9.9	7.8	24.5
Urinalysis	2.2	1.5	13.1	14.1	18.3	11.3
Childcare	0.3	0.0	0.0	0.3	0.6	0.0
Other patient activities	1.6	1.3	3.4	4.3	5.4	2.4
Total	45.3	62.6	180.0	249.8	65.5	47.5

Exhibit IV.B-16. Mean Dollars Spent Per Average Month in *Direct Service Activities Not Related to Accreditation*

	Management Staff (\$32.21 per hour)	Physician (\$57.69 per hour)	Nurse (\$20.83 per hour)	Counselor (\$20.19 per hour)	Other Clinical Staff (\$18.27 per hour)	Administrative Staff (\$12.50 per hour)
Initial patient assessment	\$220.30	\$712.86	\$382.86	\$459.09	\$138.57	\$56.95
Treatment planning	\$195.17	\$400.53	\$237.03	\$686.10	\$107.22	\$31.00
Initial medical services	\$60.32	\$1,061.24	\$325.35	\$56.44	\$73.26	\$33.04
Methadone dosing	\$68.05	\$307.25	\$2,060.89	\$191.00	\$135.34	\$30.24
LAAM dosing	\$1.29	\$5.90	\$7.27	\$5.72	\$6.56	\$0.29
Buprenorphine dosing	\$0.44	\$20.70	\$20.47	\$5.50	\$0.17	\$0.12
Ongoing medical services other than methadone/LAAM/buprenorphine dosing	\$70.50	\$887.61	\$465.53	\$35.27	\$49.33	\$8.71
Individual, couples, and family counseling	\$217.64	\$280.38	\$161.43	\$2,036.90	\$166.24	\$39.89
Group counseling	\$46.62	\$29.95	\$76.43	\$806.19	\$114.79	\$11.96
Case management	\$178.05	\$172.46	\$106.09	\$724.20	\$176.67	\$27.93
Patient administration	\$529.36	\$229.62	\$105.78	\$200.72	\$143.10	\$306.46
Urinalysis	\$69.58	\$88.19	\$272.27	\$285.02	\$334.14	\$140.76
Childcare	\$9.91	\$0.24	\$0.18	\$6.51	\$11.24	\$0.44
Other patient activities	\$53.04	\$75.09	\$70.36	\$87.65	\$98.57	\$30.08
Total	\$1,459.63	\$3,610.90	\$3,748.66	\$5,043.80	\$1,197.41	\$594.02

The results here follow the logical path one would assume given staff roles and responsibilities. Management and administrative staff overwhelmingly are the most engaged in patient administration. Physicians spend the majority of their time and therefore incur the most costs for initial and ongoing medical services. Nurses spend the most time administering methadone dosing. Counselors are most occupied with counseling, whether it is individuals, couples, or groups. They also spend a great deal of their time in case management. Administering drug tests through urine collection takes up the most time and money for other clinical staff.

Total direct plus indirect service costs not related to accreditation are an average \$28,656 per month.

IV.B.7 Summary

OTPs undergoing first accreditation reported the highest personnel costs to achieve compliance with accreditation standards in the areas of staff meetings, records keeping updates/reviews, treatment/continuing care plans updates/reviews, and OTP documentation. Those engaged in a subsequent accreditation process reported lower costs in these areas in general, but the high-cost areas were the same. The highest nonpersonnel cost for providers to meet accreditation standards was to renovate their physical structure.

OTPs were asked whether certain events had occurred in the past year, whether due to accreditation or not, and whether the impact of those events was positive, negative, or produced no change. With the exception of “changes in documentation activities,” more than 7 in 10 OTPs indicated that the changes had not occurred. What few changes did occur seem to have taken place independently of accreditation. More than 8 in 10 OTPs indicated that accreditation improved their program, and more than 7 in 10 reported that accreditation had an impact in 6 of the 14 areas measured. These findings are consistent with staff members’ overall impressions of the accreditation process, which indicate that more than half of the respondents believed accreditation has improved the information they have about treatment planning as well as the quality of treatment planning. Though many reported that the burdens of paperwork are higher post-accreditation, most reported that they would prefer to work for an accredited OTP.

Quality assurance processes are virtually universal among these providers, and most have had them in place even before accreditation. More than three-quarters of respondents reported undertaking 10 of the 13 QA activities surveyed. The most common source of data for QA meetings is verbal information from staff in attendance at those meetings, followed by patient charts and written information prepared for these meetings.

OTPs spend an average of \$28,656 per month on both direct and indirect services not related to accreditation, based on hours reported in the PAQ for these activities multiplied by the average payrates for each occupational type. The mean cost for indirect activities is \$13,811 per month; for direct services, it is \$14,845 per month. When broken out by occupational type, indirect expenses fall where one would expect. Physicians, nurses, counselors, and other clinical staff spend the majority of their hours implementing treatment or continuing care plans, implementing admissions procedures, or dealing with records keeping. Nurses also reported dealing with appropriate storage of controlled substances. Management and administrative staff reported spending large portions of time in program administration, as well as in the same areas as the clinical staff. The pattern is the same for direct services.

IV.C CLINICAL EVALUATION

IV.C.1 Introduction

OTP providers were asked to describe their existing treatment services along several dimensions, including dosing, treatment planning, testing for illicit drug use, and discharge policies.

Topics covered on the subject of dosing included usual dose of methadone at admission and during treatment, the largest dose of methadone prescribed during maintenance, and policies used to control the maximum dose and length of time in treatment. OTPs also were asked whether patients are informed when their methadone/LAAM/buprenorphine dose level changes and whether patients are able to influence their dose level. Several questions were posed with regard to treatment planning—areas assessed at admission because they affect treatment outcomes, assessment instruments used at admission, and criteria used to evaluate and place patients in treatment. This research also included looking at OTPs' policies with regard to take-home privileges and drug testing in the PAQ, as well as results on take-home privileges among the indepth study sample from both staff and patient interviews. OTPs further reported on how many discharges they had had in the past 3 months and for what reasons, including disciplinary actions. During the site visits, charts of 20 recently discharged patients at each OTP were examined to research the patients' reasons for leaving treatment and length of time in treatment during the current episode. Also measured was the "no show" rate of patients in the past 3 months. The PAQ explored the likelihood that a patient would receive various sanctions or disciplinary actions or be discharged for indications based on drug testing that he/she was not following treatment. Likewise, the survey included questions about whether patients would be discharged for various other negative actions.

This section of the report also investigates whether service accessibility and delivery has been affected by operating as an accredited OTP by looking at responses in the PAQ compared to the FQ. The research investigated whether the number and types of services had changed between the PAQ and the FQ. Likewise, it explored whether there had been any change in the demographics of the typical OTP patient based on responses to the PAQ and FQ. Finally, PAQ and FQ responses concerning treatment policies also were compared to determine whether accreditation had had any effect in these areas.

Finally, patients' perspectives are explored on the topics of methadone dosing, satisfaction with their OTP's services, satisfaction with treatment, and treatment outcomes.

IV.C.2 Clinical Policies and Practices Associated With Operating as an Accredited OTP

IV.C.2.1 Methadone Dose

The average dose of methadone that OTP physicians prescribe patients at admission is 36.9 mg/day (SD=18.6; median=30.0 mg/day). On average, the largest dose that OTPs prescribe patients during maintenance is 205.0 mg/day (SD=111.34; median=180.0 mg/day).

Exhibit IV.C-1. Who Determines a Patient’s Maximum Dose and Length of Treatment? (N=475)

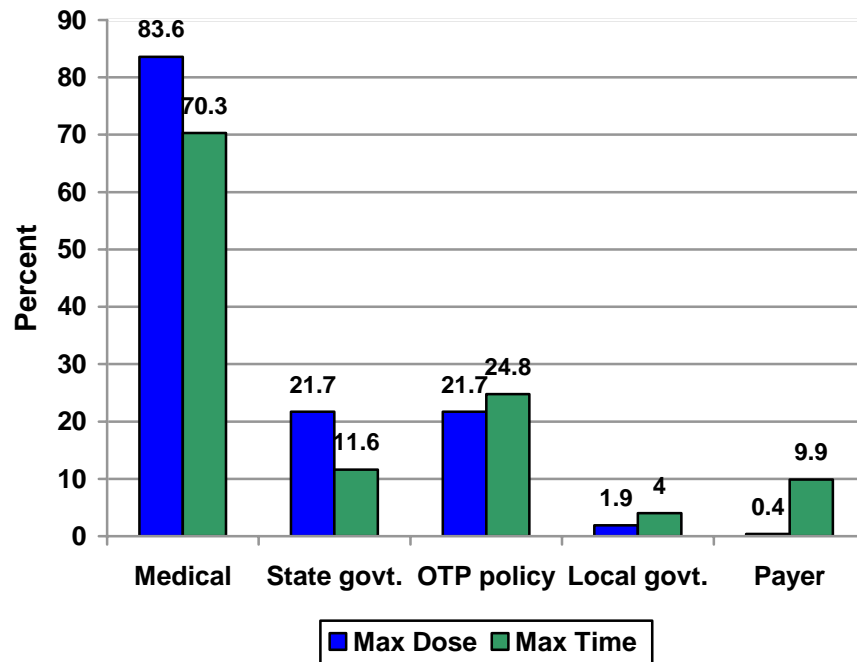


Exhibit IV-C.1 shows the primary decisionmakers regarding OTP patients’ maximum allowable methadone dosage and treatment length. At the majority of OTPs, these decisions are made by medical staff, rather than determined by State or local policies or even payer/reimbursement guidelines. However, more than 1 in 5 providers indicated that State Government regulations also play a role in determining their program’s maximum methadone dose. Although payer/reimbursement guidelines have virtually no impact on the maximum dose prescribed, about 1 in 10 OTPs indicated that these guidelines do affect treatment length.

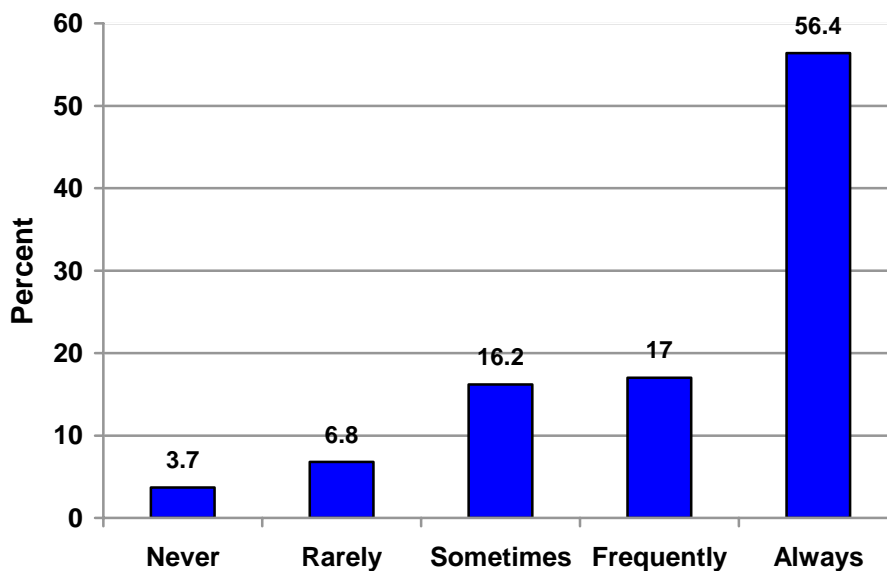
It should also be pointed out that patients themselves often are involved in determining their medication dose. When asked how often patients are informed of changes in their methadone/LAAM/buprenorphine dose, 92.7 percent of the OTP providers answered “always,” and 4.5 percent reported doing so “frequently.” Only five (1.1 percent) of the OTPs reported that they never or rarely inform patients when their dose level is changed. When providers were asked how much patients influence decisions about their dose level, the most common response is “to some extent” (72.9 percent), followed by “to a great extent” (21.5 percent), “a little” (3.6 percent), and “not at all” (1.9 percent).

Ninety-two percent of the programs surveyed offer methadone take-home privileges (usually in liquid form). Although the criteria for earning take-home privileges were not assessed in the OTP survey, providers were asked to estimate how often their staff revoke take-home privileges if a patient is suspected of diverting methadone. Responses to this question are shown in Exhibit IV.C-2.

More than half of the OTPs reported always revoking take-home privileges when a patient is suspected of diverting methadone; another 17 percent reported that they would “frequently” revoke take-home privileges under these conditions. Still, it is interesting to note that more than

one-quarter of the OTPs surveyed reported revoking such privileges either never (3.7 percent), rarely (6.8 percent), or sometimes (16.2 percent).

Exhibit IV.C-2. Likelihood of Revoking Methadone Take-Home Privileges for Suspected Diversion (N=383)



Data captured from the staff interviews conducted during the 22 OTP site visits show that the most important issue to the medical directors and nurses is clearly that of take-home privileges. There is an almost even split between those who said that take-home privileges are stricter since accreditation and those who felt that they have not changed. Significantly, only 4 of the 16 medical directors and nurses indicated that any changes had been implemented specifically due to the accreditation; 2 believed that the changes would have been implemented anyway, and the remainder either said they did not know the answer to this question or the question was not applicable.

The site visits to the indepth study sample OTPs also captured some information about patients' perceptions regarding satisfaction with take-home schedules. Approximately 63 percent of the patients interviewed reported being on some level of take-home privilege. Of these patients, 57 percent reported that they are "very satisfied" with their take-home schedules, and 31 percent reported being "somewhat satisfied." Only 12 percent are "not satisfied" with their current take-home schedules. There were no significant differences regarding satisfaction with take-homes by treatment length, treatment type, or OTP.

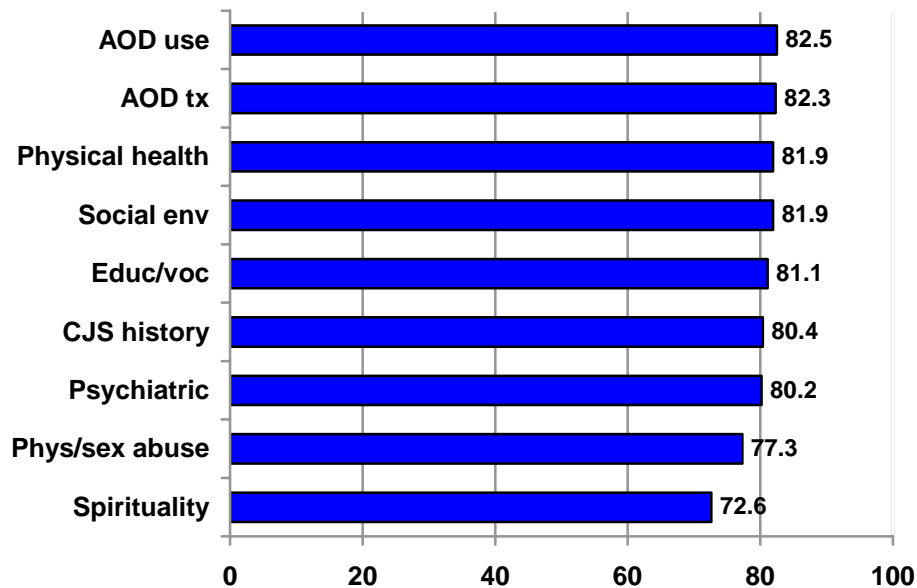
IV.C.2.2 Treatment Planning

To assess how OTPs go about developing treatment plans, providers were asked to report what areas they assess, what (if any) standardized assessment instruments they use, and what (if any) formal criteria they use to evaluate and place patients in treatment. Responses to these questions are shown in Exhibits IV.C-3 through IV.C-5.

As can be seen in Exhibit IV.C-3, more than three-quarters of the OTPs surveyed reported assessing eight of the nine domains listed. Spirituality is the least likely of the domains to be assessed, though even it is assessed by nearly 73 percent of the programs. Although most programs reported assessing a broad array of patient factors, it is still noteworthy that nearly 18

percent of the programs do not assess patients' alcohol and other drug (AOD) use history at admission. Likewise, nearly 1 in 5 OTPs surveyed does not assess either patients' physical health, social environment, educational/vocational histories, psychiatric status, or prior criminal justice system (CJS) involvement.⁷

Exhibit IV.C-3. Areas in Which All Patients Are Assessed at Admission (N=475)

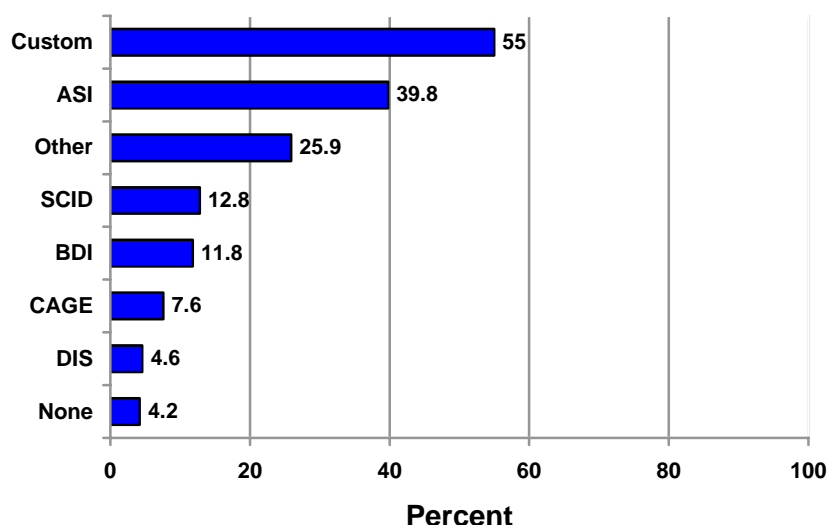


When asked what type(s) of instruments they use to assess patients at admission, the most common response (55.0 percent) is an instrument developed by their own program (shown as “custom” in Exhibit IV.C-4). Almost 40 percent of the OTPs reported using the Addiction Severity Index (ASI). Similar percentages of programs reported using the Structured Clinical Interview for DSM-IV (SCID) and the Beck Depression Inventory (BDI) (12.8 percent and 11.8 percent, respectively). The CAGE⁸ and Diagnostic Interview Schedule (DIS) are each reportedly used by less than 10 percent of the sample. Twenty of the OTPs surveyed reported that they do not use any type of assessment instrument. When these categories are collapsed to form a dichotomous measure of known standardized assessments versus other instruments, data indicate that larger programs (current enrollment of more than 100 patients) are more likely than are smaller programs (100 or fewer patients) to use standardized intake assessments (25.0 percent versus 17.9 percent, respectively). Responses also vary by financial structure, with Government-run OTPs being the most likely to use standardized intake assessments (31.8 percent), followed by for-profit OTPs (25.4 percent). Only 18.8 percent of the nonprofit OTPs reported using standardized assessments.

⁷ Note: Although required by accreditation standards, these areas are not assessed by the OTP programs.

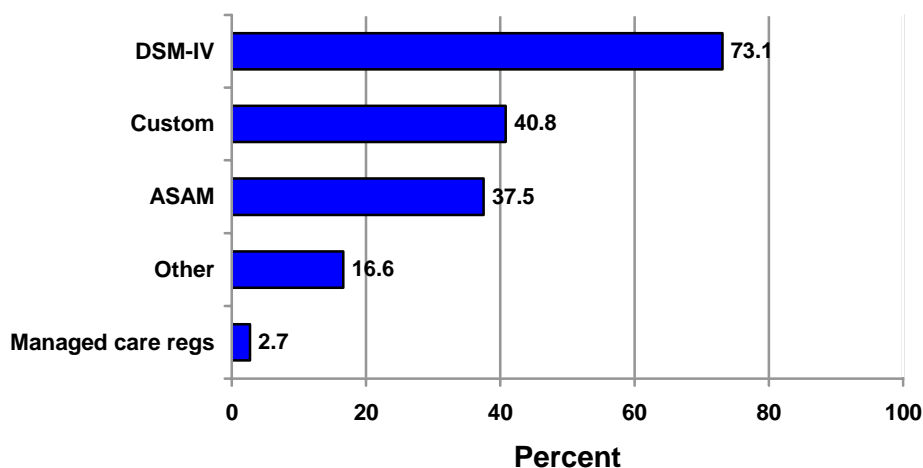
⁸ Substance abuse dependence is likely if the patient gives two or more positive answers to the following questions: Have you ever felt you should **Cut** down on your drinking? Have people **Annoyed** you by criticising your drinking? Have you ever felt bad or **Guilty** about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**Eye-opener**)?

Exhibit IV.C-4. Types of Assessment Instruments Used by OTPs (N=475)



Nearly three-quarters of the OTPs reported relying on DSM-IV criteria to evaluate patients and place them in an appropriate level of care. Forty-one percent reported using criteria developed at their own OTP (referred to as “custom” in Exhibit IV.C-5). ASAM patient placement criteria are also popular (37.5 percent). Less than 3 percent of the OTPs base patient placement decisions on managed care regulations.

Exhibit IV.C-5. Criteria Used To Evaluate and Place Patients in Treatment (N=475)



Interviews with medical directors, nurses, and counselors conducted as part of the indepth study asked how their program changed in order to meet accreditation standards and improve the quality of the process of treatment planning. For the counselors, the most frequently cited change involves providing more individualized treatment planning, followed by keeping updated records and charts, keeping updated treatment plans, and involving patients more in their treatment planning. For the medical directors and nurses, the most prevalent themes are similar: keeping up-to-date records and charts, developing new forms, increasing patient involvement with treatment planning, and providing more individualized treatment planning. Interestingly, of those

who identified keeping up-to-date records and charts, approximately half identified it as a positive, while half indicated that this change means less time for taking care of patients.

IV.C.2.3 Testing for Use of Illicit Drugs

Only five (1.2 percent) of the OTPs reported in the PAQ that they do not collect urine samples from patients. The most commonly reported frequency is once per month (40.6 percent). Thirteen percent of the sample reported that they only collect urine samples from patients at admission. When asked how patients are selected for testing, more than half (55.1 percent) of the respondents indicated that patients are selected at random, 34.9 percent reported that some patients are selected at random while others are specifically identified, and 10.1 percent reported that all tested subjects are specifically identified.

To gauge how OTPs incorporate drug test results into patients’ treatment plans, providers were asked about the likelihood of the clinical staff using each of the following actions in response to a patient having two positive urine test results for opioids or two negative tests for methadone. (Original responses were recoded from a 4-point scale to reflect the percentage of respondents endorsing the actions as either “somewhat likely” or “extremely likely.”) The responses are shown in Exhibit IV.C-6.

Exhibit IV.C-6. OTP Responses to Patients With Two Positive Drug Tests for Opioids or Two Negative Tests for Methadone (N=428)

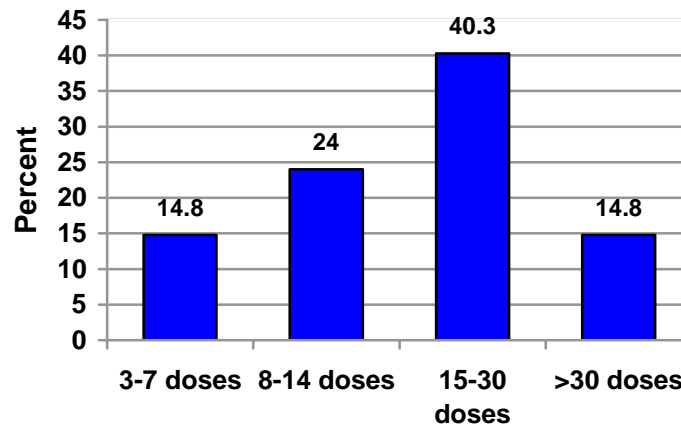
Action	% Somewhat/Extremely Likely
Revision to treatment plan	89.7
Loss of privileges	87.2
Dose increase	85.5
Verbal reprimand	62.8
Discharge	9.8
Monetary penalty	4.4
Counseling session	4.0

According to the OTP providers in the PAQ survey sample, recurring opioid use and/or failure to adhere to a methadone dosing schedule are most likely to result in a revision to the patient’s treatment plan and a loss of privileges. Eighty-six percent of the OTPs reported that such noncompliance would also likely result in an increased dose, and nearly 63 percent of the providers stated that the patient would be verbally reprimanded. Only about 10 percent of the respondents indicated that these behaviors would likely result in a discharge. Less than 5 percent of the sample reported that they would respond with a monetary penalty or counseling session.

IV.C.2.4 Discharge Policies

The PAQ also included a set of questions concerning the conditions under which patients would be discharged from the program. Nearly 9 in 10 (88.5 percent) of the providers reported that they would discharge a patient for missing a certain number of doses.

Exhibit IV.C-7. Number of Missed Doses/Sessions Required To Discharge a Patient (N=325)



As can be seen in Exhibit IV.C-7, the most common “threshold” for discharging a patient from an OTP is 15 to 30 missed doses/sessions. Of course, other behaviors can result in a discharge from the program. To assess these behaviors, OTP providers were asked to review a list of 11 actions and rate how likely it would be that their OTP would discharge a patient for engaging in each. The results are summarized in Exhibit IV.C-8.

Exhibit IV.C-8. Patient Behaviors Likely To Result in Discharge from OTP (N=457)

Action	% Somewhat/Extremely Likely To Result in a Discharge
Violent behavior on site	99.1
Diverting methadone	96.6
Attempted diversion of methadone	94.4
Sexual activity on site	92.2
Failure to pay for treatment	62.4
Missing dosing appointments	60.9
Missing counseling/therapy sessions	34.8
Abusing alcohol	34.4
Using illicit drugs	29.2
Being arrested for nondrug illicit activities	19.2

The behaviors most likely to result in discharging a patient before he or she completes treatment are engaging in violence and diverting (or attempting to divert) methadone. More than 90 percent of the OTPs also rated onsite sexual activity as likely to result in early discharge. As might be expected, providers viewed missed dosing appointments as being much more serious than missed counseling/therapy sessions. The actions least likely to result in early discharge are substance abuse and (nondrug) criminal justice involvement.

As part of the indepth study, data were abstracted at each program from records of 20 recently discharged patients. The data collected included the length of time in treatment at that OTP and the reason for discharge. The length of time that the recently discharged patients remained in treatment ranged from a single day to 34.2 years. The mean length of treatment

episode was 25.6 months or 2.1 years. Exhibit IV.C-9 shows the reasons why patients were discharged and the average length of stay.

Exhibit IV.C-9. Reasons for Discharge Based on Patient Charts (N=20)

Reason for Discharge	% of Patients	Avg. Months in Treatment
Withdrew/dropped out	40.1	27.4
Noncompliance	11.2	20.0
Completed treatment	10.1	26.5
Transferred to different program	8.7	22.0
Incarcerated	8.2	9.0
Deceased	5.6	73.5
Left against medical advice	5.6	17.2
Other	5.2	26.1
Nonpayment	3.0	11.1
Moved	0.9	26.3
Hospitalized for physical health	0.9	15.9
Information not in record	0.5	-

More than one-third of the patients (40.1 percent) withdrew or dropped out of treatment after spending an average of 27.4 months in treatment. It is interesting that the 10.1 percent of patients discharged because they completed their treatment plan only remained in treatment for 26.5 months. This finding may be explained by the fact that the length of time in treatment may not be the sole variable in the reason for discharge. The only significant difference in the length of time in treatment and the reason for discharge was for patients who died. This group had a significantly longer stay in treatment on average.

IV.C.3 Effects Associated With Operating as an Accredited OTP on Service and Delivery

One of the goals of this study was to assess the changes associated with operating as an accredited OTP on service accessibility and delivery. The first step toward addressing this question involved comparing the array of services offered by OTP providers at the time of the PAQ (as soon as possible after programs had achieved accreditation) with the array of services offered at the time of the FQ administered approximately 6 months later. This would seem to be a relatively short period of time, but in fact some changes were already apparent.

Exhibit IV.C-10. Post-Accreditation Changes in OTP Services Offered (N=171)

Service	% Offering Service	
	Baseline	Followup
Counseling	97.7	98.8
Individual/group therapy for opiate addiction	95.3	99.4*
Post-treatment follow-up	76.0	78.5
Treatment for alcohol abuse	71.9	71.6
Treatment for cocaine abuse	71.4	71.0
Case management	69.6	76.5
Psychological testing	57.3	65.8*
Psychiatric services	51.5	50.3
Nutritional counseling	50.3	57.5
12-Step program	45.0	52.5*
Vocational assistance	42.7	45.6
Detoxification from a substance other than heroin	42.1	44.8
Housing/shelter assistance	39.8	39.0
General medical care	39.2	42.6
Aftercare	36.3	55.1*
Educational assistance	34.5	41.9
HIV/AIDS-related medical care	29.2	38.4*
Smoking cessation	29.2	31.9
Financial assistance	28.1	26.9
Transportation	24.6	24.8
Acupuncture	12.9	14.9
Legal assistance	8.8	14.9*
Childcare	5.9	5.8

* Difference is statistically significant at the .05 level.

As seen in Exhibit IV.C-10, none of these services were significantly reduced between the administration of the PAQ and the FQ. Indeed, when compared against their own baseline levels, a significantly greater proportion of OTPs at followup reported providing increased medical care for HIV/AIDS, psychological testing, legal assistance, individual or group therapy for opiate addiction, 12-Step programs, and aftercare.

The patient interviews at the 22 OTPs provided further insights into the types of education and services being provided to the patients. Exhibit IV.C-11 shows the types of education that patients reported receiving at their current treatment clinic.

Exhibit IV.C-11. Types of Education Patients in the Indepth Study Sample Reported Receiving From Current OTP (N=590)

Type of Education	% Reporting Education Provided by OTP
Confidentiality of records	97.3
Clinic guidelines/rules/services/regulations	96.4
Drug screening/urinalysis procedures	95.0
Rights as a patient	94.5
Benefits of treatment	89.2
HIV/hepatitis C prevention	86.3
Relapse prevention	83.0
Medication and its side effects	79.3
Nature of addictive disorders	77.8
Potential drug interactions	77.5
Aftercare*	63.9
How to file a grievance/complaint	63.5
Sign/symptoms of overdose	60.2
Parenting skills/childcare/prenatal issues*	48.7

* Among those who did not report the issue as not applicable

Patients at most programs reported receiving information about the confidentiality of their records (97.3 percent), the clinic's guidelines/rules/services/regulations (96.4 percent), drug screening and urinalysis procedures (95.0 percent), their rights as a patient (94.5 percent), and the benefits of treatment (89.2 percent). Only 48.7 percent of patients who have children or are pregnant, however, reported that they had received any information on parenting skills/childcare/prenatal issues. Also of some concern are the findings that only 60.2 percent had been educated about the signs of an overdose, 63.5 percent were told how to file a grievance or complaint, and 77.5 percent were given information about potential drug interactions with their methadone. These findings may be influenced by the fact that this type of information is usually provided when a patient enrolls in a program. During this time, a patient is either in withdrawal or is still using opioids, both of which may influence retention of the information.

During the interviews, patients were asked about the different services that they may have received at their current program. Patients also were asked whether they had received the service at a different provider. The analysis in Exhibit IV.C-12 only looks at the services delivered by the OTP that participated in the site visit.

A significant majority of patients (91.5 percent) reported having received a psychosocial assessment at their current program. The proportion of patients receiving such an assessment differed significantly by OTP. At one end of the spectrum, all of the patients at three OTPs reported receiving an assessment, while only 71 percent of patients in another program had received one.

Approximately 76.2 percent of patients reported having a medical exam at the OTP. Four OTPs offer this service to all their patients. Only 10 percent of patients at another program received this service from their clinic. However, this does not mean that patients never had a medical exam, but rather, this program may have referred their patients to a doctor offsite or made other arrangements for their patients to receive an exam.

Exhibit IV.C-12. Services Patients in Indepth Study Sample Report Being Delivered by Current OTP (N=590)

Type of Service	% Receiving Services at the OTP
Psychosocial assessment	91.5
Individual treatment planning	86.0
Any type of substance abuse counseling	83.3
Medical exam	76.2
HIV/AIDS treatment, testing, or counseling	52.8
Case management and referral	50.0
Other type of mental health counseling	32.9
Psychiatric evaluation/services	30.9
Discharge planning or aftercare	28.4
Treatment for alcohol abuse	25.0
Peer support or self-help groups	25.0
Assistance with finances	24.3
Other counseling	21.1
Other services (housing/shelter, food services, transportation, educational and/or vocational services, legal assistance)	18.0
Child care services	3.9

While the percentage is high for patients reporting receiving substance abuse counseling (83.3 percent), it is somewhat worrisome that this percentage is not higher. All the patients interviewed at one program (100 percent) reported receiving this service. At five other programs, however, only about two-thirds of the patients reported receiving substance abuse counseling services. There is a significant difference by treatment length as to whether patients had received substance abuse counseling. Patients in treatment for less than 6 months are less likely to report getting substance abuse counseling services than are patients in treatment for more than 6 months. The same finding applies to mental health counseling services in that patients in treatment for more than 6 months are more likely to report having received these services.

As for HIV/AIDS treatment, testing, or counseling, 52.8 percent of patients reported receiving this service. Again, there is a difference based on length of time in the current treatment episode. The longer a patient has been in treatment, the more likely that he or she is to have received HIV/AIDS treatment, testing, or counseling services. This finding is also true for other types of services, such as discharge planning, individual treatment planning, and other services (housing/shelter, food services, transportation, educational and/or vocational services, and legal assistance).

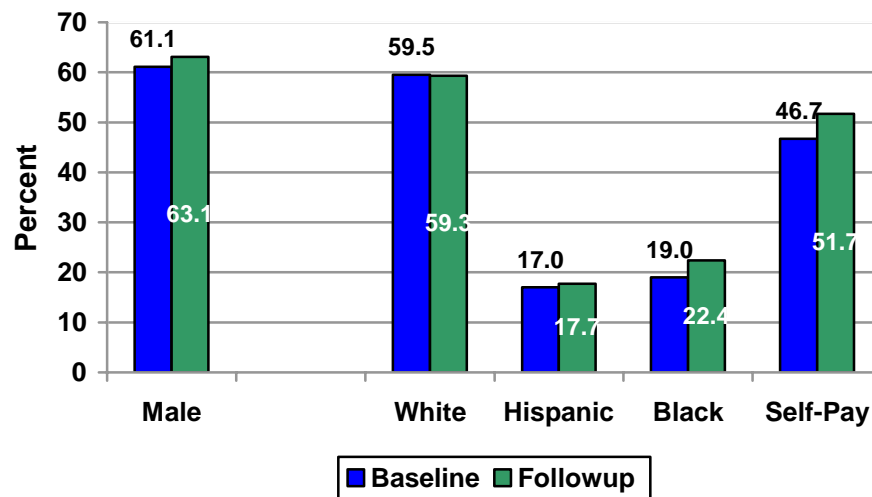
Patients receiving treatment for addiction to pain medications only are twice as likely to have received a psychiatric evaluation/services as those being treated for addictions to only heroin or both heroin and pain medications. Likewise, there are significant differences by OTP. For example, at one OTP, only 4 percent of patients reported receiving psychiatric evaluation/services, compared to another OTP at which 77 percent of patients received this service.

The least frequently occurring services were child care services (3.9 percent), other services (18.0 percent), assistance with finances (24.3 percent), treatment for alcohol abuse (25.0 percent), and peer support or self-help groups (25.0 percent). In fact, only 59.4 percent of patients reported that same-sex support groups are available to all patients.

IV.C.4 Effects Associated With Operating as an Accredited OTP on Service and Delivery Outcomes

This set of analyses sought to examine whether changes occurred in the characteristics of OTP patients between the administration of the OTP Post-Accreditation Questionnaire and the OTP Followup Questionnaire. It is important to keep in mind that these analyses are limited to the subset of OTP providers that completed both forms. As a result, some of the baseline (PAQ) statistics in this section differ from those reported for the full sample earlier in this report.

Exhibit IV.C-13. Post-Accreditation Changes in OTP Patient Characteristics (N=171)



As can be seen in Exhibit IV.C-13, no significant changes occurred in the composition of the OTP patient population with regard to gender, race/ethnicity, or self-pay status (included here as a proxy for socioeconomic status).

These results are supported by interview data from the site visits. None of the medical directors or nurses interviewed said that the characteristics of the patients they serve had changed with program accreditation. Of the 34 counselors who answered this question, 24 said that they had seen no changes; 8 did not know. Only 2 reported that the characteristics had changed.

IV.C.5 Effects on Patient Outcomes Associated With Operating as an Accredited OTP

IV.C.5.1 Methadone Dosing

By and large, few substantial changes occurred in the way OTPs provided services between the time of the PAQ and the FQ. There did appear to be a slight trend during this period toward prescribing lesser amounts of methadone at admission (baseline mean=36.1 mg/day, SD=17.7; followup mean=33.7 mg/day, SD=18.4) and a similarly slight downward trend in the largest dose of methadone prescribed during the maintenance phase (baseline mean=217.1 mg/day, SD=139.9; followup mean=206.1 mg/day, SD=110.2). As might be expected given the large standard deviations, however, these trends are not statistically significant.⁹

Perhaps the most dramatic change occurred with regard to the level of influence OTP patients have in determining their methadone dose levels. Among programs responding to the FQ, the

⁹ It should be noted that the initial dose at admission is limited to 30 mg, not to exceed, 40 mg, unless the person is transferring from another program and has a substantiated dose (by CSAT Guidelines and accreditation standards).

percent reporting that patients influence their dose “to a great extent” significantly increased from 17.6 percent at baseline to 76.5 percent 6 months later.

One of the questions captured during the site visits to the 22 OTPs evaluated how often the patients believed that they are involved with decisions regarding their methadone dosing. Fifty-seven percent of the patients interviewed during in the indepth study felt that they are involved in decisions about the level of their medication “most or all of the time.” Approximately 28 percent of the patients reported that they are involved in the decisions “often” or “sometimes.” The remaining 15 percent felt that they are “rarely” or “never” included in decisions regarding the levels of their medication. No significant differences are found among the results regarding treatment length or the drug for which patients are receiving treatment.

When asked whether their current dose of medication is too high, just right, or too low:

- 7 percent of patients believed their dose is too high.
- 76 percent of patients believed their dose is just right.
- 16 percent of patients believed their dose to be too low.

Responses to this question vary significantly between patients depending on their treatment length stratum and their drug of addiction. As would be expected, the longer patients have been in treatment, the more likely they are to report that their dose is appropriate. The average dose for patients in treatment for less than 6 months is 77 mg/day, based on chart abstractions. This is statistically different from patients in treatment for 6 to 12 months (average dose of 94 mg/day) and patients in treatment for more than 1 year (average dose of 96 mg/day). Heroin-only users also are more likely to believe that their dose is just right, whereas patients being treated for addiction to only pain medications believed that their dose is too low. There are significant differences in the average dose between heroin-only users (83 mg/day) and both pain medication-only users (103 mg/day) and heroin and pain medication users (104 mg/day). There is no significant difference between males and females.

Major differences in this area can be seen based on the individual OTPs in which patients receive treatment. The range of average doses across the 22 programs is 70 mg/day to 112 mg/day. Patients at 4 OTPs are more likely to report that their dosage is correct. Patients at 12 of the OTPs participating in the indepth study reported that their doses are too low, and patients at the 4 remaining clinics reported that their dosing levels are too high. Patients at the smallest clinics (100 or fewer patients) have the highest average dose at 104 mg/day, and patients at the largest clinics (more than 400 patients) have the lowest average dose at 77 mg/day.

IV.C.5.2 Satisfaction With Services

The majority of patients at the indepth study OTPs reported that they are satisfied with the services they have been receiving. The patients indicated that they are treated with respect and that overall the staff are able to help them address their individual treatment needs.

Ninety-two percent of patients reported that their OTP treats them with respect. Almost 95 percent believed that patients in general are treated with respect by the OTP staff. There are some statistically significant differences by treatment length, however, as patients in treatment for less than 6 months reported higher levels of respect from staff than did patients in treatment for longer periods. There was also a great deal of difference in patient’s perceptions of respect by individual OTP.

Likewise, when asked whether they believed that they have ever been treated unfairly:

- 90.6 percent reported being treated unfairly “never” or “rarely”
- 8.4 percent reported being treated unfairly “sometimes” or “often”
- 1 percent reported being treated unfairly “most or all of the time.”

Eighty-eight percent reported a willingness to file a complaint with the OTP management if they felt that they were being treated unfairly.

Ninety-one percent of the patients reported that the OTP facility (including the bathrooms) reflects the needs of patients. The larger the clinic’s patient population is, the less likely the patients are to believe that the facility meets their needs, however. As for whether the counselors are well-informed about the special needs of patients in treatment, such as pregnancy, disabilities, and co-occurring disorders, 91.3 percent believed that statement to be true.

However, only 71.2 percent of the individuals interviewed believed that patients with special needs receive treatment they would describe as “very good” or “excellent.” In general, the smaller the clinic is, the better able it is to meet special needs.

IV.C.5.3 Satisfaction With Treatment

Almost two-thirds (66 percent) of the patients interviewed during the site visits reported that their individual treatment plan “completely” meets their needs. One-third (33 percent) reported that their treatment plan meets their needs to “some extent.” There is no significant difference between the three treatment length strata, the type of drug for which they are receiving treatment, or by individual OTP.

Patients were asked to rate their satisfaction with the treatment they had received in the past 3 months. Seventy-seven percent reported that their treatment has been “very good” or “excellent,” 17 percent reported that their treatment has been “good,” and 6 percent reported that their treatment has been “poor.” Patients in treatment for between 6 months and 1 year gave less favorable ratings than did those in treatment for either less than 6 months or more than 1 year. There is no difference based on the drug for which they were receiving treatment. There was a difference based on the OTP, however, as the overall satisfaction with treatment at smaller clinics is significantly higher than that of the quality of treatment at larger clinics.

IV.C.5.4 Treatment Outcomes

In looking at OTPs’ responses to the PAQ and FQ, another promising trend involved a statistically significant increase in the number of patient outcomes tracked by OTPs, from an average of 5.5 (SD=2.5) patient outcomes tracked at baseline to 6.4 (SD=2.7) outcomes tracked at the time of the FQ. More detail on patient outcomes was provided by data from the patient interviews at the 22 OTPs.

- **Continued drug use**—69 percent of the patients reported using some type of drug at least once in the past 30 days. The most commonly referenced drug is alcohol (28.5 percent), followed by pain medication (26 percent), marijuana (23.3 percent), cocaine/crack (15.5 percent), and heroin (19.5 percent). (Patients also were asked about stimulant and tranquilizer use, but this use is not reported here because there is no way to determine whether it was related to a prescribed drug or an illegally obtained drug.)

Men are more likely than are women to have reported relapsing and using multiple drugs. There also is a significant difference between reported use by treatment

length. As might be expected, patients in treatment for less than 6 months are more likely to relapse and use multiple illicit drugs than are patients in treatment for more than 6 months. There is not a significant difference in relapse or the use of multiple drugs for patients in treatment for 6 to 12 months and patients in treatment for more than 1 year.

There is a significant difference in relapse and use of multiple drugs based on the type of drug for which patients are receiving treatment. Individuals being treated for addictions to only pain medication are less likely to relapse than are patients receiving treatment for addictions to either heroin only or heroin and pain medication. Likewise, patients addicted to pain medications only are more likely to continue using only pain medications rather than any other drug.

- **Employment**—One-third of the patients reported being employed at the time of their interview. Of those individuals, 79.8 percent reported working at least 35 hours a week. There is no significant difference in employment by treatment length. There is a difference, however, based on the drug for which the patient is being treated. Patients reporting using only pain medications are much more likely to be working. There also is a significant difference in employment—from a low of 10 percent being employed to a high of 80 percent being employed—based on the size of the OTP. Patients at very large clinics (more than 400 patients) are the least likely to be employed. This finding may be partially explained by the fact that the three largest clinics to participate in the study were from New York (two) and California, where methadone treatment is a Medicaid-reimbursable service.
- **Criminal justice system involvement**—With the caveat that the data collection in patient interviews was self-reported and unverifiable, patients reported very little involvement with the criminal justice system. Only 16.6 percent of the patients reported that they are currently on probation or parole, currently awaiting charges/sentencing, or under the jurisdiction of the criminal justice system in some way. Likewise, only 6.5 percent of patients reported that they are legally mandated to participate in treatment as part of probation or parole stipulation. As for the number of times that they had been arrested in the past 3 months:
 - 91.8 percent reported no arrests
 - 6.3 percent reported one arrest
 - 1.9 percent reported between 2 and 5 arrests (a total of 11 patients).

There is no significant difference in arrests based either on the drug for which the patients are being treated or by the OTP at which they are receiving treatment. There is a significant difference by treatment length, however. The longer a patient has been in treatment, the more likely he or she is to avoid arrests. Patients in treatment for less than 6 months are 3 times more likely to be arrested than are those in treatment for more than 1 year. Likewise, patients in treatment for between 6 and 12 months are 2 times more likely to be arrested than are patients in treatment for more than 1 year.

- **Health status**—Responses varied greatly when patients were asked about their current health status. Thirty-four percent believed that their current health is either “excellent” or “very good.” Approximately 32 percent reported that their health is “good.” The final 34

percent reported that their health is “fair” or “poor.” There is a significant difference between treatment length, as the less time patients have been in treatment, the healthier they perceive themselves to be. Patients who are addicted to only pain medications also reported being healthier than did individuals who reported using either heroin only or heroin and pain medications.

IV.C.6 Summary

The results of the PAQ in the areas of clinical practices and policies indicate that OTPs are performing as would be expected and that the accreditation process does not seem to have had any adverse effect in these critical areas. Both service and delivery outcomes and patient outcomes were reported to be similar from the time of the PAQ to the time of the FQ. If anything, the variations in results between the two surveys are encouraging in that OTPs are providing more support and services to their patients.

The indepth study sample results support those of the PAQ. While staff are evenly divided between those who believed take-home privileges are stricter post-accreditation and those who said they are not, most did not agree that this change is specifically related to accreditation. Patients indicated they are overwhelmingly satisfied (88 percent very or somewhat satisfied) with these privileges.

The most interesting result from the patient interviews is that the average length of stay for those who completed the program is less (26.5 months on average) than for those who dropped out (27.4 months). Patients who had died during treatment had been in treatment the longest (73.5 months).

Nine in 10 patients reported receiving a psychosocial assessment at their OTP, while only 8 in 10 indicated receiving any type of substance abuse counseling. One-third of patients or fewer reported getting some kind of mental health support.

More than half of patients said they are involved in the decisions regarding their dosing level most or all of the time, and 76 percent feel their dose is just right. Most patients are satisfied with the services at the OTP and with their treatment. Seven in 10, however, reported using some type of drug at least once in the past 30 days, though not surprisingly, drug use is more prevalent among those who have been in treatment for less time. Patients being treated for pain medication addiction are more likely to work at least 35 hours a week. Most patients indicated that they are not currently involved with the criminal justice system. Sixty-six percent believed their health is at least “good,” or even “very good” or “excellent.”

IV.D FULL IMPLEMENTATION EVALUATION

IV.D.1 Introduction

This section of the report looks at questions related to the larger issues associated with accreditation policy and costs. That is, OTP providers weighed in on whether improvements could be made to the accreditation process and to the standards being used by the accreditation bodies (ABs). The study also (1) reveals the problems associated with measuring the cost-effectiveness and cost-benefits of a national implementation of OTP accreditation and (2) investigates the projected costs to individual OTPs of undergoing and continuing accreditation.

IV.D.2 Suggested Improvements to Accreditation Process

In interviews conducted as part of the site visits, medical directors, nurses, and counselors were asked for suggestions about how to improve the accreditation process by making future survey preparation easier. Among the medical directors and nurses ($N=16$) and counselors ($N=37$), the majority either had no suggestions, said they did not know, or thought the process was already efficient; few offered specific, positive suggestions for change. The most frequently cited concrete area for both groups concerned the need to improve the interaction with the AB before, during, and after the survey (medical directors/nurses [$N=4$] and counselors [$N=5$]). Among the counselors, other important themes included reducing the costs of accreditation, reducing the duplication between the State and Federal authorities, and reducing paperwork.

Program directors [$N=31$] were asked a slightly different question. They were asked to give suggestions to improve the survey process (as opposed to the accreditation process). The most frequently cited suggestion was to improve interaction with the AB, followed by reducing the cost of accreditation and standardizing the process across ABs. Many, however, had no suggestions or did not know.

IV.D.3 Suggested Changes to Accreditation Bodies' Standards

When the program directors were asked how they would change the accreditation standards to better accommodate their program, 11 of the 31 respondents said that they would not make any changes, and an additional 3 said that they did not know. Among those who suggested areas for improvement, two themes came to the forefront: the need to simplify the standards (including making them more “reader-friendly”) and to reduce the paperwork.

IV.D.4 Cost to Government of National Implementation of OTP Accreditation

In absolute terms, a total of \$1,678,719 was spent on technical assistance efforts by the Federal Government, according to information collected by JBS International, Inc., on behalf of CSAT. Based on this information, the cost was a mean \$2,012 and a median \$2,109 per effort, ranging from \$197 to \$11,921.¹⁰ Unfortunately, the specific programs participating in a given TA effort could not be identified by the agencies reporting TA costs. For example, “Seattle” is listed as receiving TA three times on three different dates. Therefore, the cost of TA efforts for specific programs could not be determined.

Because data were not available for Government expenditures for the prior accreditation procedure, the cost to the Government of the new accreditation procedure could not be compared to the old accreditation procedure.

¹⁰ Because \$0 and \$.99 were reported for TA costs at some sites, according to the spreadsheet, and because these cost data were considered nonsensical, those values were treated as missing and excluded from the above calculations.

IV.D.5 Cost-Effectiveness of National Implementation of OTP Accreditation

Although there is strong interest in reporting the cost-effectiveness and cost-benefit of the new accreditation procedure for OTPs, it is difficult for the OTP Accreditation Evaluation study to determine either cost-effectiveness or cost-benefit quantitatively with objective measures.

IV.D.5.1 Problems Measuring Effectiveness

Measuring the cost-effectiveness of the SAMHSA/CSAT accreditation effort would require (1) a reliable and valid measure of the *effectiveness* of accreditation for each program (in terms of improvements in program operations after accreditation, for example), as well as (2) a reliable and valid measure of the *cost* of accrediting the program. Delays in the start of the OTP Accreditation Evaluation, however, meant that most OTPs were accredited by the time the study could begin. Thus, while the data gathered from the PAQ answer the cost part of this equation post-accreditation, the study does not include this information from before the OTPs had been accredited. Therefore, changes in program operations cannot be measured with satisfactory validity.

The PAQ does include a qualitative measure of effectiveness by asking whether an OTP has been improved or worsened by accreditation. Unfortunately, because this measure is qualitative, it is ordinal, rather than an interval or ratio, and therefore it cannot be combined mathematically with quantitative measures of costs to measure the cost-effectiveness of the new accreditation procedure. In addition, because the question is subjective and most OTPs had just completed accreditation, it is likely that there was a bias toward reporting that accreditation had improved the OTP. Without corroborating data that are both more objective and less prone to such demand characteristics, it is difficult to determine the validity of this self-report of program improvement. No other measure of the effectiveness of accreditation was available, in terms of the effects the accreditation procedure may have had on program operations or the outcomes of program operation in terms of patient substance abuse.

Use of N-SSATS data to derive potentially applicable pre-accreditation measures of program impact was briefly considered when MAP I data and other sources were not available. Resources were not available at that point to pursue this line of analysis, however.

One way to describe the relationship between costs and effectiveness as reported by the OTP, since it is not possible to calculate cost-to-effectiveness, would be to represent each OTP as a point on a graph with the cost of accreditation on the horizontal axis and the degree of reported improvement on the vertical axis (cf. Yates, 1980, 1996, 1999). Because the number of months spent preparing for accreditation was not requested of programs on the PAQ, however, the costs of accreditation for programs could not be measured with precision. As detailed in Exhibit IV.D-2, programs reported in considerable detail the amount of time they spent in specific activities related to accreditation for the average month but not for the number of months spent preparing for accreditation. Nonpersonnel costs were reported for the entire accreditation effort rather than for the average month, as detailed in Exhibit IV.D-4, but personnel costs likely composed the majority of accreditation preparation costs. Therefore, in the absence of the pre-accreditation data, the cost-effectiveness of accreditation based on a pre/post survey model cannot be measured.

IV.D.5.2 Problems Measuring Benefits

Measuring the *cost-benefit* of the accreditation procedure would require a reliable and valid measure of the monetary outcomes of that procedure relative to income and service use before

accreditation. Cost savings to an OTP could be generated by accreditation in several ways, including:

- Making the OTP more effective in improving patient income, reducing unnecessary use of health services by patients, and reducing criminal justice services required by patients
- Reducing the costs of treatment procedures used by the OTP to improve patient functioning
- Improving the effectiveness of management of the OTP by program administrators
- Reducing the amount of resources needed to manage an OTP by improving the efficiency of program administration
- Reducing the burden of accreditation-related paperwork and other activities required by accreditation that did not in fact make the OTP or its management more effective or less costly.

No reliable and valid quantitative measures of these potential savings are available for the current research effort. Questions that did compare program costs pre- versus post-accreditation were only ordinal in scale, in that they did not measure the *amount* of cost-savings, but only whether there was, in the opinion of the program director, a change in programs costs (and, if so, whether that change was an increase or decrease).

It was hoped that at least the reduction in costs of treatment-related activities between the first and subsequent accreditations could be measured, and contrasted to the cost of the first accreditation, for a cost-benefit analysis of accreditation that would generate net benefit and benefit/cost ratios. Again, because the OTP questionnaire could be administered to programs only after they were accredited, changes in treatment- and accreditation-related costs could not be measured.

The costs of treatment- and accreditation-related activities could at least be compared for programs that recently experienced their first accreditation and programs that recently experienced their second or subsequent accreditation at the time they completed the PAQ. These two groups of programs may not necessarily be comparable, however. Some programs that had experienced their second or subsequent accreditation had done so because their initial accreditation had been for a briefer-than-typical period due to a number of concerns of the AB regarding adherence to program requirements. Other programs had experienced their second accreditation because they had participated in the MAP I study and received their first accreditation earlier than most sites. Less time spent in activities for a second or subsequent procedure could reflect less devotion to accreditation preparation as well as, or instead of, more efficient accreditation. More time spent in accreditation-related activities for a second or subsequent accreditation would be unexpected but could occur if insufficient time and effort had been devoted to preparation for the first accreditation.

After examining initial analyses, the evaluation team concluded that comparisons of time spent in both treatment- and accreditation-related activities for programs that underwent their first versus their second or subsequent accreditations should be reported. However, further analysis of the data and conclusions drawn from the data should take into consideration the potentially very different samples surveyed (those who were looking for their first accreditation and those who were applying for a subsequent accreditation). It is interesting to note, as one would hope, the data indicate that the average number of hours spent on several activities related

to preparing for accreditation was lower for OTPs that answered the survey about their subsequent accreditation.

Exhibit IV.D-1. Mean Number of Hours Per Month Spent in Activities Not Related to Accreditation

	First Accreditation (N=395)	Subsequent Accreditation (N=83)
Staff meetings	57	31*
Staff training	36	23*
Review/update of records keeping	57	40
Review/update of treatment and continuing care plans	46	33
Development of quality assurance plan	19	11*
Preparation of accreditation application	11	6*
Preparation of OTP documentation	38	22*
Interaction with external consultant	12	7*
Accreditation survey	25	16*

* Difference is statistically significant at the .05 level.

Exhibit IV.D-2. After the First Accreditation, Significantly and Substantially Less Time Is Spent in Some Activities Related to Preparing for Accreditation

	First Accreditation (N=395)	SD	Subsequent Accreditation (N=83)	SD
Staff meetings related to accreditation	57.4	115.3	30.7*	31.9
Staff training related to accreditation	36.2	58.8	23.3*	34.5
Review/update of records keeping	56.5	121.7	40.1	59.9
Review/update of treatment plans or continuing care plans and procedures	45.8	83.5	33.3	39.4
Review/update of admission procedures	20.3	43.8	16.9	25.0
Review/update of storage of controlled substances	13	34.5	11.1	27.4
Review/update of facilities	14.1	28.5	9.8	25.7
Development of quality assurance plan	18.9	36.1	11*	14.7
Preparation of accreditation application	10.7	30.7	5.7*	9.4
Communication with accrediting body	7.1	19.7	5.5	12.5
Preparation of OTP documentation	38.4	98.4	21.9*	31.9
Mock survey from accrediting body	18.5	41.2	13.7	31.7
Development/review/update of community relations procedures	10.2	25.5	9.6	19.7
Development/review/update of diversion control plan	9.9	24.0	9.6	25.9
Interaction with external consultant	12.2	35.9	6.8*	13.3
Accreditation survey	25.2	35.3	15.9*	21.0

* Difference is statistically significant at the .05 level.

It is interesting to speculate why some activities related to accreditation appear to decrease significantly and substantially following accreditation, while others do not. Given the high variability of these times (as indicated by the standard deviations listed in the “SD” columns), however, such speculation might better await findings from nonparametric tests that could be less affected by nonnormal distributions. This same comment can be made for Exhibits IV.D-3 and IV.D-4, which show significant and nonsignificant differences in time devoted to activities not related to accreditation.

To estimate staff costs for first versus subsequent accreditation, a series of analyses of covariance attempted to replicate the significance tests in these exhibits, treating program size as a covariate. These analyses, performed separately for each type of activity, found *no* statistically significant ($p < .05$) differences between first and subsequent accreditation groupings for any of the types of activities, despite the numerous statistical comparisons.

Exhibits IV.D-3 and IV.D-4 suggest that time spent in some direct and indirect services actually decreases, significantly and substantially, between the first and subsequent accreditations. More research is needed to further explore these findings.

Exhibit IV.D-3. After First Accreditation, Time Spent in Some Activities Not Related to Accreditation Decreases Significantly

	First Accreditation	SD	Subsequent Accreditation	SD
	(N=395)		(N=83)	
Staff meetings	38.9	51.4	33.7	30.5
Staff training	16.1	21.3	12.6	13.1
Records keeping	102.7	124.5	86.8	81.3
Implementing treatment plans or continuing care plans and procedures	85.1	128.0	68.0	157.0
Implementing admissions procedures	55.2	71.1	40.8*	41.9
Appropriate storage of controlled substances	24.9	35.7	19.0	32.1
Maintenance of facilities	20.5	37.2	11.1*	25.8
Staff supervision	43.5	59.1	93.8	442.3
Quality assurance	28.5	40.2	28.0	29.3
Program administration	53.1	73.2	103.0	316.5
Community relations	13.0	22.5	12.1	20.2
Diversion control	32.3	68.4	85.2	510.2

* Difference is statistically significant at the .05 level.

Exhibit IV.D-4. Time Spent in Some Direct Patient Services Is Significantly Reduced After First Accreditation

	First Accreditation	SD	Subsequent Accreditation	SD
	(N=395)		(N=83)	
Initial patient assessment	65.3	90.2	47.7*	39.7
Treatment planning	60.7	94.6	39.3*	49.4
Initial medical services	39.8	69.1	27.6*	35.1
Methadone dosing	112.2	112.2	102.9	62.3
LAAM dosing	0.8	7.7	0.5	2.6
Buprenorphine dosing	1.3	7.7	0.4	2.5
Ongoing medical services other than methadone/LAAM/buprenorphine dosing	38.5	83.0	27.1	38.3
Individual, couples, and family counseling	110.6	162.2	138.5	180.5
Group counseling	50.1	183.1	25.9	49.7
Case management	53.7	94.2	31.4*	38.8
Patient administration	52.6	97.1	33.9*	57.0
Urinalysis	43.0	54.1	50.5	97.5
Childcare	1.1	6.9	0.0*	0.1

* Difference is statistically significant at the .05 level.

Data also show that time spent in activities related to accreditation was highly correlated with program size, which could be expected to differ in the two groups, r s from .77 to .92, all p s $<.001$ (see Exhibit IV.D-5 for individual correlations for specific types of staff). These correlations likely reflect the additional effort that larger programs, with more patients, staff, and records, often need to spend in accreditation-related activities or the greater resources they have available. These correlations also may reflect relationships between other program characteristics, such as financial organization of the program and time the program was willing to allocate to accreditation preparation.

Exhibit IV.D-5. Time OTPs Spent on Accreditation Activities Is a Function of Program Size

Total Time Spent Preparing for Accreditation in Past Month	Correlation (r) of Activity With Program Size (# Patients Currently Enrolled), N s > 230*
Management staff	.88
Physician	.78
Nurse	.85
Counselor	.92
Other clinical staff	.77
Administrative staff	.86

* $p < .0001$

IV.D.6 Projected Costs to Individual OTPs of Undergoing and Continuing Accreditation

Costs of accreditation were measured in the PAQ using an “ingredients summation” approach in which programs were asked to indicate how much of each item related to accreditation was used during accreditation preparation. Programs reported whether their costs decreased or increased or stayed the same for a variety of resources, including personnel time and nonpersonnel expenditures. In an attempt to obtain more specific, quantitative information about the major resource category that was likely affected by accreditation, OTPs also were asked to report time spent by personnel in an average month during preparation for accreditation. As noted previously, however, data were not available on the number of months that the programs spent preparing for accreditation.

IV.D.6.1 Nonpersonnel Costs Reported

Nonpersonnel resources for which programs were asked to report their average monthly cost included methadone, LAAM, buprenorphine, equipment and utilities, renovation of or construction on the physical structure of the OTP, transportation, rent or mortgage payments, staff health insurance, HIV testing, and STD testing. Programs also were asked whether these costs had increased, decreased, or stayed the same following accreditation.

Exhibit IV.D-6. Average Monthly Nonpersonnel Costs for Past 3 Months

	Total (N=324)	Number of Patients Enrolled at OTP When Questionnaire Completed			
		≤100 (N=64)	101–200 (N=86)	201–300 (N=60)	> 300 (N=107)
Health insurance for staff	\$8,958	\$11,698	\$5,425	\$8,216	\$10,938
Methadone	\$6,237	\$4,039	\$5,968	\$3,822	\$9,186
Rent/mortgage	\$5,433	\$2,559	\$4,894	\$5,438	\$7,642
Equipment/utilities	\$2,885	\$1,761	\$2,173	\$2,609	\$4,246
Renovation to/construction on OTP’s physical structure	\$2,693	\$1,803	\$526	\$655	\$6,352
HIV testing	\$521	\$401	\$201	\$501	\$931
Transportation	\$475	\$580	\$209	\$466	\$676
STD testing	\$322	\$164	\$162	\$179	\$738
Buprenorphine	\$140	\$173	\$87	\$165	\$125
LAAM	\$67	\$0	\$0	\$124	\$138
Total	\$21,817	\$15,792	\$17,025	\$16,849	\$33,213

Exhibit IV.D-7. OTPs Report of Whether Nonpersonnel Costs Increased, Decreased, or Stayed the Same Since Accreditation

	Increased (%)	Decreased (%)	Stayed the Same (%)
Renovation to/construction on OTP’s physical structure	36	1	63
Equipment/utilities	32	-	68
Health insurance for staff	32	-	68
Rent/mortgage	18	1	81
Methadone	14	-	86
STD testing	12	1	87
Transportation	9	1	90
HIV testing	9	2	89
Buprenorphine	6	-	94
LAAM	2	9	89

The majority of OTPs reported that nonpersonnel costs had stayed the same since they had received accreditation. The results were virtually the same regardless of program size.

In addition, OTPs also reported whether, to achieve accreditation standards, resource expenditures were made in the areas of renovating the program’s physical structure, acquiring additional space, purchasing major equipment, purchasing supplies and materials, purchasing furniture and accessories, and purchasing and installing computers and software and, if so, the cost to the program. Exhibit IV.D-8 shows the average nonpersonnel costs for each of these accreditation-related expenditures based on program size, as well as the number of each type of program reporting these expenditures.¹¹

¹¹ Note: Only includes those OTPs that report undertaking each expenditure to achieve accreditation standards.

Exhibit IV.D-8. Mean Nonpersonnel Costs To Achieve Accreditation Standards, Among Only Programs That Indicated Having These Expenditures, Broken Down by Program Size

	Total	Number of Patients Enrolled at OTP When Questionnaire Completed			
		≤100	101–200	201–300	> 300
Renovating the program's physical structure	\$30,047 N=83	\$16,229 N=12	\$76,583 N=15	\$8,780 N=15	\$29,883 N=41
Acquiring additional space	\$18,991 N=12	\$0 N=0	\$75,005 N=2	\$4,000 N=2	\$8,736 N=8
Purchasing major equipment	\$8,653 N=30	\$4,738 N=5	\$11,493 N=7	\$17,000 N=7	\$6,304 N=11
Purchasing supplies and materials	\$2,190 N=112	\$1,906 N=17	\$1,424 N=23	\$1,709 N=22	\$2,885 N=50
Purchasing furniture and accessories	\$3,126 N=61	\$1,308 N=6	\$4,585 N=17	\$1,954 N=14	\$3,277 N=24
Purchasing and installing computers and software	\$12,049 N=50	\$11,357 N=7	\$7,947 N=9	\$10,994 N=16	\$17,833 N=18
Total	\$27,655 N=153	\$13,008 N=26	\$47,316 N=33	\$14,273 N=35	\$32,242 N=59

Conclusions regarding nonpersonnel costs as a function of program size need to be qualified for some types of expenditures, particularly space acquisition, due to the extremely low number of programs seeking those additional resources (none to two programs in most size categories). One of these programs expended a large amount of money acquiring space, making the space and total nonpersonnel expenditures for its category seem unusually high. The median of the other categories seems more representative of the amount of nonpersonnel expenditures.

A more conservative estimate of nonpersonnel costs is generated by including programs that did not report expenditures in a particular category (counting nonresponse or “blanks” as \$0). These are reported in Exhibit IV.D-9.

Exhibit IV.D-9. Mean Nonpersonnel Costs To Achieve Accreditation Standards, Including Programs That Did Not Indicate Having These Expenditures, Broken Down by Program Size

	Total (N=478)	Number of Patients Enrolled at OTP When Questionnaire Completed			
		≤100 (N=109)	101–200 (N=118)	201–300 (N=86)	> 300 (N=70)
Renovating the program's physical structure	\$5,846	\$1,787	\$9,735	\$1,531	\$3,751
Acquiring additional space	\$477	\$0	\$1,271	\$93	\$679
Purchasing major equipment	\$706	\$217	\$682	\$1,384	\$467
Purchasing supplies and materials	\$554	\$297	\$277	\$437	\$806
Purchasing furniture and accessories	\$405	\$72	\$661	\$318	\$374
Purchasing and installing computers and software	\$1,512	\$729	\$606	\$2,045	\$286
Total	\$9,501	\$3,103	\$13,232	\$5,809	\$6,363

Although the largest proportion of OTPs falls in the category of 101 to 200 patients, because the results in Exhibit IV.D-8 include only a small number of programs in this group for acquiring new space, it seems likely that the surprisingly higher total cost reported by programs of this size

is unrepresentative. Thus, a better estimate of nonpersonnel costs for an average OTP would be a mean cost of \$5,809 from the programs that had between 201 and 300 patients.

IV.D.6.2 Personnel Costs Reported

To calculate program costs, the time spent in accreditation-related activities by a given type of personnel was summed across activities and then multiplied by the payrate for that type of personnel.¹² Personnel costs were reported per month. Experts’ estimates for the number of months that a program typically spends in accreditation preparation and related activities range from 2 to (with more emphasis) 3 to 4 months (and up to 6 months). These results can be found in Section IV.B.2. Exhibit IV.D-10 assembles these personnel costs with the nonpersonnel costs shown in Section IV.D.6.1.¹³

Exhibit IV.D-10. Costs of Accreditation, Distinguishing Between Nonpersonnel and Personnel Costs

	Calculating Cost of Accreditation, Assuming OTP Accreditation Activities Occur for ...					
	1 Month	2 Months	3 Months	4 Months	5 Months	6 Months
Nonpersonnel costs to achieve accreditation standards	mean: \$9,501–\$27,655					
Personnel activities related to preparing for accreditation	\$9,501*	\$19,002	\$28,503	\$38,004	\$47,505	\$57,006
Total estimated cost of accreditation	\$19,002–\$37,156	\$28,503–\$46,657	\$38,004–\$56,158	\$47,505–\$65,659	\$57,006–\$75,160	\$66,507–\$84,661

* Based on total cost of activities performed by personnel in an average month, as found in Section IV.B.2.

With 2 to 4 months being the most likely time spent on accreditation, accreditation costs for OTPs ranged from \$28,503 to \$65,659. These estimates require a number of assumptions in addition to the number of months involved. A more complete, and possibly more accurate, range of estimates could be generated using medians instead of means. For both measures of central tendency, estimates could be provided separately for programs with different financial organizations and for programs of different sizes. Note also that some sites may always be preparing for their next accreditation and, many times, OTPs responding to the survey may well have had differing interpretations of which costs were related to accreditation.

Furthermore, these estimates of personnel costs assume that the amount of time spent in each type of accreditation-related activity would not vary depending on the number of months it was performed. This is unlikely. If fewer months are available for accreditation-related activities, programs could be expected to devote more time to accreditation-related activities during those few months to get the essential tasks of accreditation preparation done. In contrast, some accreditation preparation activities could be expected to take only 1 month (e.g., preparation of the accreditation application), whereas others may take as many months as are available before accreditation visits (e.g., staff meetings related to accreditation).

¹² When calculating means, values of \$0 reported for these activities were treated as missing values.

¹³ Note: Costs are based on self-reported information.

IV.D.7 Summary

When asked about accreditation policy and cost, medical directors, nurses, and counselors from the indepth study sample agreed that the most important area is interaction with the accreditation body before, during, and after accreditation. Counselors also expressed a desire to reduce the cost of accreditation, the duplication between State and Federal authorities, and the paperwork. Program directors, though asked about the survey process rather than accreditation, gave essentially the same responses. This same theme arose with regard to the accreditation bodies' standards during interviews—simplify the standards and reduce the paperwork.

Though it was not possible to quantify the cost-effectiveness or cost-benefit of the national accreditation effort, OTPs undergoing a subsequent accreditation appear to have experienced lower costs in preparing for accreditation, for both personnel activities and nonpersonnel costs than did OTPs undergoing accreditation for the first time. Based on an average preparation time of 2 to 4 months, the cost of accreditation for OTPs was between \$28,000 (\$9,501 as the low end of nonpersonnel costs, plus \$9,501 a month for personnel costs times 2 months) and \$66,000 (\$27,655 as the high end of nonpersonnel costs, plus \$9,501 a month for personnel costs times 4 months).

V. CONCLUSIONS AND RECOMMENDATIONS

The results of this evaluation indicate that the shift from an enforcement model (administered by FDA) to a regulatory model (accredited by SAMHSA) of OTP oversight has had a positive overall impact on OTPs and on the field of opioid treatment more generally—particularly with regard to tracking patient outcomes, increased patient involvement in determining appropriate dosing levels, and ensuring more uniform standards of care across States. Perceptions of the accreditation process are generally favorable, though most providers (particularly clinic directors) acknowledge that achieving accreditation can be a burdensome process. In spite of the challenges associated with achieving accreditation, approximately 8 in 10 OTP providers indicated that—if given the choice—they would prefer to work in a program that is accredited than one that is not.

Based on the findings summarized in this report, the evaluation team offers the following recommendations to further improve the OTP accreditation process:

- Continue to emphasize the need for OTPs to use standardized intake assessments and patient placement criteria
- Strongly encourage OTPs to use computerized records to track patient performance and outcomes (only about half of the programs currently use computers for this purpose)
- Increase interaction/communication between OTPs and ABs before, during, and after administering the accreditation surveys
- Encourage OTPs to expand efforts to educate patients about overdose signs and potential drug interactions with methadone
- Continue to recognize the importance of achieving and maintaining OTP satisfaction with the accreditation process.
- In training, increase staff's sensitivity to patients' differences related to their time in treatment, primary drug, etc.

These recommended changes should further enhance the positive changes already seen in the transition from an FDA enforcement model to a SAMHSA-administered accreditation model.

APPENDIX A: OTP POST-ACCREDITATION QUESTIONNAIRE

The PAQ and FQ were designed to gather information about an OTP's experiences with the accreditation process and changes in its operation and services. Questionnaire topics examined the activities, resources, and costs associated with accreditation preparation (topics addressed in retrospective questions); activities, resources, and costs associated with maintaining accreditation; and the cost and type of services provided by the OTP.

Opioid Treatment Program Accreditation Evaluation

Form Approved
OMB NO. 0930-0254
Exp. Date 12/31/05

OTP POST-ACCREDITATION QUESTIONNAIRE

Site ID _____

Date Completed: ____/____/____

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0254); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0254.

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

INSTRUCTIONS

This questionnaire is designed to learn about your OTP in terms of its characteristics, operations, and treatment services as well as how your OTP is responding to the new accreditation requirement and how it is faring through the accreditation process. As an appreciation of your time and effort, you will receive a **\$25 honorarium** after your completed questionnaire has been returned to Northrop Grumman IT/CHS.

Please note the following before beginning the survey:

- Sign and date the ***Informed Consent form*** included in the package.
- This survey asks you to respond to questions about this OTP site. If your program has more than one site, please complete this questionnaire for this site only.
- This survey is voluntary. Your responses to this survey are confidential. Your name will not be used in any report.
- For each question, read all the response categories and mark an X in the appropriate space(s).
- The last few pages of the survey are to be completed by the Program Director as well as additional staff members (i.e., Clinician, Counselor, and Medical Director).

Within 1 week of receipt of this survey, please mail the completed survey and signed informed consent form to Northrop Grumman IT/CHS in the return envelope included in the package, or mail to:

Kristin Zempolich
OTP Accreditation Evaluation Project
Northrop Grumman IT/CHS
1700 Research Blvd., Suite 400
Rockville, MD 20852

If you have any questions regarding this survey or the study, please call **1-866-OTP-1122 (1-866-687-1122)** for assistance.

THANK YOU VERY MUCH FOR YOUR TIME!

Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire

OTP Post-Accreditation Questionnaire

OTP Characteristics

1. Which of the following best describes your OTP's setting?

Please mark only one choice.

- General hospital with an outpatient substance abuse unit on site
- Psychiatric hospital with an outpatient substance abuse unit on site
- Other specialized hospital with an outpatient substance abuse unit on site
- Outpatient substance abuse treatment facility affiliated with a hospital
- Outpatient substance abuse treatment facility not affiliated with a hospital
- Outpatient substance abuse treatment facility that is part of a larger corporate entity
- Co-occurring disorders treatment center
- Community mental health center or other mental health facility that provides a variety of services
- Community health center, including Migrant Health Center, Urban Indian Program, Health Care for the Homeless Center
- Halfway house
- Therapeutic community
- Other residential substance abuse treatment facility
- Community or religious organization/agency that provides a variety of social services
- Housing for women and children program with substance abuse treatment on site and off site
- HIV treatment center with substance abuse treatment
- Located in a correctional facility
- Other (Specify _____)

2. a. Which of the following best describes your OTP's physical location?

Please mark only one choice.

- Surrounded by other businesses
- By itself on its own block
- In a residential area
- In a rural area
- Other (Specify _____)

b. Are you located in a hospital?

- Yes
- No

c. What is the approximate square footage of your OTP (including hallways, administrative offices, and conference rooms)?

_____ Sq. ft.

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

3. Please indicate which of the following are available at your OTP (*mark all that apply*):

- Electronic methadone dispensing
- Electronic patient records
- Handicapped accessibility
- Confidential meeting areas

4. a. Which of the following services are offered by your OTP?

Please mark “yes” or “no” for each row and indicate the percentage of patients at this OTP that receive each service offered.

Service	Offered by this OTP		Percentage of patients at this OTP receiving service
	Yes	No	
a. General medical care			%
b. HIV/AIDS-related medical care			%
c. Psychological services/counseling			%
d. Psychiatric services			%
e. Educational assistance			%
f. Vocational assistance			%
g. Financial assistance			%
h. Legal assistance			%
i. Counseling/therapy (includes drug and alcohol counseling, family counseling)			%
j. Housing/shelter assistance			%
k. Post-treatment follow-up			%
l. Acupuncture			%
m. Detoxification from a substance other than heroin			%
n. Treatment for alcohol addiction/abuse			%
o. Treatment for cocaine addiction/abuse			%
p. Treatment for other drug addiction/abuse			%
q. Individual or group therapy for opiate addiction			%
r. Other group therapy			%
s. Nutritional counseling			%
t. 12-Step program for alcohol, cocaine, or other drug addiction/abuse			%
u. Smoking cessation			%
v. Case management			%
w. Childcare			%
x. Transportation			%
y. After-care program			%
z. Other (Specify _____)			%

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

b. Are specialized services for the following patient populations offered at this OTP?

Please mark one box for each row.

	Yes	No
a. Racial/ethnic minorities		
b. Non-English-speaking patients		
c. Women		
d. Patients with HIV/AIDS		
e. Pregnant women		
f. Patients with psychiatric diagnoses		
g. Victims of sexual/physical abuse		
h. Children of substance abusers		
i. Polydrug users		
j. Patients involved with the criminal justice system		
k. Homeless patients		
l. Older populations		
m. Youth		
n. Gay/bisexual patients		
o. Patients with disabilities		
p. Other (Specify _____)		

5. Please indicate how many staff members of the following job types are currently on staff at your OTP (*enter 0 if appropriate*).

	Number
Medical Directors	
Psychiatrists	
Physicians	
Registered Nurses (RN)	
Nurse Practitioners (NP)	
Other Licensed Nurses	
Pharmacists	
Physicians Assistants (PA)	
Other Medical Personnel	
Psychologists (M.A.)	
Psychologists (Ph.D.)	
Social Workers (certified)	
Social Workers (not certified)	
Counselors (certified)	
Counselors (not certified)	
Case Managers (certified)	
Case Managers (not certified)	
Other Therapists or Rehabilitation Specialists	
Teachers	
Childcare Workers	
Program Administrative Staff	
Clinical Supervisors	
Team Leaders	
Other--paid	
Other--volunteers	
Student interns—unpaid	
TOTAL STAFF SIZE	

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

6. a. Thinking back over the past 3 months, please indicate your OTP's average monthly cost for the following (*enter 0 if appropriate*):

Methadone	\$ _____
LAAM	\$ _____
Buprenorphine	\$ _____
Equipment/utilities	\$ _____
Renovation to/construction on OTP's physical structure	\$ _____
Transportation	\$ _____
Rent/mortgage	\$ _____
Health insurance for staff	\$ _____
HIV testing	\$ _____
STD testing	\$ _____

b. Compared to the costs **before your OTP received accreditation**, please indicate whether current costs (from 6a) have increased, decreased, or stayed the same for each of the following (*mark one box for each row*):

	Increased	Decreased	Stayed the same
Methadone			
LAAM			
Buprenorphine			
Equipment/utilities			
Renovation to/construction on OTP's physical structure			
Transportation			
Rent/mortgage			
Health insurance for staff			
HIV testing			
STD testing			

7. a. Does your OTP involve community members, including neighbors, in the following (*mark one box for each row*):

	Yes	No
Representation on the OTP governing body or board?		
Policy decisions?		
Development of community relations plan?		

b. Did your OTP involve community members, including neighbors, in the following **before your OTP received accreditation** (*mark one box for each row*):

	Yes	No
Representation on the OTP governing body or board?		
Policy decisions?		
Development of community relations plan?		

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

8. Has your OTP established partnerships with other organizations?
_____ Yes ⇨ What types of organizations? _____
_____ No
9. What percentage of your patients use the following types of payment for their treatment?
- | | | |
|-----------------------------|-------|---|
| a. Cash self-payment | _____ | % |
| b. Medicaid | _____ | % |
| c. Medicare | _____ | % |
| d. CHAMPUS or CHAMPVA | _____ | % |
| e. Private health insurance | _____ | % |
| f. Other (Specify _____) | _____ | % |
10. For patients who pay for at least some of their treatment out of their own pockets, how much do you estimate each patient typically pays per week?
\$_____ per week
11. What is your OTP's patient capacity for methadone/LAAM/buprenorphine treatment?
_____ patients
12. Has the patient capacity for methadone/LAAM/buprenorphine treatment changed in the past 6 months at your OTP?
_____ Yes ⇨ Why? _____
_____ No
13. How many patients are currently enrolled for methadone/LAAM/buprenorphine treatment at your OTP?
_____ patients
14. Of the total number of patients indicated in Question 13, what percentage are male?
_____ %
15. Of the total number of patients indicated in Question 13, what percentage are of Hispanic/Latino origin or descent?
_____ %
16. a. Of the currently enrolled population indicated in Question 13, what is the racial distribution of the non-Hispanic/Latino patients?
- | | | |
|--|-------|---|
| American Indian/Alaska Native | _____ | % |
| Asian | _____ | % |
| Black/African American | _____ | % |
| Native Hawaiian/Other Pacific Islander | _____ | % |
| White | _____ | % |

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

b. What is the age distribution of the currently enrolled population indicated in Question 13?

Under 18 years old	_____ %
18–25 years old	_____ %
25–50 years old	_____ %
Over 50 years old	_____ %
TOTAL	100%

17. During the past 6 months, what was the average number of patients enrolled in methadone/LAAM/buprenorphine treatment at your OTP on any given day?

_____ patients enrolled on any given day

a. During the past 6 months, what percentage of patients were receiving:

Methadone treatment?	_____ %
LAAM treatment?	_____ %
Buprenorphine treatment?	_____ %
Other? (Specify _____)	_____ %
TOTAL	100%

b. During the past 6 months, what percentage of patients were receiving treatment for:

Heroin?	_____ %
Oxycodone products?	_____ %
Morphine products?	_____ %
Other? (Specify _____)	_____ %

18. During the past 6 months, what was the total number of admissions for methadone/LAAM/buprenorphine treatment at your OTP?

_____ admissions in the past 6 months

19. During the past 6 months, approximately what percentage of admissions (from Question 18) were re-admissions for methadone/LAAM/buprenorphine treatment?

_____ %

20. Is there a waiting list for methadone/LAAM/buprenorphine treatment at your OTP?

_____ Yes

_____ No ⇒ *Skip to Question 21*

a. How many people are currently on your waiting list? _____

b. What is the average wait time before a person is admitted to your OTP? _____ days

21. What percentage of current patients have received methadone/LAAM/buprenorphine treatment at your OTP for:

Less than 6 months?	_____ %
Between 6 months and 1 year?	_____ %
Between 1 year and 2 years?	_____ %
More than 2 years?	_____ %
TOTAL	100%

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

The Accreditation Process

22. From which organization did your OTP receive accreditation?

- JCAHO
 CARF
 COA
 Other (Specify _____)

23. When was your accreditation survey conducted by this organization?

_____ / _____
 Month Year

24. Please estimate how much time each of these activities related to preparing for accreditation has required of various staff in an average month since your OTP started preparing for accreditation (*enter 0 if appropriate*).

	Management staff	Physician	Nurse	Counselor	Other clinical staff	Administrative staff
a. Staff meetings related to accreditation	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
b. Staff training related to accreditation	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
c. Review/update of records keeping	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
d. Review/update of treatment plans or continuing care plans and procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
e. Review/update of admission procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
f. Review/update of storage of controlled substances	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
g. Review/update of facilities	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
h. Development of quality assurance plan	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
i. Preparation of accreditation application	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
j. Communication with accrediting body	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
k. Preparation of OTP documentation	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
l. Mock survey from accrediting body	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
m. Development/review/update of community relations procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
n. Development/review/update of diversion control plan	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
o. Interaction with external consultant	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
p. Accreditation survey	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
q. Other accreditation activities (Specify _____)	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

28. What changes to the accreditation process would you recommend?

OTP Operations

29. Independent of accreditation, there are routine activities in which OTP staff engage. Please estimate how much time each of these activities, not related to preparing for accreditation, requires of various staff in an average month (*enter 0 if appropriate*).

	Management staff	Physician	Nurse	Counselor	Other clinical staff	Administrative staff
a. Staff meetings	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
b. Staff training	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
c. Records keeping	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
d. Implementing treatment plans or continuing care plans and procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
e. Implementing admissions procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
f. Appropriate storage of controlled substances	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
g. Maintenance of facilities	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
h. Staff supervision	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
i. Quality assurance	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
j. Program administration	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
k. Community relations	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
l. Diversion control	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
m. Other nonaccreditation activities (Specify _____)	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

30. Please estimate how much time each of these direct patient services requires of various staff in an average month (*enter 0 if appropriate*).

	Management staff	Physician	Nurse	Counselor	Other clinical staff	Administrative staff
a. Initial patient assessment	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
b. Treatment planning	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
c. Initial medical services	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
d. Methadone dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
e. LAAM dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
f. Buprenorphine dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
g. Ongoing medical services other than methadone/LAAM/buprenorphine dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
h. Individual, couples, and family counseling	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
i. Group counseling	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
j. Case management	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
k. Patient administration	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
l. Urinalysis	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
m. Childcare	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
n. Other patient activities (Specify _____)	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

31. Please indicate which of the following has occurred in the past year and the impact it has had on your OTP.

	Did not occur	Occurred due to accreditation	Occurred independently of accreditation	Impact on OTP		
				Positive	No change	Negative
a. An agency reorganization						
b. Change in the program, medical, or OTP director						
c. Change in OTP ownership						
d. Change in program or OTP treatment methods/philosophy						
e. OTP joined a coalition or provider association						
f. A net reduction in direct care staff						
g. A net reduction in other staff						
h. A net increase in direct care staff						
i. A net increase in other staff						
j. A general reduction in OTP services						
k. A general expansion of OTP services						
l. Wage or salary reductions						
m. Fringe benefit reductions						
n. Extensive staff turnover						
o. Wage or salary increases						
p. Fringe benefit increases						
q. Decreased staff turnover						
r. Other major events						
s. Any new state or local laws or regulations that affected OTP operations						
t. Change in documentation activities						

Treatment Services

Dosing

32. What is the usual dose of methadone that your OTP currently prescribes for patients at admission?

_____ mg/day usual dose at admission

33. Of your OTP's current methadone patients who have been in treatment for at least 2 weeks, what percentage receive the following doses:

Less than 40 mg _____ %
 40–59 mg _____ %
 60–79 mg _____ %
 80–99 mg _____ %
 100 or more mg _____ %
 Total 100%

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

34. What is the largest dose of methadone your OTP currently prescribes for patients during maintenance?
_____ mg/day maximum dose during maintenance

35. Which of the following determine the maximum dose a patient can receive?

Please mark all that apply.

- State government policy
- Local government policy
- OTP/program policy
- Payer or reimbursement guidelines
- Medical decision
- Other (Specify _____)

36. Which of the following determine the maximum length of time that a patient can spend in methadone/LAAM/buprenorphine treatment at your OTP?

Please mark all that apply.

- State government policy
- Local government policy
- OTP/program policy
- Payer or reimbursement guidelines
- Medical decision
- Other (Specify _____)

37. How often are patients informed when their methadone/LAAM/buprenorphine dose level is changed?

- Never
- Rarely
- Sometimes
- Frequently
- Always

38. How much do patients influence decisions about their dose level?

- Not at all
- A little
- To some extent
- To a great extent

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

Treatment Planning

39. In which of the following areas are all patients assessed when they enter treatment?

Please mark all that apply.

- Substance use history
- Substance abuse treatment history
- Psychiatric health and functioning
- Social environment
- Education/work history
- Physical or sexual abuse history
- Physical health and functioning
- Criminal justice history
- Spirituality
- Other (Specify _____)

40. What standardized assessment instruments do the staff at your OTP use to assess patients at admission?

Please mark all that apply.

- Addiction Severity Index (ASI)
- CAGE or CAGEAID
- Structured Clinical Interview (SCID)
- Diagnostic Interview Schedule (DIS)
- Beck Depression Inventory
- Instrument developed by your OTP or program
- Other (Specify _____)
- None

41. Which, if any, of the following criteria do staff at your OTP use to evaluate and place patients in treatment?

Please mark all that apply.

- American Society of Addiction Medicine criteria
- DSM-IV criteria
- Criteria developed by your OTP or program
- Different criteria depending on the managed care organization
- Other (Specify _____)
- None

Compliance with Treatment Regimen

42. a. How many discharges did your OTP have in the past 3 months?

_____ discharges

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

b. Of all discharges in the past 3 months, please indicate the percentage of patients discharged for the following reasons:

- | | | |
|-------------------------------------|-------------|---|
| 1. Completed treatment | _____ | % |
| 2. Withdrew/stopped coming | _____ | % |
| 3. Transferred to another program | _____ | % |
| 4. Moved | _____ | % |
| 5. Discharged due to noncompliance | _____ | % |
| 6. Incarcerated/placed in detention | _____ | % |
| 7. Hospitalized for physical health | _____ | % |
| 8. Hospitalized for mental health | _____ | % |
| 9. Insurance coverage expired | _____ | % |
| 10. Patient deceased | _____ | % |
| 11. Other (Specify _____) | _____ | % |
| 12. Information not available | _____ | % |
| TOTAL | 100% | |

43. Of all patients discharged in the past 3 months, what percentage were discharged as a result of disciplinary action? (Examples of disciplinary action include discharging a patient because of consistent positive testing for heroin, poor behavior in the clinic, violence, missed methadone dose, failed take-home call back, not paying fees, or refusing to go to a higher level of care).

_____ %

44. In the past 3 months, what was the approximate “no show” rate of patients to any of their appointments?

_____ missed appointments per patient

45. How likely is it that the clinical staff would use each of the following actions in response to a patient having two consecutive positive urines for opioids, two or more nonconsecutive positive urines for opioids, or testing negative for methadone?

Please mark one box for each row.

	Extremely likely	Somewhat likely	Somewhat unlikely	Extremely unlikely
a. Verbal reprimand				
b. Loss of privileges				
c. Revision to treatment plan				
d. Dose increase				
e. Discharge				
f. Monetary penalty				
g. Counseling session(s)				
h. Other (Specify _____)				

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

46. a. Does your OTP officially discharge patients after missing a number of doses or treatment sessions? *Please mark one choice for each row and, if yes, indicate the number of doses or treatment sessions a patient can miss before being discharged.*

	Yes	No	If yes, number of missed doses/sessions
Doses			
Treatment sessions			

⇒ If “no” is marked for both, skip to Question 47.

- b. How long does your OTP typically wait before officially discharging the patient?

Please mark only one choice.

- 3–7 days
 8–14 days
 15–30 days
 More than 30 days
 Varies, rely on counselor’s discretion

47. For any patient who engages in one of the following actions, how likely is it that your OTP will discharge the patient before he or she completes treatment?

Please mark one box in each row.

	Extremely likely	Somewhat likely	Somewhat unlikely	Extremely unlikely
a. Using illicit drugs				
b. Being arrested for illegal activities other than using illicit drugs				
c. Missing counseling or therapy sessions				
d. Missing dosing appointments				
e. Failure to pay for treatment				
f. Violent behavior on site				
g. Sexual activity on site				
h. Attempted diversion of methadone				
i. Diverting methadone				
j. Violating site rules or regulations other than those indicated above (Specify _____)				
k. Abusing alcohol				
l. Other reasons (Specify _____)				

Take-Home Privileges

48. Does your OTP ever give methadone patients take-home privileges?

- Yes
 No ⇒ Skip to Question 53

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

49. What form of methadone is distributed to patients with take-home privileges?

Please mark all that apply.

Solid (pill)

Liquid

50. Is this form of methadone consistent across all patient situations?

Yes

No ⇨ (Please explain: _____)

51. What percentage of each of the following groups of patients who are currently enrolled for methadone treatment at your OTP have take-home privileges at the levels shown below?

Percentages should sum to 100% across each row.

	No privileges	1 dose/wk	2 doses/wk	3 doses/wk	4-6 doses/wk	7 or more doses/wk	Total
In treatment less than 3 months							100%
In treatment 3-6 months							100%
In treatment 6-9 months							100%
In treatment 9-12 months							100%
In treatment 1-2 years							100%
In treatment over 2 years							100%

52. How often do staff at your OTP revoke take-home privileges if a patient is suspected of diverting methadone?

Never

Rarely

Sometimes

Frequently

Always

53. Which of the following methods does your OTP typically rely on to discourage diversion of methadone?

Please mark all that apply.

Strict OTP policies recommending or requiring patient discharge for diversion of methadone

Management staff review/monitor the methadone dispensing records

Observe patients as they take their methadone

Systematic observation by security guards or site staff of the OTP and surrounding area

Enforcing a policy of no loitering on site premises

Systematically make patients aware of risks and consequences of diverting methadone

Empty bottle return

Other (Specify _____)

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

Urine Testing

54. According to your OTP's policy, how often does your OTP collect patient urine samples?

Please mark only one choice.

- Never ⇒ *Skip to Question 57*
- Less than 1 time per month
- 1 time per month
- 2 times per month
- 3 times per month
- 4 times per month
- 5 or more times per month
- Other (Specify _____)

55. How does your OTP select patients for urine testing?

- All selected at random
- Some selected at random and some specifically identified
- All specifically identified

56. Which of the following quality control (QC) procedures does your OTP use as part of its urine collection procedures? ***Please mark all that apply.***

- Observation (either in person or through a mirror)
- Monitoring using a video camera
- Do not have running water in urine sampling area
- Use of blue toilet water
- Checking urine temperature
- Other (Specify _____)

Patient Outcomes

57. Which of the following patient outcome measures are tracked on a regular basis at your OTP?

Please mark all that apply.

- Heroin use
- Involvement with criminal justice system
- Nonopioid drug use (stimulants, cannabis, alcohol, and other drugs)
- Retention in treatment
- Amount of income
- Sources of income
- Living arrangement
- Satisfaction with services
- Employment
- Other (Specify _____)

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

58. How does your OTP collect information on patient outcomes?

Please mark all that apply.

- Patient questionnaires
- In-person interviews
- Telephone interviews
- Other (Specify _____)

59. Does your OTP use a computerized system to track patient outcomes?

- Yes ⇨ What system are you using? _____
- No

60. Does your OTP maintain any contact with a patient once he/she leaves treatment?

- Yes
- No

Continuing Program Operation

61. Does your OTP have an ongoing QA or CQI process or procedure?

- Yes
- No ⇨ *Skip to Question 65*

62. Did your OTP have an ongoing QA or CQI process or procedure before receiving accreditation?

- Yes
- No

63. In which of the following activities does this OTP engage as part of its QA system?

Please mark all that apply.

- Hold regular staff meetings to discuss patients
- Review patient charts selected at random to check for record completeness
- Review patient charts selected at random to compare services received with treatment plans
- Collect data on indicators of treatment outcomes and monitor trends
- Assess effectiveness of actions taken to correct identified problems
- Communicate relevant information about QA problems to key staff
- Review records of patients who leave the program against medical advice or who are discharged because of rule violations
- Review records of patients with special serious conditions
- Review records of patients with staff in cases of patient death or other adverse events
- Assess patient satisfaction with treatment services
- Solicit suggestions on how to improve services
- Peer review
- Presentation of case studies
- Other (Specify _____)

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

64. What sources of information do staff at your OTP use in QA meetings?

Please mark all that apply.

- Verbal information from staff in attendance
- Written information prepared specifically for the meeting
- Patient charts
- Information from this OTP's or program's data system
- Information from state's data system
- MTQAS quarterly feedback
- Other (Specify _____)
- No QA meeting

65. Does your OTP have a disaster plan or plan for emergency administration of medication?

- Yes
- No ⇒ **Skip to Question 66**

a. What does your emergency plan include?

Please mark all that apply.

- Keeping a backup copy of up-to-date patient identification and dosing information off site (electronic or hard copy)
- Establishing relationships with other methadone providers to service your OTP's clients in cases of emergency
- Other (Please specify _____)

b. Please indicate how clients at your OTP are informed of the emergency plan (**mark all that apply**).

- New patient orientation
- Patient handbook
- Practice drills
- Other (Please specify _____)

c. Please indicate how staff at your OTP are informed of the emergency plan (**mark all that apply**).

- New staff orientation
- Training sessions
- Practice drills
- Other (Please specify _____)

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

Overall Impressions

Please have the appropriate staff members complete items 66-69.

66. Overall Impressions of Accreditation Process—*to be completed by Program Manager/Director*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

67. Overall Impressions of Accreditation Process—*to be completed by Clinician-Nurse or Physician*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

68. Overall Impressions of Accreditation Process—*to be completed by Counselor*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

**Opioid Treatment Program Accreditation Evaluation
OTP Post-Accreditation Questionnaire**

69. Overall Impressions of Accreditation Process—*to be completed by Medical Director*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

APPENDIX B: OTP FOLLOWUP QUESTIONNAIRE

The PAQ and FQ were designed to gather information about an OTP's experiences with the accreditation process and changes in its operation and services. Questionnaire topics examined the activities, resources, and costs associated with accreditation preparation (topics addressed in retrospective questions); activities, resources, and costs associated with maintaining accreditation; and the cost and type of services provided by the OTP.

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

INSTRUCTIONS

This questionnaire is designed to learn about your OTP in terms of its characteristics, operations, and treatment services as well as how your OTP is responding to the new accreditation requirement and how it is faring through the accreditation process. As an appreciation of your time and effort, you will receive a **\$25 honorarium** after your completed questionnaire has been returned to Northrop Grumman IT/HS.

Please note the following before beginning the survey:

- Sign and date the ***Informed Consent form*** included in the package.
- This survey asks you to respond to questions about this OTP site. If your program has more than one site, please complete this questionnaire for this site only.
- This survey is voluntary. Your responses to this survey are confidential. Your name will not be used in any report.
- For each question, read all the response categories and mark an X in the appropriate space(s).
- The last few pages of the survey are to be completed by the Program Director as well as additional staff members (i.e., Clinician, Counselor, and Medical Director).

Within 1 week of receipt of this survey, please mail the completed survey and signed informed consent form to Northrop Grumman IT/HS in the return envelope included in the package, or mail to:

Kristin Zempolich
OTP Accreditation Evaluation Project
Northrop Grumman IT/HS
1700 Research Blvd., Suite 400
Rockville, MD 20852

If you have any questions regarding this survey or the study, please call **1-866-OTP-1122 (1-866-687-1122)** for assistance.

THANK YOU VERY MUCH FOR YOUR TIME!

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

OTP Followup Questionnaire

OTP Characteristics

1. Which of the following services are offered by your OTP?

Please mark “yes” or “no” for each row and indicate the percentage of patients at this OTP that receive each service offered.

Service	Offered by this OTP		Percentage of patients at this OTP receiving service
	Yes	No	
a. General medical care			%
b. HIV/AIDS-related medical care			%
c. Psychological services/counseling			%
d. Psychiatric services			%
e. Educational assistance			%
f. Vocational assistance			%
g. Financial assistance			%
h. Legal assistance			%
i. Counseling/therapy (includes drug and alcohol counseling, family counseling)			%
j. Housing/shelter assistance			%
k. Post-treatment follow-up			%
l. Acupuncture			%
m. Detoxification from a substance other than heroin			%
n. Treatment for alcohol addiction/abuse			%
o. Treatment for cocaine addiction/abuse			%
p. Treatment for other drug addiction/abuse			%
q. Individual or group therapy for opiate addiction			%
r. Other group therapy			%
s. Nutritional counseling			%
t. 12-Step program for alcohol, cocaine, or other drug addiction/abuse			%
u. Smoking cessation			%
v. Case management			%
w. Childcare			%
x. Transportation			%
y. After-care program			%
z. Other (Specify _____)			%

2. What is the approximate square footage of your OTP (including hallways, administrative offices, and conference rooms)? _____ Sq. ft.

3. Please indicate which of the following are available at your OTP (*mark all that apply*):

- _____ Electronic methadone dispensing
- _____ Electronic patient records
- _____ Handicapped accessibility
- _____ Confidential meeting areas

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

4. Are specialized services for the following patient populations offered at this OTP?
Please mark one box for each row.

	Yes	No
a. Racial/ethnic minorities		
b. Non-English-speaking patients		
c. Women		
d. Patients with HIV/AIDS		
e. Pregnant women		
f. Patients with psychiatric diagnoses		
g. Victims of sexual/physical abuse		
h. Children of substance abusers		
i. Polydrug users		
j. Patients involved with the criminal justice system		
k. Homeless patients		
l. Older populations		
m. Youth		
n. Gay/bisexual patients		
o. Patients with disabilities		
p. Other (Specify _____)		

5. Please indicate how many staff members of the following job types are currently on staff at your OTP (*enter 0 if appropriate*).

	Number
Medical Directors	
Psychiatrists	
Physicians	
Registered Nurses (RN)	
Nurse Practitioners (NP)	
Other Licensed Nurses	
Pharmacists	
Physicians Assistants (PA)	
Other Medical Personnel	
Psychologists (M.A.)	
Psychologists (Ph.D.)	
Social Workers (certified)	
Social Workers (not certified)	
Counselors (certified)	
Counselors (not certified)	
Case Managers (certified)	
Case Managers (not certified)	
Other Therapists or Rehabilitation Specialists	
Teachers	
Childcare Workers	
Program Administrative Staff	
Clinical Supervisors	
Team Leaders	
Other—paid	
Other—volunteers	
Student Interns—unpaid	
TOTAL STAFF SIZE	

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

6. a. Thinking back over the past 3 months, please indicate your OTP's average monthly cost for the following (*enter 0 if appropriate*):

Methadone	\$ _____
LAAM	\$ _____
Buprenorphine	\$ _____
Equipment/utilities	\$ _____
Renovation to/construction on OTP's physical structure	\$ _____
Transportation	\$ _____
Rent/mortgage	\$ _____
Health insurance for staff	\$ _____
HIV testing	\$ _____
STD testing	\$ _____

b. Do the costs for the items above vary substantially from month to month?

_____ Yes ⇨ (Please explain: _____)
 _____ No

7. Does your OTP involve community members, including neighbors, in the following (*mark one box for each row*):

	Yes	No
Representation on the OTP governing body or board?		
Policy decisions?		
Development of community relations plan?		

8. Has your OTP established partnerships with other organizations?

___ Yes ⇨ What types of organizations? _____
 ___ No

9. What percentage of your patients use the following types of payment for their treatment?

a. Cash self-payment	_____ %
b. Medicaid	_____ %
c. Medicare	_____ %
d. CHAMPUS or CHAMPVA	_____ %
e. Private health insurance	_____ %
f. Other (Specify _____)	_____ %

10. For patients who pay for at least some of their treatment out of their own pockets, how much do you estimate each patient typically pays per week?

\$ _____ per week

11. What is your OTP's patient capacity for methadone/LAAM/buprenorphine treatment?

_____ patients

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

12. Has the patient capacity for methadone/LAAM/buprenorphine treatment changed in the past 6 months at your OTP?

____ Yes ⇨ Why? _____
 ____ No

13. How many patients are currently enrolled for methadone/LAAM/buprenorphine treatment at your OTP?

_____ patients

14. Of the total number of patients indicated in Question 13, what percentage are male?

_____ %

15. Of the total number of patients indicated in Question 13, what percentage are of Hispanic/Latino origin or descent?

_____ %

16. a. Of the currently enrolled population indicated in Question 13, what is the racial distribution of the non-Hispanic/Latino patients?

American Indian/Alaska Native	_____ %
Asian	_____ %
Black/African American	_____ %
Native Hawaiian/Other Pacific Islander	_____ %
White	_____ %

b. What is the age distribution of the currently enrolled population indicated in Question 13?

Under 18 years old	_____ %
18–25 years old	_____ %
25–50 years old	_____ %
Over 50 years old	_____ %
TOTAL	100%

17. During the past 6 months, what was the average number of patients enrolled in methadone/LAAM/buprenorphine treatment at your OTP on any given day?

_____ patients enrolled on any given day

a. During the past 6 months, what percentage of patients were receiving:

Methadone treatment?	_____ %
LAAM treatment?	_____ %
Buprenorphine treatment?	_____ %
Other? (Specify _____)	_____ %
TOTAL	100%

b. During the past 6 months, what percentage of patients were receiving treatment for:

Heroin?	_____ %
Oxycodone products?	_____ %
Morphine products?	_____ %
Other? (Specify _____)	_____ %

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

23. To what extent has achieving accreditation had the following effects?
Please mark one box for each row.

	Not at all	To some extent	To a great extent
a. Require additional documentation of patient progress			
b. Enhance the efficiency of this OTP's treatment			
c. Improve coordination of care or improved case management			
d. Improve the treatment practices of this OTP			
e. Require new quality assurance procedures			
f. Hinder staff from performing their daily activities			
g. Lead to the purchase of additional computer equipment			
h. Require increased monitoring of patient outcomes			
i. Require this OTP to do more with fewer resources			
j. Improve the ability of staff to monitor patient progress			
k. Improve links with community resources or referrals			
l. Improve safety			
m. Increase patient participation in OTP planning			
n. Increase patient participation in individual treatment planning			

24. Now that at least 6 months has passed since your accreditation survey, what has been the overall impact of accreditation on your OTP?

- _____ Significantly improved the program
- _____ Somewhat improved the program
- _____ No impact
- _____ Somewhat worsened the program
- _____ Significantly worsened the program
- _____ Don't know

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

25. Please indicate which of the following has occurred in the past 6 months and the impact it has had on your OTP.

	Occurred	Did not occur	Impact on OTP		
			Positive	No change	Negative
a. An agency reorganization					
b. Change in the program, medical, or OTP director					
c. Change in OTP ownership					
d. Change in program or OTP treatment methods/philosophy					
e. OTP joined a coalition or provider association					
f. A net reduction in direct care staff					
g. A net reduction in other staff					
h. A net increase in direct care staff					
i. A net increase in other staff					
j. A general reduction in OTP services					
k. A general expansion of OTP services					
l. Wage or salary reductions					
m. Fringe benefit reductions					
n. Extensive staff turnover					
o. Wage or salary increases					
p. Fringe benefit increases					
q. Decreased staff turnover					
r. Other major events					
s. Any new state or local laws or regulations that affected OTP operations					
t. Change in documentation activities					

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

26. Please estimate how much time each of these activities requires of various staff in an average month (*enter 0 if appropriate*).

	Management staff	Physician	Nurse	Counselor	Other clinical staff	Administrative staff
a. Staff meetings related to accreditation	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
b. Staff meetings	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
c. Staff training	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
d. Review/update of record keeping procedure	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
e. Record keeping	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
f. Review/update of treatment plans or continuing care plans and procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
g. Implementing treatment plans or continuing care plans and procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
h. Review/update of admission procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
i. Implementing admissions procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
j. Review/update of procedures for storage of controlled substances	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
k. Appropriate storage of controlled substances	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
l. Review/update of facilities	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
m. Maintenance of facilities	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
n. Staff supervision	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
o. Review/update of quality assurance plan	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
p. Quality assurance	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
q. Program administration	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
r. Review/update of community relations procedures	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
s. Community relations	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
t. Review/update of diversion control plan	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
u. Diversion control	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
v. Other activities related to maintaining accreditation (Specify _____)	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
w. Other nonaccreditation activities (Specify _____)	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

27. Please estimate how much time each of these direct patient services requires of various staff in an average month (*enter 0 if appropriate*).

	Management staff	Physician	Nurse	Counselor	Other clinical staff	Administrative staff
a. Initial patient assessment	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
b. Treatment planning	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
c. Initial medical services	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
d. Methadone dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
e. LAAM dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
f. Buprenorphine dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
g. Ongoing medical services other than methadone/LAAM/buprenorphine dosing	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
h. Individual, couples, and family counseling	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
i. Group counseling	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
j. Case management	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
k. Patient administration	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
l. Urinalysis	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
m. Childcare	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.
n. Other patient activities (Specify _____)	hrs.	hrs.	hrs.	hrs.	hrs.	hrs.

Treatment Services

Dosing

28. What is the usual dose of methadone that your OTP currently prescribes for patients at admission?
_____ mg/day usual dose at admission

29. Of your OTP's current methadone patients who have been in treatment for at least 2 weeks, what percentage receive the following doses:

Less than 40 mg	_____ %
40-59 mg	_____ %
60-79 mg	_____ %
80-99 mg	_____ %
100 mg or more	_____ %
TOTAL	100%

30. What is the largest dose of methadone your OTP currently prescribes for patients during maintenance?
_____ mg/day maximum dose during maintenance

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

31. Which of the following determine the maximum dose a patient can receive?

Please mark all that apply.

- State government policy
- Local government policy
- OTP/program policy
- Payer or reimbursement guidelines
- Medical decision
- Other (Specify _____)

32. Which of the following determine the maximum length of time that a patient can spend in methadone/LAAM/buprenorphine treatment at your OTP?

Please mark all that apply.

- State government policy
- Local government policy
- OTP/program policy
- Payer or reimbursement guidelines
- Medical decision
- Other (Specify _____)

33. How often are patients informed when their methadone/LAAM/buprenorphine dose level is changed?

- Never
- Rarely
- Sometimes
- Frequently
- Always

34. How much do patients influence decisions about their dose level?

- Not at all
- A little
- To some extent
- To a great extent

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

Treatment Planning

35. In which of the following areas are all patients assessed when they enter treatment?

Please mark all that apply.

- Substance use history
- Substance abuse treatment history
- Psychiatric health and functioning
- Social environment
- Education/work history
- Physical or sexual abuse history
- Physical health and functioning
- Criminal justice history
- Spirituality
- Other (Specify _____)

36. What standardized assessment instruments do the staff at your OTP use to assess patients at admission?

Please mark all that apply.

- Addiction Severity Index (ASI)
- CAGE or CAGEAID
- Structured Clinical Interview (SCID)
- Diagnostic Interview Schedule (DIS)
- Beck Depression Inventory
- Instrument developed by your OTP or program
- Other (Specify _____)
- None

37. Which, if any, of the following criteria do staff at your OTP use to evaluate and place patients in treatment?

Please mark all that apply.

- American Society of Addiction Medicine criteria
- DSM-IV criteria
- Criteria developed by your OTP or program
- Different criteria depending on the managed care organization
- Other (Specify _____)
- None

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

Compliance with Treatment Regimen

38. a. How many discharges did your OTP have in the past 3 months?

_____ discharges

b. Of all discharges in the past 3 months, please indicate the percentage of patients discharged for the following reasons:

- | | | |
|-------------------------------------|--------------|-------------|
| 1. Completed treatment | _____ | % |
| 2. Withdrew/stopped coming | _____ | % |
| 3. Transferred to another program | _____ | % |
| 4. Moved | _____ | % |
| 5. Discharged due to noncompliance | _____ | % |
| 6. Incarcerated/placed in detention | _____ | % |
| 7. Hospitalized for physical health | _____ | % |
| 8. Hospitalized for mental health | _____ | % |
| 9. Insurance coverage expired | _____ | % |
| 10. Patient deceased | _____ | % |
| 11. Other (Specify _____) | _____ | % |
| 12. Information not available | _____ | % |
| TOTAL | _____ | 100% |

39. Of all patients discharged in the past 3 months, what percentage were discharged as a result of disciplinary action? (Examples of disciplinary action include discharging a patient because of consistent positive testing for heroin, poor behavior in the clinic, violence, missed methadone dose, failed take-home call back, not paying fees, or refusing to go to a higher level of care).

_____ %

40. In the past 3 months, what was the approximate “no show” rate of patients to any of their appointments?

_____ missed appointments per patient

41. How likely is it that the clinical staff would use each of the following actions in response to a patient having two consecutive positive urines for opioids, two or more nonconsecutive positive urines for opioids, or testing negative for methadone?

Please mark one box for each row.

	Extremely likely	Somewhat likely	Somewhat unlikely	Extremely unlikely
a. Verbal reprimand				
b. Loss of privileges				
c. Revision to treatment plan				
d. Dose increase				
e. Discharge				
f. Monetary penalty				
g. Counseling session(s)				
h. Other (Specify _____)				

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

42. a. Does your OTP officially discharge patients after missing a number of doses or treatment sessions? *Please mark one choice for each row and, if yes, indicate the number of doses or treatment sessions a patient can miss before being discharged.*

	Yes	No	If yes, number of missed doses/sessions
Doses			
Treatment sessions			

⇒ If “no” is marked for both, skip to Question 43.

- b. How long does your OTP typically wait before officially discharging the patient?

Please mark only one choice.

- 3–7 days
 8–14 days
 15–30 days
 More than 30 days
 Varies, rely on counselor’s discretion

43. For any patient who engages in one of the following actions, how likely is it that your OTP will discharge the patient before he or she completes treatment?

Please mark one box in each row.

	Extremely likely	Somewhat likely	Somewhat unlikely	Extremely unlikely
a. Using illicit drugs				
b. Being arrested for illegal activities other than using illicit drugs				
c. Missing counseling or therapy sessions				
d. Missing dosing appointments				
e. Failure to pay for treatment				
f. Violent behavior on site				
g. Sexual activity on site				
h. Attempted diversion of methadone				
i. Diverting methadone				
j. Violating site rules or regulations other than those indicated above (Specify _____ _)				
k. Abusing alcohol				
l. Other reasons (Specify _____)				

Take-Home Privileges

44. Does your OTP ever give methadone patients take-home privileges?

- Yes
 No ⇒ *Skip to Question 49*

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

45. What form of methadone is distributed to patients with take-home privileges?

Please mark all that apply.

- Solid (pill)
 Liquid

46. Is this form of methadone consistent across all patient situations?

- Yes
 No ⇨ (Please explain: _____)

47. What percentage of each of the following groups of patients who are currently enrolled for methadone treatment at your OTP have take-home privileges at the levels shown below?

Percentages should sum to 100% across each row.

	No privileges	1 dose/wk	2 doses/wk	3 doses/wk	4–6 doses/wk	7 or more doses/wk	Total
In treatment less than 3 months							100%
In treatment 3–6 months							100%
In treatment 6–9 months							100%
In treatment 9–12 months							100%
In treatment 1–2 years							100%
In treatment over 2 years							100%

48. How often do staff at your OTP revoke take-home privileges if a patient is suspected of diverting methadone?

- Never
 Rarely
 Sometimes
 Frequently
 Always

49. Which of the following methods does your OTP typically rely on to discourage diversion of methadone?

Please mark all that apply.

- Strict OTP policies recommending or requiring patient discharge for diversion of methadone
 Management staff review/monitor the methadone dispensing records
 Observe patients as they take their methadone
 Systematic observation by security or site staff of the OTP and surrounding area
 Enforcing a policy of no loitering on site premises
 Systematically make patients aware of risks and consequences of diverting methadone
 Empty bottle return
 Other (Specify _____)

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

Urine Testing

50. According to your OTP's policy, how often does your OTP collect patient urine samples?

Please mark only one choice.

- Never ⇒ *Skip to Question 53*
- Less than 1 time per month
- 1 time per month
- 2 times per month
- 3 times per month
- 4 times per month
- 5 or more times per month
- Other (Specify _____)

51. How does your OTP select patients for urine testing?

- All selected at random
- Some selected at random and some specifically identified
- All specifically identified

52. Which of the following quality control (QC) procedures does your OTP use as part of its urine collection procedures?

Please mark all that apply.

- Observation (either in person or through a mirror)
- Monitoring using a video camera
- Do not have running water in urine sampling area
- Use of blue toilet water
- Checking urine temperature
- Other (Specify _____)

Patient Outcomes

53. Which of the following patient outcome measures are tracked on a regular basis at your OTP?

Please mark all that apply.

- Heroin use
- Involvement with criminal justice system
- Nonopioid drug use (stimulants, cannabis, alcohol, and other drugs)
- Retention in treatment
- Amount of income
- Sources of income
- Living arrangement
- Satisfaction with services
- Employment
- Other (Specify _____)

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

54. How does your OTP collect information on patient outcomes?

Please mark all that apply.

- Patient questionnaires
- In-person interviews
- Telephone interviews
- Other (Specify _____)

55. Does your OTP use a computerized system to track patient outcomes?

- Yes ⇨ What system are you using? _____
- No

Quality Assurance

56. In which of the following activities does your OTP engage as part of its QA system?

Please mark all that apply.

- Hold regular staff meetings to discuss patients
- Review patient charts selected at random to check for record completeness
- Review patient charts selected at random to compare services received with treatment plans
- Collect data on indicators of treatment outcomes and monitor trends
- Assess effectiveness of actions taken to correct identified problems
- Communicate relevant information about QA problems to key staff
- Review records of patients who leave the program against medical advice or who are discharged because of rule violations
- Review records of patients with special serious conditions
- Review records of patients with staff in cases of patient death or other adverse events
- Assess patient satisfaction with treatment services
- Solicit suggestions on how to improve services
- Peer review
- Presentation of case studies
- Other (Specify _____)

57. What sources of information do staff at your OTP use in QA meetings?

Please mark all that apply.

- Verbal information from staff in attendance
- Written information prepared specifically for the meeting
- Patient charts
- Information from this OTP's or program's data system
- Information from state's data system
- MTQAS quarterly feedback
- Other (Specify _____)
- No QA meeting

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

Emergency Planning

58. Does your OTP have a disaster plan or plan for emergency administration of medication?

Yes

No ⇒ *Skip to Question 59*

a. What does your emergency plan include?

Please mark all that apply.

Keeping a backup copy of up-to-date patient identification and dosing information off site (electronic or hard copy)

Establishing relationships with other methadone providers to service your OTP's clients in cases of emergency

Other (Please specify _____)

b. Please indicate how clients at your OTP are informed of the emergency plan (***mark all that apply.***).

New patient orientation

Patient handbook

Practice drills

Other (Please specify _____)

c. Please indicate how staff at your OTP are informed of the emergency plan (***mark all that apply.***).

New staff orientation

Training sessions

Practice drills

Other (Please specify _____)

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

Overall Impressions

Please have the appropriate staff members complete items 59-62.

59. Overall Impressions of Accreditation Process—*to be completed by Program Manager/Director*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

60. Overall Impressions of Accreditation Process—*to be completed by Clinician-Nurse or Physician*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

61. Overall Impressions of Accreditation Process—*to be completed by Counselor*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

**Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire**

62. Overall Impressions of Accreditation Process—*to be completed by Medical Director*

How strongly do you agree or disagree with the following?

Please mark one box for each row.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information I have about treatment planning is better now than before accreditation.					
The quality of treatment planning is better now than before accreditation.					
Accreditation caused more problems than it fixed.					
Patients are happier and more satisfied now than before accreditation.					
Record keeping requirements are tougher now than before accreditation.					
Accreditation improved the treatment environment.					
This OTP handles grievances and rule violations in a more objective and clear fashion now than before accreditation.					
Preparing for accreditation was burdensome.					
Coordinating the logistics of the accreditation visit (e.g., scheduling staff time, communicating with the accrediting body) was burdensome.					
The effort associated with maintaining accreditation standards is not as bad as the effort required when preparing for the accreditation visit.					
The array of services offered is better now than before accreditation.					
Accreditation solved more problems than it caused.					
If I had a choice, I would rather work in a program that is accredited than one that is not.					

Do you have any additional comments about the accreditation process?

THANK YOU FOR YOUR TIME!

Opioid Treatment Program Accreditation Evaluation
OTP Followup Questionnaire

Form Approved
OMB NO. 0930-0254
Exp. Date 12/31/05

**OTP FOLLOWUP
QUESTIONNAIRE**

Site ID _____

Date Completed: ____/____/____

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 1.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0254); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0254.

APPENDIX C: PATIENT QUESTIONNAIRE

The Patient Questionnaire was intended to provide a patient perspective to the evaluation and, as feasible, to validate information collected from the OTP questionnaires. Topics that were addressed in the Patient Questionnaire included satisfaction with services received, assessment of treatment received, and patient demographics.

Opioid Treatment Program Accreditation Evaluation

Patient Questionnaire

Conducted by:
NGIT Health Solutions and Services
1700 Research Boulevard, Suite 400
Rockville, MD 20850

Conducted for:
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD 20852

September 2003

Site ID: _____ **Client ID:** _____

Date Completed: ____/____/____

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx.

Interviewer: _____ Start Time: _____ End Time: _____

**Opioid Treatment Program Accreditation Evaluation Project
Patient Questionnaire**

Current treatment information

1. How long have you been in treatment at this program? (Please think of only your current treatment episode).

_____ # months _____ # years

2. Have you been in opioid addiction treatment (that is, methadone, LAAM, or buprenorphine treatment) before?

Yes 1
No..... 2 (Skip to question 4)

3a. How many total years have you been in opioid addiction treatment? _____

3b. Where did you receive opioid addiction treatment before?

At the current program..... 1 (Skip to question 3d)
Different program 2
Both..... 3
Skipped 66

If received treatment at different program previously: (i.e. answered 2 OR 3 to question 3b ask...

3c. How many different programs have you received treatment at? _____

If received treatment at current program previously: (i.e. answered 1 OR 3 to question 3b ask...

3d. How many previous times have you been in treatment at this OTP? _____

4. Are you receiving Methadone/LAAM/Buprenorphine treatment at this clinic for heroin or oxycontin use?

Heroin 1 (Skip to question 5)
Oxycontin..... 2 (Skip to question 5)
Both heroin and oxycontin..... 3 (Skip to question 5)
Neither heroin nor oxycontin 4



4b. What are you receiving treatment for? _____

5. To what extent does your treatment plan meet all of your treatment needs?

Completely	1
To some extent	2
Not at all	3
Refused	77

6. Do you feel that you are treated with as much respect as you would like?

Yes	1
No	2

7. How would you rate the clinic's treatment of patients, especially those with special needs such as patients who are disabled, pregnant, or with co-occurring disorders (more than one disorder at the same time)?

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5
Refused	77
Don't Know	88

8. How satisfied are you with your take-home schedule?

Very satisfied	1
Somewhat satisfied	2
Not satisfied	3
Refused	77
Not Applicable	99

9. We would like to know if, during your current treatment at this program, you have received any of the following services through this clinic directly or through referral to another program. We would also like to know if you received the services in the last 30 days and if you were satisfied with the services. (Interviewer: Mark an “X” in the appropriate box for each service listed).

To interviewer: if No in column 1, skip to next service.

	Received service since in the current program?					Received service in the last 30 days?		How satisfied with service?			
	Yes, at clinic (1)	Yes, from another provider by referral (2)	Yes, from another provider but <u>not by referral</u> (3)	No, offered but didn't need (4)	No, not offered (5)	Yes (1)	No (2)	Very satisfied (1)	Somewhat satisfied (2)	Not satisfied (3)	Refused (77)
a. An interview by an OTP staff person about substance abuse, mental health issues or social issues (i.e. Psychosocial assessment)											
b. Medical exam (physical to assess health status, including medical history, checking vital signs, lab tests, etc.)											
c. Psychiatric evaluation or other psychiatric services											
d. Any type of substance abuse counseling (individual, group, etc.)											

	Received service since in the current program?					Received service in the last 30 days?		How satisfied with service?			
	Yes, at clinic (1)	Yes, from another provider by referral (2)	Yes, from another provider but <u>not by referral</u> (3)	No, offered but didn't need (4)	No, not offered (5)	Yes (1)	No (2)	Very satisfied (1)	Somewhat satisfied (2)	Not satisfied (3)	Refused (77)
e. Any other type of mental health counseling not provided by a psychiatrist (individual, group, etc.)											
f. Any other type of counseling (family, spiritual, etc.)											
g. AIDS/HIV medical treatment, testing, or counseling											
h. Assistance with finances											
i. Case Management and referral											
j. Child care services											
k. Other services: Housing/shelter, food services, transportation, educational and/or vocational services, legal assistance											
l. Discharge planning or after care											

	Received service since in the current program?					Received service in the last 30 days?		How satisfied with service?			
	Yes, at clinic (1)	Yes, from another provider by referral (2)	Yes, from another provider but <u>not by referral</u> (3)	No, offered but didn't need (4)	No, not offered (5)	Yes (1)	No (2)	Very satisfied (1)	Somewhat satisfied (2)	Not satisfied (3)	Refused (77)
m. Individual treatment planning											
n. Treatment for alcohol dependence or substance abuse other than heroin or other opiates											
o. Peer support or self-help groups											
p. Other (specify: _____)											

10. As a part of your treatment, did you receive education in any of the following?
(Interviewer: For each item listed, please circle 1 if the patient received education on that topic or 2 if he/she did not).

	Yes	No	N/A
a. Signs and symptoms of overdose and when to seek emergency assistance	1	2	
b. The medication you are taking and its side effects	1	2	
c. The nature of addictive disorders	1	2	
d. The benefits of treatment	1	2	
e. Clinic guidelines, rules, services and regulations; treatment planning; consequences of noncompliance	1	2	
f. Your rights as a patient	1	2	
g. The confidentiality of your records	1	2	
h. Drug-screening and urinalysis procedures	1	2	
i. HIV/Hepatitis C prevention (such as sexual behavior, safe needle practice, needle exchange program)	1	2	
j. Relapse prevention	1	2	
k. After care	1	2	99
l. Parenting skills; Childcare and prenatal issues	1	2	99
m. How to file a grievance/complaint	1	2	
n. Potential drug interactions	1	2	

11. I am going to read you a list of statements about how the clinic handles various issues in treatment. For each statement, please tell me whether the statement is mostly true or mostly false.

	Mostly True	Mostly False
a. Treatment of patients is respectful and safe.	1	2
b. Bathrooms and other physical arrangements reflect the specific needs of patients.	1	2
c. Counselors are well informed about the special needs of patients in treatment.	1	2
d. Patients are assigned counselors who can help them with individual issues such as domestic violence, sexual abuse, etc.	1	2
e. Single-sex groups are available to all patients.	1	2

12. In the past 3 months, how often have you been involved in decisions about your methadone/LAAM/buprenorphine dosing?

- Never0
- Rarely 1
- Sometimes2
- Often.....3
- Most or all of the time.....4

12b. Do you feel your methadone/LAAM/buprenorphine dose is too high, too low, or just right?

Too high 1
Just right..... 2
Too low..... 3
Refused.....77

13. In the past 3 months, how often have you been involved in decisions about the counseling services you receive?

Never 0
Rarely 1
Sometimes 2
Often..... 3
Most or all of the time..... 4

14. In the past 3 months, how often have the clinic staff treated you unfairly?

Never 0
Rarely 1
Sometimes 2
Often..... 3
Most or all of the time..... 4
Refused 77

14.b. If a member of the staff treated you unfairly, would you be comfortable filing a complaint in writing to the OTP management?

Yes 1
No..... 2

15. Overall, how would you rate your treatment in this clinic during the past 3 months?

Excellent 1
Very good 2
Good..... 3
Fair..... 4
Poor 5
Refused 77

Health status

16. In general, how would you describe your current health?

Excellent..... 1
Very good..... 2
Good 3
Fair 4
Poor 5
Refused... ..77
Don't Know.....88

17. In the past 3 months, how many nights did you spend in the hospital for ...

_____ Physical health reasons (# nights)?

_____ Substance abuse reasons (# nights)?

_____ Mental health reasons (# nights)?

18. In the past 3 months, how many nights did you spend at a detoxification facility?

_____ # nights

19. In the past 3 months, how many times did you visit an emergency room for any kind of treatment?

_____ # times

20. In the last 30 days, how often did you...

	Not at all (1)	Only once (2)	2-3 days for the month (3)	1-2 days a week (4)	3-6 days a week (5)	Daily (6)	Refused (77)
a. Drink alcohol?							
b. Smoke marijuana?							
c. Use cocaine or crack?							
d. Use heroin?							
e. Use painkillers?							
f. Use stimulants?							
g. Use tranquilizers?							
h. Use a needle to inject any illegal drug?							

21. Have you or someone you know ever bought or sold _____ on the street?

	Yes (1)	No (2)	Refused (77)
a. Methadone			
b. LAAM			
c. Buprenorphine			
d. Oxycontin			

22. Are you currently on probation or parole, currently awaiting charges/sentencing, or currently under the jurisdiction of the criminal justice system in any way?

Yes1
 No.....2
 Refused.....77

23. Are you currently in treatment as part of a probation or parole stipulation, or otherwise legally mandated to treatment?

- Yes1
- No.....2
- Refused.....77

24. How many times have you been arrested in the past 3 months, if at all?

- _____ # times
- Refused (77)

25. Which of the following categories best describes what you were doing most of last week?

(Only check one) Hand respondent the response card

- Working for pay**1 *(Skip to Question 26)*
- Ill, disabled, or unable to work**2 *(Skip to Question 27)*
- Retired**.....3 *(Skip to Question 27)*
- Taking care of home or family**.....4 *(Skip to Question 27)*
- Going to school**5 *(Skip to Question 27)*
- Trying to find employment**6 *(Skip to Question 27)*
- Incarcerated**.....7 *(Skip to Question 27)*
- Hanging out**8 *(Skip to Question 27)*
- Other**9

25b. (If other) What words best describe what you were doing most of last week?

_____) *(Skip to Question 27)*

26. Do you usually work 35 or more hours per week?

- Yes1 *(Skip to Question 27)*
- No.....2
- Skipped66

26b. How many hours per week do you usually work? _____

27. Do you have health insurance, including Medicaid, Medicare, or VA?

- Yes1
- No.....2 *(Skip to Question 30)*

28. What type of health insurance do you have?

- Medicaid**.....1 *(Skip to question 29)*
- CHAMPUS, VA, or military health**2 *(Skip to question 29)*
- Medicare**3 *(Skip to question 29)*
- Private health insurance**.....4 *(Skip to question 29)*
- Other**5
- Skipped66

28b. (If other) Please describe the insurance you have _____

29. Is your methadone/LAAM/buprenorphine treatment paid for by the insurer you just named?

- Yes1
- No.....2
- Skipped66

Patient Demographics

30. What is your age? ____ yrs.

31. Are you of Spanish or Hispanic origin?

- Yes.....1
- No.....2

32. What race do you consider yourself to be? (Patient may select one or more of the choices.)

- American Indian or Alaska Native.....1
- Asian2
- Black or African American3
- Native Hawaiian or Other Pacific Islander4
- White5

33. Gender: (*Observation*)

- Male1
- Female.....2

Thank you for taking the time to participate in this survey. Have a great day!

APPENDIX D: CHART ABSTRACTION FORM

The goal of the chart abstraction data collection effort was to assess limited patient outcomes. A Chart Abstraction Form was developed in which to enter information on a patient's treatment history at the OTP (including current dose) and data on his or her urinalysis test results and oral fluid test results.

Form Approved
OMB NO. 0930-0254
Exp. Date 12/31/05

Opioid Treatment Program Accreditation Evaluation

Chart Abstraction Form

Conducted by:
NGIT Health Solutions and Services
1700 Research Boulevard, Suite 400
Rockville, MD 20850

Conducted for:
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD 20852

September 2003

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 1 hour per site visit for pulling and re-filing patient charts. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx.

Site ID: _____ Today's Date: ____/____/____
 NGIT client ID: _____ NGIT Team Member: _____

I. Treatment History at Current OTP

Start date of current treatment episode: _____

Medication used in treatment:

- Methadone _____
- LAAM _____
- Buprenorphine _____
- Other (Specify _____) _____

Current dose (today's date): _____mg

II. Urinalysis Records

Record the following information regarding the client's urine test results for the past 6 months since today's date:

Results of urine tests (Mark with an X if substance found)								
	Dates of tests	Reason for Testing*	Codeine	Morphine	Methadone, methadone metabolite (EDDP)	Other opiate or metabolite (Specify ____)	Cocaine	Other drug or metabolite (Specify ____)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Key for reasons: **S** = suspected other drug use **R** = random/spot testing

III. Oral Fluid Test Records

Record the following information regarding the client's oral fluid test results for the past 6 months since today's date:

Results of urine tests (Mark with an X if substance found)								
	Dates of tests	Reason for Testing*	Codeine	Morphine	Methadone, methadone metabolite (EDDP)	Other opiate or metabolite (Specify ____)	Cocaine	Other drug or metabolite (Specify ____)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Key for reasons: **S** = suspected other drug use **R** = random/spot testing

APPENDIX E: DISCHARGE RECORD ABSTRACTION FORM

A review of the records of recently discharged patients was undertaken to assess the OTPs' discharge practices in terms of length of treatment and reason for discharge. The Discharge Record Abstraction Form contained fields to capture the dates of admission and discharge and the reason for the discharge.

Opioid Treatment Program Accreditation Evaluation

Discharge Record Abstraction Form

Conducted by:
NGIT Health Solutions and Services
1700 Research Boulevard, Suite 400
Rockville, MD 20850

Conducted for:
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD 20852

September 2003

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 1 hour per site visit for pulling and re-filing patient charts. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx.

Site ID: _____

Today's Date: ___/___/___

NGIT Team Member: _____

Record the following information for patients most recently discharged from the OTP.

	Date Admitted	Date Discharged*	1 Completed treatment	2 Withdrew/ stopped coming/ dropped out	3 Transferred to another program	4 Moved	5 Non-compliance	6 Incarcerated	7 Hospitalized for physical health	8 Hospitalized for mental health	9 Non-payment	10 Deceased	11 Other (Specify)	12 Against medical advice	13 Info not available
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															
16															
17															
18															
19															
20															

*Define "discharge" however the site defines it (e.g. date case was closed, date of last dose, etc.)

APPENDIX F: STAFF ACTIVITY LOG

The Staff Activity Log included lists of personnel activities to be tracked on a weekly basis for up to 6 months. These logs included both patient-level activities related to the provision of services and general activities related to maintaining accreditation (e.g., staff meetings, training seminars, implementation of clinical procedures). Template spreadsheets for aggregate cost data were created in both paper and electronic formats. The activity logs aimed to enhance the study's cost analyses by permitting costs to be assigned to each of the staff and activities included in the logs.

Daily Staff Activity Log (from staff to site activity log contact)

Site ID: [prefilled] **Staff ID:** [from NGIT]
Period Covered: [insert week] **Staff Job** [from Job Code List]
Date Completed: [insert date]

Record how much time you spent on this activity each day (round to the nearest 15 min.):

Service Codes:	<u>Patient Services:</u>	Sat.	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Total
01	Initial patient assessment								
02	Treatment planning								
03	Initial medical services								
04	Methadone dosing								
05	LAAM dosing								
06	Buprenorphine dosing								
07	On-going medical services other than methadone/LAAM/ buprenorphine dosing								
08	Individual, couples, and family counseling								
09	Group counseling								
10	Case management								
11	Patient administration								
12	Urinalysis								
13	Childcare								
14	Other--Patient activities								
<u>Accreditation Preparation Activities:</u>									
15	Staff meetings								
16	Training								
17	Reviewing/Updating records keeping								
18	Reviewing/Updating treatment plans or continuing care plans and procedures								
19	Reviewing/Updating admissions procedures								
20	Reviewing/Updating storage of controlled substances								
21	Reviewing/Updating facilities								
22	Developing quality assurance plan								
23	Preparing accreditation application								
24	Communication with accrediting body								
25	Preparation of OTP documentation								
26	Mock survey from accrediting body								
27	Reviewing/Updating community relations procedure								
28	Reviewing/Updating diversion control plan								
29	Other--Accreditation preparation activities								
<u>Non-Direct/Non-Accreditation Activities:</u>									
30	Staff meetings								
31	Training								
32	Records keeping								
33	Implementing treatment plans or continuing care plans and procedures								
34	Implementing admissions procedures								
35	Appropriate storage of controlled substances								
36	Maintenance of facilities								
37	Staff supervision								
38	Quality assurance								
39	Program administration								
40	Community relations								
41	Diversion control								
42	Other--Non-direct activities								

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 6 minutes per day, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information (including instructions for data providers, send comments to Washington, DC 20543-0182); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0254.

Weekly Staff Summary Log (from activity log contact to NGIT staff)

Site ID: [prefilled]
Period Covered: [drop-down week]
Date Completed: [insert date]

Please indicate the total time (hours) spent by your staff on these **activities** during the past week.

	Insert Staff IDs:-->								
Activity Code:									
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									
37									
38									
39									
40									
41									
42									
Totals									

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 1 hour per week, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0254); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0254.

Service Codes	Patient Services
01	Initial patient assessment
02	Treatment planning
03	Initial medical services
04	Methadone dosing
05	LAAM dosing
06	Buprenorphine dosing
07	On-going medical services other than methadone/LAAM/buprenorphine dosing
08	Individual, couples, and family counseling
09	Group counseling
10	Case management
11	Patient administration
12	Urinalysis
13	Childcare
14	Other--Patient activities
Accreditation Preparation Activities	
15	Staff meetings
16	Training
17	Reviewing/Updating records keeping
18	Reviewing/Updating treatment plans or continuing care plans and procedures
19	Reviewing/Updating admissions procedures
20	Reviewing/Updating storage of controlled substances
21	Reviewing/Updating facilities
22	Developing quality assurance plan
23	Preparing accreditation application
24	Communication with accrediting body
25	Preparation of OTP documentation
26	Mock survey from accrediting body
27	Reviewing/Updating community relations procedure
28	Reviewing/Updating diversion control plan
29	Other--Accreditation preparation activities
Non-Direct/Non-Accreditation Activities	
30	Staff meetings
31	Training
32	Records keeping
33	Implementing treatment plans or continuing care plans and procedures
34	Implementing admissions procedures
35	Appropriate storage of controlled substances
36	Maintenance of facilities
37	Staff supervision
38	Quality assurance
39	Program administration
40	Community relations
41	Diversion control
42	Other--Non-direct activities

Service Definitions

Service Code	Patient Services	Service Definition
01	Initial patient assessment	pre-admittance interview/screening of social history, abuse profile, and other problems. It includes initial assessment, and psychosocial evaluation.
02	Treatment planning	treatment and medication planning.
03	Initial medical services	initial medical exam including medical history, vital signs, and initial laboratory testing.
04	Methadone dosing	includes preparation for, handing out, and closing down of actual methadone dosing.
05	LAAM dosing	includes preparation for, handing out, and closing down of actual LAAM dosing.
06	Buprenorphine dosing	includes preparation for, handing out, and closing down of actual Buprenorphine dosing.
07	On-going medical services other than methadone/LAAM/buprenorphine dosing	medical services such as urinalysis, HIV testing, other laboratory services, medical supplies and medicines (excluding methadone/LAAM/buprenorphine). This refers to medical services that occur after initial medical services. This includes monitoring and reporting of these services.
08	Individual, couples, and family counseling	one-on-one meeting with counselor; includes review of treatment plan progress and discussions about patient specific problems. Meetings can be with patient, and/or patient's significant other, and/or patient's family. These three types of counseling are grouped together because each of them is related to a single patient.
09	Group counseling	facilitated sessions presented to multiple patients with discussion and visual aids focusing on disease progression, denial, recovery, attitudes, spirituality, relaxation, coping, and support.
10	Case management	includes activities related to helping patients access for housing, legal, education, medical, income, and other problems. It also includes outreach/ancillary services such as transportation to and from treatment, recruitment of patients, educational services, vocational services, HIV/AIDS education, life skills training, parenting skills, problem-solving, self-help group meetings (e.g., AA), and other educational services. The educational services included in this category are over and above such services that may be presented in counseling sessions.
11	Patient administration	includes clinical administrative activities directly related to patient's treatment (e.g., clinical notes, incidence reports, arranging meetings with patients).
12	Urinalysis	testing procedure used to monitor and evaluate patient's progress in treatment. Urine samples can be tested for opiates, methadone, amphetamines, cocaine, barbiturates or any other drug based on individual patient need. This includes monitoring and reporting of this service.
13	Childcare	includes childcare services provided while patient is receiving services on-site at your program.
14	Other--Patient activities	includes any other tasks not included in the above categories
Accreditation Preparation Activities		
15	Staff meetings	includes staff discussions related to the accreditation process
16	Training	includes staff training and education related to the accreditation process
17	Reviewing/Updating records keeping	includes activities related to accurate documentation of individual treatment planning and patient treatment outcomes; record retention; and maintenance of patient confidentiality. Patient records includes the initial assessment report, narrative bio-psychosocial history, medical reports, dated case entries of all significant contacts with patients, dates and results of case conferences for patients, the treatment plan, correspondence with patient and family members, referrals, consent forms, and a closing summary.
18	Reviewing/Updating treatment plans or continuing care plans and procedures	includes activities related to assessing patient's progress through treatment. This refers to review of patient's treatment plan or continuing care plan, procedures to retain patient in treatment, and procedures to prevent relapse.
19	Reviewing/Updating admissions procedures	includes activities related to admission of patient. Such activities include determining treatment eligibility, developing a treatment plan, and establishing outcome measures. Applicant assessment includes physical examination, laboratory workup, psychosocial assessment, preliminary treatment plan, and patient orientation.
20	Reviewing/Updating storage of controlled substances	includes activities related to proper substance storage such as implementing appropriate security measures and maintaining accurate inventory of substance in stock at all times.
21	Reviewing/Updating facilities	refers to activities related to management of the facility and clinical environment. This includes ensuring sufficient space and adequate equipment is available on site; maintain a clean facility; ensuring protection of confidentiality by using secure storage methods; and providing services during hours that meet the needs of patient population.
22	Developing quality assurance plan	includes activities related to establishing quality assurance and improvement goals and action steps within the treatment program.
23	Preparing accreditation application	includes activities related to completing the application process such as acquiring the manual from accrediting body and completion of application.

Service Code	Patient Services	Service Definition
24	Communication with accrediting body	includes contact and consultation with accrediting body on any issue related to accreditation
25	Preparation of OTP documentation	includes activities related to documentation of staff development plans, program policies and procedures, periodic patient satisfaction surveys, and treatment outcome measures.
26	Mock survey from accrediting body	includes activities related to mock survey provided by accrediting body. Also refers to technical assistance provided by accrediting body.
27	Reviewing/Updating community relations procedure	includes any activities related to reviewing or updating community relations procedures. Community relations is defined in "Community relations" (number 40 below).
28	Reviewing/Updating diversion control plan	includes any activities related to reviewing or updating diversion control plan. Diversion control is defined in "Diversion control" (number 41 below).
29	Other--Accreditation preparation activities	includes any other task not included in the above categories
Non-Direct/Non-Accreditation Activities		
30	Staff meetings	includes staff discussions not related to the accreditation process
31	Training	includes staff training and education not related to the accreditation process
32	Records keeping	includes activities related to accurate documentation of individual treatment planning and patient treatment outcomes; record retention; and maintenance of patient confidentiality. Patient records includes the initial assessment report, narrative bio-psychosocial history, medical reports, dated case entries of all significant contacts with patients, dates and results of case conferences for patients, the treatment plan, correspondence with patient and family members, referrals, consent forms, and a closing summary.
33	Implementing treatment plans or continuing care plans and procedures	includes activities related to assessing patient's progress through treatment. This refers to review of patient's treatment plan or continuing care plan, procedures to retain patient in treatment, and procedures to prevent relapse.
34	Implementing admissions procedures	includes activities related to admission of patient. Such activities include determining treatment eligibility, developing a treatment plan, and establishing outcome measures. Applicant assessment includes physical examination, laboratory workup, psychosocial assessment, preliminary treatment plan, and patient orientation.
35	Appropriate storage of controlled substances	includes activities related to proper substance storage such as implementing appropriate security measures and maintaining accurate inventory of substance in stock at all times.
36	Maintenance of facilities	refers to activities related to management of the facility and clinical environment. This includes ensuring sufficient space and adequate equipment is available on site; maintain a clean facility; ensuring protection of confidentiality by using secure storage methods; and providing services during hours that meet the needs of patient population.
37	Staff supervision	refers to supervision of indirect clinical services and activities not related to accreditation. This also includes clinical case review, receiving clinical supervision, mentoring, and supervision of student interns.
38	Quality assurance	includes clinical case review, billing oversight, dispute resolutions
39	Program administration	includes administrative activities not directly related to a patient's treatment such as file review, answering phones, greeting patients, activities associated with obtaining reimbursements, and non-clinical activities associated with regulatory (federal, state, Local) or accreditation compliance.
40	Community relations	includes education of all entities impacted by the treatment program including the medical community, neighbors, and those who may provide supportive services. This also refers to developing and implementing a general set of practices, policies, and procedures that: elicit input from the community, open communication with community leaders such as local boards and businesses, and support a community relations plan.
41	Diversion control	includes activities to restrict the abuse of methadone/LAAM/buprenorphine outside the program.
42	Other--Non-direct activities	includes any other task not included in the above categories
		*It is often the case that case management and counseling occur during the same appointment. In such instances, document the time spent for the service the appointment is scheduled for. For example, if a counseling appointment is scheduled and during that appointment some case management occurs, document the time spent as an Individual, Couples, and Family Counseling service.

Job Type Codes	
01	Medical Director
02	Psychiatrist
03	Physicians
04	Registered Nurse (RN)
05	Nurse Practitioner (NP)
06	Other Licensed Nurse
07	Pharmacist
08	Physicians Assistant (PA)
09	Other Medical Personnel
10	Psychologist (MA)
11	Psychologist (Ph.D.)
12	Social Worker (MSW) - certified
13	Social Worker (MSW) - not certified
14	Social Worker (DSW) - certified
15	Social Worker (DSW) - not certified
16	Counselor BA or Above - certified
17	Counselor BA or Above - not certified
18	Counselor AA - certified
19	Counselor AA - not certified
20	Case Manager (certified)
21	Case Manager (non-certified)
22	Other Therapist or Rehabilitation Specialist
23	Teacher
24	Child Care Worker
25	Program Administrative
26	Clinical Supervisor
27	Team Leader
28	Clerical
29	Other-paid
30	Other-Volunteers
31	Student interns - unpaid

APPENDIX G: STAFF QUESTIONNAIRES

Interviews were conducted with various staff members to help distinguish between changes in program procedures that were initiated in response to accreditation versus those initiated in response to internally or externally generated desires to improve the program. Interview guides (see Appendix G) were developed containing relevant questions for different staff categories.

- Program Director/Administrative Staff
- Medical Director/Nursing Staff
- Counselor.

Opioid Treatment Program Accreditation Evaluation

Accreditation Questionnaire OTP Program Director/Administrative Staff

Conducted by:
NGIT Health Solutions and Services
1700 Research Boulevard, Suite 400
Rockville, MD 20850

Conducted for:
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD 20852

June 2003

OTP Staff ID _____

Date Completed: ____/____/____

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx.

OTP Staff ID: _____

NGIT Team Member: _____

This interview is being conducted as part of an evaluation process to help us assess the accreditation process, and to provide input into how the process might be improved. Any information that you share with me during this interview will remain confidential and will not be shared with anyone else. Also, to help ensure the accuracy of your responses, I will be recording the interview. Do you have any questions before we begin?

1. First, I'd like to talk to you about the accreditation process. Now that you've been surveyed, what are your opinions about the survey process?
2. Did you budget enough resources (staff time and funds) for completing the accreditation preparation process? Did you anticipate all the expenses you incurred?
3. How much did the materials, training, and technical assistance you received end up helping your program prepare for accreditation?
4. Now that you've gone through the survey process, what is your opinion about having to go through accreditation on an ongoing basis?
5. How has your role changed since the survey?
6. What were the most challenging aspects of the survey process for you and your program?
7. What suggestions can you make to improve the survey process?
8. How would you change the accreditation standards to better accommodate your program?
9. What changes did your program have to make in order to have a successful survey experience?
10. Would your program have made any of these changes in the absence of accreditation preparation?
11. What other effects has accreditation had on you and your program?
12. In what ways do accreditation and State certification / licensure differ?
13. In what ways is mandatory accreditation of OTPs nationwide benefiting the field?
14. Now I'd like to ask you to describe your program. How would you characterize your program's patient population? Have there been any changes since your program received accreditation?

15. How many staff does your program have, in what positions? Have there been any changes since your program received accreditation? Is this number of staff sufficient, or would you like to have more? If yes, what is preventing you from increasing the number of staff?
16. Where does your program receive its funding from? Have there been any changes since your program received accreditation?
17. One of the areas of interest for us is the relationship your program has with its neighbors, including community-based organizations (CBOs). What is your opinion about the relationships your program has with its neighbors? Have there been any changes since your program received accreditation?
18. How does community opinion of your program affect daily operations?
19. Does your program track patient outcomes, and, if so, in what way? Have there been any changes since your program received accreditation?

Opioid Treatment Program Accreditation Evaluation

Accreditation Questionnaire OTP Medical Director / Nursing Staff

Conducted by:
NGIT Health Solutions and Services
1700 Research Boulevard, Suite 400
Rockville, MD 20850

Conducted for:
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD 20852

June 2003

OTP Staff ID _____

Date Completed: ____/____/____

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx.

OTP Staff ID: _____

NGIT Team Member: _____

This interview is being conducted as part of an evaluation process to help us assess the accreditation process, and to provide input into how the process might be improved. Any information that you share with me during this interview will remain confidential and will not be shared with anyone else. Also, to help ensure the accuracy of your responses, I will be recording the interview. Do you have any questions before we begin?

1. How have your role and responsibilities changed since the program's accreditation survey? How do these changes make you feel?
2. What were the most challenging aspects of survey preparation for you?
3. What suggestions can you make about the process of accreditation that would make future survey preparation easier for you?
4. How has accreditation benefited your program?
5. One area of interest for us is clinical policies and practices. What is the program's current practices regarding dosing and take-home privileges? What changes have been made to the policies and procedures of dosing? Were these made specifically to prepare for accreditation, or would they have been made anyway?
6. In recent years, treatment planning has become an important issue. In what ways will your program need to change in order to meet the accreditation standards and improve the quality of the process of treatment planning?
7. What changes have been made to urine testing and the use of urine tests for patient management? In what ways have these changes affected your program? What is your opinion about these changes? Would they have been made in the absence of accreditation?
8. Now I'd like to ask you to describe your program. How would you characterize your program's patient population? Have there been any changes since the program received accreditation?
9. What is your opinion about the way this program treats patients? Has this changed since your program began preparing for accreditation? What improvements could be made?
10. How often are you at the program and what do you do when you are there? Has this changed since the program received accreditation? [Medical Director only]
11. One of the areas of interest for us is the relationship your program has with its neighbors, including community-based organizations (CBOs). What is your opinion about the relationships your program has with its neighbors? Have there been any changes in these relationships since your program received accreditation?

12. What are the barriers to fully effective treatment faced by patients?
13. What services does your program offer in-house? What services must a patient receive through referral? What services would you like to see added in-house? What changes have been made since the program began preparing for accreditation in the way treatment is provided to patients? What improvements could be made in the way treatment is provided at this program?
14. Are there any other potential changes you would like to discuss?
15. In what ways does your OTP currently meet the standards regarding the number and types of services delivered? What is your opinion about making changes to this area in order to become accredited?

Opioid Treatment Program Accreditation Evaluation

OTP Counselor Questionnaire

Conducted by:
NGIT Health Solutions and Services
1700 Research Boulevard, Suite 400
Rockville, MD 20850

Conducted for:
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD 20852

June 2003

OTP Staff ID _____

Date Completed: ____/____/____

Notice to Respondents

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx.

OTP Staff ID: _____

NGIT Team Member: _____

This interview is being conducted as part of an evaluation process to help us assess the accreditation process, and to provide input into how the process might be improved. Any information that you share with me during this interview will remain confidential and will not be shared with anyone else. Also, to help ensure the accuracy of your responses, I will be recording the interview. Do you have any questions before we begin?

1. How have your role and responsibilities changed since the program's accreditation survey? How do these changes make you feel?
2. What were the most challenging aspects of survey process for you?
3. What suggestions can you make about the process of accreditation that would make future survey preparation easier for you?
4. How has accreditation benefited your program?
5. What treatment services are provided at your program? What services are not provided that you think should be? Were services added as part of your program's survey preparation? If so, do you think they would have been added anyway?
6. What is your opinion about the patient to staff ratio and caseload? Do you feel that your OTP has an adequate number of staff to support treatment of patients at your OTP?
7. In recent years, treatment planning has become an important issue. In what ways did your program change in order to meet the accreditation standards and improve the quality of the process of treatment planning?
8. Now I'd like to ask you to describe your program. How would you characterize your program's patient population? Has this changed since your program received accreditation?
9. What is your opinion about the way this program treats patients? Has this changed since your program began preparing for accreditation? What improvements could be made?
10. One of the areas of interest for us is the relationship your program has with its neighbors, including community-based organizations (CBOs). What is your opinion about the relationships your program has with its neighbors? Have there been any changes in these relationships since your program received accreditation?
11. What are the barriers to fully effective treatment faced by patients?
12. What services does your program offer in-house? What services must a patient receive through referral? What services would you like to see added in-house? What changes have been made since the program began preparing for accreditation in the way treatment is provided to patients? What improvements could be made in the way treatment is provided at this program?

APPENDIX H: COST-EFFECTIVENESS QUESTIONS

1. Cost-effectiveness of accreditation
 - A. What is the cost of accreditation?
(While not a true cost-effectiveness question, this is both what many people think that “cost-effectiveness” means and a necessary precursor to true cost-effectiveness.)
 - i. Cost to the accreditation body?
Costs of the specific procedures followed by the accreditation body?
 - ii. Cost to the program?
Costs of the activities performed by the program for its initial accreditation?
Costs of the activities performed by the program for maintenance of current accreditation?
Costs of the activities performed by the program for reaccreditation?
 - B. What is the effectiveness of accreditation?
 - i. Does accreditation “work”?
What outcomes does accreditation impact significantly, and in the desired direction?
 - ii. What accreditation procedures lead to those outcomes?
Why do those accreditation procedures lead to those outcomes, i.e., which practices within the treatment program are responsible for those outcomes?

(*Note: Programs that did not change their practices adequately in response to accreditation, thus receiving limited or no accreditation, can be viewed as not having changed the processes that should lead to the desired outcomes of accreditation, i.e., better outcomes for clients; OR programs that did not use good accreditation preparation procedures [e.g., assigning a specific person to be in charge and releasing this person from other responsibilities] did not achieve as good an accreditation outcome.*)
 - C. What is the cost-effectiveness of accreditation?
 - i. What is the cost of achieving the outcomes of accreditation?
What is the cost of changing those treatment procedures that are both targeted by accreditation and lead to improved outcomes?
What are the procedures that are targeted by accreditation?
Which of those procedures lead to improved outcomes?
Which of the outcomes are improved?

(*Note: Although some of these outcomes could be monetary, thus allowing for a cost-benefit analysis, none of the measure outcomes are monetary or readily monetizable, so only cost-effectiveness analyses are possible.*)

2. Cost-effectiveness of treatment

- A. What is the cost of treatment?
(While not a true cost-effectiveness question, this is both what many people think that “cost-effectiveness” means and a necessary precursor to true cost-effectiveness)
- i. Cost to the treatment program?
Costs of the specific procedures followed by the treatment program?
 - ii. Cost to the client?
Costs of the activities performed by the client for treatment?
- B. What is the effectiveness of treatment?
- i. Does treatment “work”?
What outcomes does treatment impact significantly, and in the desired direction?
 - ii. What treatment procedures lead to those outcomes?
Why do those treatment procedures lead to those outcomes, i.e., which biopsychosocial processes within the client are responsible for those outcomes?
- (*Note: Clients in whom biopsychosocial processes did not change adequately in response to treatment, thus receiving limited or no real treatment, can be viewed as not having changed the processes that should lead to the desired outcomes of treatment.*)
- C. What is the cost-effectiveness of treatment?
- i. What is the cost of achieving the outcomes of treatment?
What is the cost of changing those biopsychosocial processes that are both targeted by treatment procedures and lead to improved outcomes?
What are the biopsychosocial processes that are targeted by treatment procedures?
Which of those processes lead to improved outcomes?
Which of the outcomes are improved?
- (*Note: Although some of these outcomes could be monetary, and thus allow for a cost-benefit analysis, none of the measure outcomes are monetary or readily monetizable, so only cost-effectiveness analyses are possible.*)

APPENDIX I: ANALYTIC FRAMEWORK FOR OTP ACCREDITATION EVALUATION

Assumptions: The purpose of accreditation is to reduce drug abuse and related use of health and criminal justice services, and to improve patient functioning, economic productivity, and community climate, by maximizing the effectiveness of OTP procedures by (a) detecting and maintaining those procedures that adhere to recommendations for effective treatment and (b) detecting and replacing those procedures that do not adhere to recommendations for effective treatment.

	Costs	Procedures	Processes	Outcomes
Program Perspective	Time, transportation, communications, and other resources used by the program to prepare for ¹⁴ , conduct*, respond to*, and maintain accreditation / operate as an accredited program.	<ul style="list-style-type: none"> • Receipt of, and response to, accreditation standards* • Preparing for accreditation survey* • Responses to survey* • Maintaining accreditation / operating as accredited OTP, including offering patient services (e.g., treatment planning, methadone dosing, counseling, urinalysis) and nondirect activities (e.g., staff meetings, program administration, quality assurance, community relations) • Preparing for reaccreditation • Preparing for state / local licensure 	<ul style="list-style-type: none"> • Perception that not changing treatment procedures risks loss of accreditation • Changes in program director, staff, and patient perspectives on the importance, contribution to effectiveness, and costs of different treatment procedures • Perception of the impact of accreditation on OTP, and of operating as an accredited program 	<ul style="list-style-type: none"> • Accreditation outcomes (overall accreditation result plus findings for separate standards) • Maintenance and replacement / improvement of OTP treatment and administrative practices • Patient outcomes, including reduced drug abuse, reduced use of health services, reduced use of criminal justice services, improved patient functioning, patient satisfaction, and improved patient economic productivity • Improved community climate • Increased resources devoted to treatment-related activities • Service accessibility
Accrediting Body Perspective	Time, transportation, communications, and other resources used by the accrediting body to prepare for and conduct (and sometimes follow-up) the accreditation survey.	<ul style="list-style-type: none"> • Responses to preaccreditation visit inquiries • Accreditation site visits and additional visits • Follow-up and report writing • Reaccreditation activities • Development and revision of accreditation standards 	<ul style="list-style-type: none"> • Perception that not changing treatment procedures risks loss of accreditation • Changes in program director, staff, and patient perspectives on the importance, contribution to effectiveness, and costs of different treatment procedures 	<ul style="list-style-type: none"> • Continued funding of accreditation body • Maintenance and replacement / improvement of OTP treatment and administrative practices • Patient outcomes
Funding Body (CSAT) Perspective	Grants to accrediting bodies, contract for TA provision, and Government staff time related to grant and contract oversight. Time spent in development and publication of accreditation guidelines.	<ul style="list-style-type: none"> • Grantee and contractor meetings • Grant and contract administration • Development and publication of accreditation guidelines. 	<ul style="list-style-type: none"> • OTPs' perception that accreditation less burdensome • OTPs' perception that accreditation is fair 	<ul style="list-style-type: none"> • Improved community climate • Consistent accreditation standards across ABs • Patient outcomes • Service accessibility
Patient Perspective	Time, transportation, communications, and other resources used by patients, family members, friends, and employers to participate in the accreditation survey and/or because of survey preparations. Time, transportation, communications, and other resources spent because of receiving treatment.	<ul style="list-style-type: none"> • Changes in treatment received resulting from accreditation 	<ul style="list-style-type: none"> • Changes in internal, biopsychosocial processes targeted by treatment 	<ul style="list-style-type: none"> • Patient outcomes • Service accessibility
Regulatory Body (Federal, State, Local)	Time, transportation, communications, and other resources used by the regulatory body to prepare for, respond to, or monitor the OTP accreditation process and outcomes.	<ul style="list-style-type: none"> • Development of (or changes in) policy, regulations, guidelines, or procedures as they relate to accreditation. • Responses to inquiries. • Responses to programs not receiving accreditation • Assessing impact of accreditation 	<ul style="list-style-type: none"> • OTPs' perception that not receiving accreditation risks being forced to stop doing business • OTPs' perception that not getting licensed risks being forced to stop doing business 	<ul style="list-style-type: none"> • Improvement of OTP treatment and administrative practices • Patient outcomes • Service accessibility

¹⁴ These items on the PAQ were retrospective in nature; the accreditation survey had occurred up to several years before the PAQ was completed for some OTPs.

APPENDIX J: REFERENCES

- Center for Substance Abuse Treatment. (in draft). *Opioid Treatment Program Accreditation Impact Study*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
- D'Aunno, T., & Pollack, H. A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988–2000. *JAMA*, 288(7), 850–856.
- Fals-Stewart, W., Klostermann, K., Yates, B. T., O'Farrell, T. J., & Birchler, G. R. (2005). Brief relationship therapy for alcoholism: A randomized clinical trial examining clinical efficacy and cost-effectiveness. *Psychology of Addictive Behaviors*, 19, 363–371.
- Fals-Stewart, W., Yates, B. T., & Klostermann, K. (2005). Assessing the costs, benefits, cost-benefit, and cost-effectiveness of marital and family treatments: Why we should and how we can. *Journal of Family Psychology*, 19, 28–39.
- Pelletier, L. R., & Hoffman, J. A. (2002). A framework for selecting performance measures for opioid treatment programs. *J Healthc Qual*, 24(3), 24–35.
- Phillips, C. D., Hubbard, R. L., Duntzman, G., Fountain, D. L., Czechowicz, D., & Cooper, J. R. (1995). Measuring program performance in methadone treatment using in-treatment outcomes: An illustration. *J Ment Health Adm*, 22(3), 214–225.
- Saunders, C. A., Sugar, A. M., Thompson, P. D., Weijer, C., Yaes, R. J., Dickert, N., & Grady C. (1999). What's the price of a research subject? Approaches to payment for research participation. *The New England Journal of Medicine*, 341(3), 198–203.
- Siegert, F. A., & Yates, B. T. (1980). Cost-effectiveness of individual in-office, individual in-home, and group delivery systems for behavioral child-management. *Evaluation and the Health Professions*, 3, 123–152.
- Substance Abuse and Mental Health Services Administration/Department of Health and Human Services. (2001). 42 CFR Part 8. Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Final Rule. *Federal Register* 66(11) (January 17), 4076–4102.
- Thompson, S. K. (1992). *Sampling*. New York: John Wiley & Sons, Inc.
- Yates, B. T. (1977). A cost-effectiveness analysis of a residential treatment program for behaviorally disturbed children. In P. Mittler (Ed.), *Research to practice in mental retardation: Vol. 1* (pp. 435–445). Baltimore: University Park.
- Yates, B. T. (1978). Improving the cost-effectiveness of obesity programs: Reducing the cost per pound. *International Journal of Obesity*, 2, 249–266.
- Yates, B. T. (1980a). *Improving effectiveness and reducing costs in mental health*. Springfield, IL: Thomas.
- Yates, B. T. (1980b). The theory and practice of cost-utility, cost-effectiveness, and cost-benefit analysis in behavioral medicine: Toward delivering more health care for less money. In J. Ferguson & C. B.

-
- Taylor (Eds.), *The comprehensive handbook of behavioral medicine: Vol. 3* (pp. 165–205). New York: SP Medical & Scientific.
- Yates, B. T. (1981). Testimony of the American Psychological Association on the subject of effectiveness and cost-benefit of outpatient mental health services. *Congressional Record, Serial No. 97–11*, 124–130.
- Yates, B. T. (1986). Economics of suicide: Toward cost-effectiveness and cost-benefit analysis of suicide prevention. In R. Cross (Ed.), *Non-natural death: Coming to terms with suicide, euthanasia, withholding or withdrawing treatment*. Denver, CO: Rose Medical Center.
- Yates, B. T. (1987). Cognitive vs. diet vs. exercise components in obesity bibliotherapy: Effectiveness as a function of psychological benefits versus psychological costs. *The Southern Psychologist*, 3, 35–40.
- Yates, B. T. (1994). Toward the incorporation of costs, cost-effectiveness analysis, and cost-benefit analysis into clinical research. *Journal of Consulting and Clinical Psychology*, 62, 729–736.
- Yates, B. T. (1995). Cost-effectiveness analysis, cost-benefit analysis, and beyond: Evolving models for the scientist-manager-practitioner. *Clinical Psychology: Science and Practice*, 2, 385–398.
- Yates, B. T. (1996). *Analyzing costs, procedures, processes, and outcomes in human services: An introduction*. Thousand Oaks, CA: Sage.
- Yates, B. T. (1997). From psychotherapy research to cost-outcome research: What resources are necessary to implement which therapy procedures that change what processes to yield which outcomes? *Psychotherapy Research*, 7, 345–364.
- Yates, B. T. (1999). *Measuring and improving cost, cost-effectiveness, and cost-benefit for substance abuse treatment programs* (NIH Publication No. 99-4518). Rockville, MD: National Institute on Drug Abuse. Available at <http://www.nida.nih.gov/IMPCOST/IMPCOSTIndex.html>.
- Yates, B. T. (2002). Roles for psychological procedures, and psychological processes, in cost-offset research: Cost → procedure → process → outcome analysis. In N. A. Cummings, W. T. O’Donohue, & K. E. Ferguson (Eds.), *The impact of medical cost offset on practice and research: Making it work for you* (pp. 91–123). Reno, NV: Context Press.
- Yates, B. T. (2005). Cost-effectiveness analysis and cost-benefit analysis. In D. DuBois & M. Karcher (Eds.), *Handbook for youth mentoring* (pp. 525–545). Thousand Oaks, CA: Sage Publications.
- Yates, B. T., Besteman, K. J., Filipczak, J., Greenfield, L., & De Smet, A. (1995, abstract). Resource → procedure → process → outcome analysis (RPPOA): Preliminary findings of cost-effectiveness analysis of a methadone maintenance program. In L. S. Harris (Ed.), *Problems of drug dependence, 1994: Proceedings of the 56th Annual Scientific Meeting, The College on Problems of Drug Dependence, Inc.* NIDA Research Monograph 153, p. 156. Rockville, MD: National Institute on Drug Abuse.
- Yates, B. T., Delany, P. J., & Lockwood Dillard, D. (2001). Using cost → procedure → process → outcome analysis to improve social work practice. In B. A. Thyer (Ed.), *Handbook of social work research methods* (pp. 207–238). Thousand Oaks, CA: Sage.

- Yates, B. T., Haven, W. G., & Thoresen, C. E. (1979). Cost-effectiveness analysis at Learning House: How much change for how much money? In J. S. Stumphauzer (Ed.), *Progress in behavior therapy with delinquents* (pp. 186–222). Springfield, IL: Charles C. Thomas.
- Yates, B. T., & Taub, J. (2003). Assessing the costs, benefits, cost-effectiveness, and cost-benefit of psychological assessment: We should, we can, and here's how. *Psychological Assessment, 15*, 478–495.
- Yates, B. T., Yokley, J. M., & Thomas, J. V. (1994). Cost-benefit analysis of six alternative payment incentives for child therapists. *Journal of Consulting and Clinical Psychology, 62*, 627–635.
- Zarkin, G. A., Dunlap, L. J., & Homsy, G. (2006). The costs of pursuing accreditation for methadone treatment sites: Results from a national study. *Eval Rev, 30*(2), 119–138.