ADDICTION TREATMENT

Forum

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Patients and Clinical Professionals

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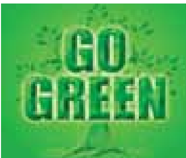

We're Going Green and Interactive!

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In This Issue

Back in the summer of 1992, we published the premier edition of the *Addiction Treatment Forum* newsletter. With our next edition, Fall 2011, we're going exclusively electronic—so this, our 70th newsletter, is the last printed version you'll receive. And it's one of our best.

We're excited about going green, going electronic, and keeping pace with the changing times. We're helping to conserve our natural resources, and taking part in the many technological innovations that speed the flow of information in the addiction treatment field.

Let's Blog!

Beginning with our Premier Edition, collaboration has been a key commitment to our colleagues and readers. As publishers, we've found communication to be a great way to generate innovative ideas and provide meaningful, practical, and effective solutions for the health care problems voiced by our readers and by the addiction-treatment community.

So, to improve our communication channels, we're converting the *AT Forum* newsletter and news updates to a blog format. Each article will have a comments section for you to voice your opinions.

We'll also be posting online surveys displaying real-time results on hot topics.

Keep in Touch

To keep informed whenever the *AT Forum* website is updated, sign up on our home page (www.ATForum.com) for e-mail notifications. To ensure that our e-mails arrive safely in your inbox, add ATForum@list.ATForum.com to your address book. If your organization controls spam mail, check with your IT department to make sure ATForum.com is on the "safe sender" list. It's also a good idea to sign up for e-notifications using your personal e-mail address.

Your friends, colleagues, and patients will find useful and interesting information at our website and in our *AT Forum* newsletters. Please do them a favor and help us spread the word so they can sign up for e-mail notifications.

Some of our current readers lack Web access. We encourage clinic management to print and display copies of the newsletter, so staff and patients can continue to read them, as before.

Follow Us on Twitter, Facebook, RSS Feeds

We know you have a favorite source for accessing information, so we offer you the option of tracking new content at our website by following us on Twitter and Facebook, or through a variety of RSS feeds.

Have Questions About MAT?

Please send them to us by clicking on our home page button, Ask *AT Forum*. We won't be able to respond to all of the questions, but we value your opinions and they will help guide our choice of topics.

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***AT Forum* is made possible by an unrestricted educational grant from Mallinckrodt Inc., a Covidien company, St. Louis, MO, a manufacturer of opiate- and alcohol-addiction products.**

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Our Sponsor

For almost two decades, the *AT Forum* newsletter and ATForum.com website have been funded exclusively by an unrestricted educational grant from Covidien Mallinckrodt. Our sponsor zeroed in on the opportunity to provide evidence-based information on medication-assisted treatment (MAT) for opioid addiction to stakeholders, health care professionals, and patients. With ongoing support from Covidien Mallinckrodt, *AT Forum* will continue to air and respond to your opinions, and to serve as a platform to highlight the accomplishments of patients and health care professionals alike.

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You'll discover a wealth of information at our website—all 70 newsletters, more than 150 months of news notes and updates, and more than 200 resources. You'll also find frequently asked questions (FAQs), patient education brochures you can download in English and Spanish, links to more than 200 related websites, and lists of key addiction-related events, including webinars, conferences, and meetings.

We so appreciate your continued interest in *AT Forum*. As always, we greatly value your feedback, so we can keep in touch with you, our readers.

Sue Emerson, Publisher
ATForum@ATForum.com

Advocates Help New Moms in Methadone Treatment Fight Child Protective Services

After more than 50 years of evidence showing that methadone maintenance (MM) treatment works, the courts—both civil and criminal—are making decisions only a doctor should make, telling patients to stop taking their legally prescribed methadone. These decisions are coming down particularly hard on women, who in some cases are being told by Child Protective Services (CPS) that they have to get off methadone if they want custody of their newborn child.

This happened in a case of a model patient who entered MM treatment, and then found out that she was pregnant. The case, described to *AT Forum* by Emma Ketteringham, JD, director of legal advocacy for National Advocates for Pregnant Women (NAPW), involved a woman who was stable and doing well in MM treatment. "She did everything right, availing herself of all the services the opioid treatment program (OTP) had to offer, including parenting classes," says Ms. Ketteringham. Yet when her baby was born, and she told the hospital she was receiving MM treatment, and even showed documentation from the program, someone from the hospital reported her to CPS. This report resulted in an immediate investigation, with the CPS caseworker telling her that she had to go off methadone if she wanted her baby back. She wanted to continue her successful MM treatment and regain custody of her child.

The law is on the side of women in MM treatment in OTPs. It is against the law for the court system—or any other government agency—to single out people in medication-assisted treatment (MAT) and require them to stop taking their medication, or to switch to another medication or another form of treatment, according to the Legal Action Center. If a child welfare caseworker tells a woman that she must stop taking methadone in order to gain custody of her child, this is a violation of the Americans with Disabilities Act (ADA), says Katie O'Neill, JD, senior vice president of the Legal Action Center. The ADA prohibits disability-based discrimination. "People who participate in MM treatment for opiate addiction are considered to be individuals with a disability, so you cannot legally prohibit someone from receiving that treatment."

But the job of CPS is to protect infants and children from abuse and neglect. When a newborn is going through the neonatal withdrawal syndrome, a caseworker who is not knowledgeable about methadone treatment may conclude that the mother has "exposed" her newborn to a drug—methadone. The caseworker interprets that as neglect, and threatens the mother with loss of her baby if she stays in MM treatment.

If a child welfare caseworker tells a woman that she has to stop taking methadone in order to gain custody of her child, this is a violation of the Americans with Disabilities Act.

CPS investigations are secret—the person reporting the "neglect" does so anonymously. "We see cases from all over the country where women are threatened with loss of custody or have had their children removed because they receive MM treatment during pregnancy," says Ms. Ketteringham. Family court

judges who make decisions about custody do so without a jury, and in some states, the mother has no attorney or is discouraged from fighting the charges by her own attorney, says Ms. Ketteringham. Family courts "notoriously make decisions relying on claims made by caseworkers rather than on evidence presented by experts," she adds.

"Many lawyers appointed to represent women facing a loss of custody in family court are not knowledgeable about clinical or legal realities of MM treatment," adds Ms. O'Neill.

The best way to prevent any problems after the baby is born is communication between the OTP, the hospital where the baby will be delivered, and the obstetrician. "Although the mother should not have to, she should organize advocacy on her behalf before the baby is born," Ms. Ketteringham says. "She should make sure someone in her program will advocate on her behalf, have the printed or online literature about MM treatment during pregnancy handy, and contact a lawyer or organization that advocates for pregnant women and parents in the child welfare system."

The model patient, Ms. Ketteringham's client, eventually won her case, but it took nine months, during which time her baby was in foster care. When *AT Forum* went to press, the decision in the case had not yet been published, but the judge had returned the baby to the mother. She is still in MM treatment and doing well.

Resources on discrimination and pregnancy available at www.ATForum.com.

Prescription Opioids Account for a Greater Share of Treatment Admissions

Over a ten year-period, admissions to substance abuse treatment for opioids, attributable mainly to prescription opioids, rose from 8 percent in 1999 to 33 percent in 2009, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Overall, opioids accounted for 21 percent of all treatment admissions—second after alcohol (42 percent) and followed by marijuana (18 percent) and cocaine (9 percent).

In 2009, medication-assisted treatment was planned for 19 percent of admissions when the primary drug of abuse was a prescription opioid, compared to 28 percent of admissions when it was heroin.

These data are from *Treatment Episode Data Set (TEDS) 1999-2009*, a SAMHSA report released in June. TEDS is based on reporting from treatment facilities across the country. For the data file, go to http://atforum.com/addiction-resources/documents/teds2k9nweb.pdf.

Economic Impact of Illicit Drug Use in the U.S.

Societal costs of illicit drug use were $193 billion in 2007, according to a report out this spring from the National Drug Intelligence Center, part of the federal Department of Justice. Included were costs due to crime ($61 million), health costs ($11 billion), and productivity costs ($120 billion).

Public costs of specialty treatment totaled $3.3 billion: $650 million for methadone programs, $1 billion for other outpatient programs, $1.2 billion for residential programs, and $465 million for detoxification. These figures apply to treatment for what the report calls "illicit drug use," which includes heroin use and prescription drug misuse.

The report also looks at the difference between "instrumental offenses"–such as larceny committed by a heroin addict in order to purchase drugs—with "related offenses," such as murder committed while under the influence of a drug like cocaine. The report categorizes instrumental offenses as those that would not have occurred absent the addiction—in other words, the heroin addict would not have stolen if he or she had not had to purchase illicit drugs.

For the report, *The Economic Impact of Illicit Drug Use on American Society*, go to http://atforum.com/addiction-resources/documents/economicimpact.pdf.

Events to Note

KEEPING IT REAL 2011 CONFERENCE – Street-Level Intervention Strategies for Addiction, HIV/AIDS, and Hepatitis
October 17-19, 2011
Silver Spring, Maryland
Contact: www.attcnetwork.org

American Psychiatric Association (APA) Institutes on Psychiatric Services
October 27-30, 2011
San Francisco, California
Contact: www.psych.org

Association for Medical Education and Research in Substance Abuse (AMERSA) 35th National Conference
November 3-5, 2011
Arlington, Virginia
Contact: www.amersa.org/conf.asp

Society for Neuroscience Annual Meeting
November 12-16, 2011
Washington, DC
Contact: www.sfn.org

American Academy of Addiction Psychiatry (AAAP) 22nd Annual Meeting and Symposium
December 8-11, 2011
Scottsdale, Arizona
Contact: www2.aaap.org

Buprenorphine Diversion May Signal Need For More MAT and Greater Oversight

As more buprenorphine is prescribed in physicians' offices to treat opioid addiction, the potential for diversion and misuse increases. But people buying buprenorphine on the street are not generally doing so for its euphoric effects. Most are taking it because they are dependent on heroin or prescription opioids, or both, and want to prevent withdrawal symptoms between "highs," according to Jane C. Maxwell, PhD. Dr. Maxwell, a research professor at the Addiction Research Institute at the University of Texas at Austin, is an epidemiologist who studies drug abuse trends nationwide. She tells *AT Forum* that the amount of the drug being prescribed reflects increasing demand for opioid treatment.

Background

The Drug Addiction Treatment Act of 2000 (DATA) made it possible for any licensed physician to treat opioid addiction with Schedule III, IV, and V medications in their private offices by obtaining a federal waiver. Buprenorphine is a Schedule III drug. Methadone, a Schedule II drug, is not covered by DATA.

Two formulations of buprenorphine are approved under DATA: Subutex (buprenorphine), and Suboxone (buprenorphine with naloxone) (naloxone is added as a protection against abuse and diversion). Suboxone, the most commonly prescribed form of buprenorphine, comes as sublingual tablets and as a sublingual film. Both dissolve under the tongue. Generic buprenorphine without naloxone also is available.

As part of DATA 2000, the federal government required additional protection against buprenorphine diversion:

- An eight-hour training course for physicians approved by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Physician registration with the federal Drug Enforcement Administration (DEA).
- Regulatory limitations on the number of patients a physician may treat at any one time. DATA's initial allowance of up to 30 patients was increased to 100 patients in 2006.
- Physicians must have the capacity to provide counseling, or to refer patients for it.

Buprenorphine Abuse and Supply Increases Linked

Buprenorphine was first approved for treating opioid dependence in 2002. Within two years the DEA was issuing warnings about buprenorphine abuse, especially in the Northeast. Nicholas Reuter, MPH, senior public health advisor for the division of pharmacologic therapies at SAMHSA's Center for Substance Abuse Treatment, told *AT Forum* in May that buprenorphine diversion is a "significant concern."

Diversion and abuse increase with supply, Mr. Reuter says. The New England and Southern regions have the highest buprenorphine supply, and highest diversion rates. "The more you prescribe and the more that's available and out there, the more that can bleed out into the illicit market."

Put in context however, buprenorphine abuse "pales in comparison to other prescription opioids," says Mr. Reuter. "We have a prescription drug abuse problem in the United States that Suboxone is a part of, but the abuse levels are dramatically less than for other opioids."

Reasons and Sources For Diverted Buprenorphine

An ethnographic study in Massachusetts and Vermont found that Suboxone is used to avoid opioid withdrawal when preferred opioids are not available or are too expensive, says Mr. Reuter. Sixty percent of study participants obtained Suboxone illicitly from an individual holding a legitimate prescription for the medication. When legitimate access to prescription Suboxone was unavailable, participants went to other sources, including 39 percent who went to heroin dealers to purchase the drug, he says.

Diversion and illicit use of Suboxone are increasingly reported in incarcerated populations. Recent news reports tell of Suboxone pills and the new Suboxone film being smuggled into prisons and jails. The tablets have been crushed and mixed with crayons, used to color pictures, then licked off the paper. The film has been tucked behind envelope seams and stamps.

Many recreational drug users are finding buprenorphine readily available, and naïve opioid users feel some euphoria from Suboxone, especially when taken in combination with alcohol or other sedative drugs.

A study presented at the College of Problems on Drug Dependence in June found that the greatest risk factor for misuse of buprenorphine was being unable to get into treatment.

The unfolding buprenorphine experience with diversion may just reinforce anti-MAT attitudes and make all opioid agonist treatment more restrictive and less accessible.

Recent Ohio Report Confirms Buprenorphine Diversion and Increased Need For MAT

Ohio's most recent surveillance report found that street availability of Suboxone is high in most regions. It's not clear where the diverted Suboxone is coming from, but the market for it on the street indicates a need for more treatment for opioid addiction, says Orman Hall, director of the Ohio Department of Alcohol and Drug Addiction Services. Mr. Hall tells *AT Forum* that buprenorphine diversion in the state is now a concern.

The rise in prescription opioid abuse is causing Ohio to change the way it treats addiction, by adding more medication-assisted treatment (MAT), says Mr. Hall. "Historically, Ohio has been an abstinence state. We're now looking at a number of medications, and we'll revamp our methadone treatment guidelines as well."

Should Buprenorphine Regulations Be More Restrictive?

Dr. Maxwell is concerned that if buprenorphine diversion continues to rise, stigma will increase, and policy makers may begin to view it negatively. This would result in heightened controls and reduced access to all MAT. The unfolding buprenorphine experience with diversion may just reinforce anti-MAT attitudes and make all opioid agonist treatment more restrictive and less accessible.

Finally, while DATA-waived physicians must certify the capacity to refer patients for counseling, counseling is not required with buprenorphine treatment. A SAMHSA/CSAT evaluation conducted in 2007 indicated considerable variation in the amount of counseling provided by DATA-waived physicians. Some prescribing physicians are not providing counseling on a regular basis, according to Mr. Reuter. This could contribute to the diversion of prescribed buprenorphine.

Sources available at ATForum.com.

How Methadone Treatment is Funded in OTPs

Over the years *AT Forum* readers have asked how methadone maintenance (MM) treatment in opioid treatment programs (OTPs) is funded, and why some patients pay for their treatment while others receive it free.

The answer depends on the patient's income and insurance status, the state's funding scenario, and even the program's status (profit or not-for-profit).

MM treatment is usually financed from a combination of public and private sources and patient self-pay, and the combination varies by state and by OTP.

"Public" funding includes funding from the federal Substance Abuse Prevention and Treatment block grant, the state block grant match, Medicaid, and other state, county, and local funding. Some states have no "public" funding for OTPs.

"Self-pay" means the patient pays out-of-pocket (for some or all of their treatment).

"Private" is what is paid by private insurance companies, private managed care companies, or directly by employers, or by a combination of these.

Public Funding

Medicaid coverage of addiction treatment varies from state to state, according to a 2008 report prepared for the National Council of State Legislatures: *Medication-Assisted Treatment (MAT) for Opiate Addiction and the Public Financing of that Treatment*. Author Suzanne Gelber, PhD, Avisa Group, tells *AT Forum* that not all states offer Medicaid funding for OTPs. States can opt not to offer Medicaid substance abuse coverage, even under parity. The most recent data were collected by Dr. Gelber of Avisa in 2005 and published in 2008 by the Avisa and the National Council for State Legislatures on a special website (http://www.ncsl.org/default.aspx?tabid=14132). At that time 36 states used Medicaid funding, at least in part, for methadone treatment in OTPs (*for the table, go to* http://www.ncsl.org/Default.aspx?TabId=14144).

Federal Substance Abuse and Mental Health Services Administration (SAMHSA) funding to each state comes via the Substance Abuse Prevention and Treatment block grant (*see sidebar)*. Block grants allow states to fund treatment for patients who are not covered by Medicaid, or to supplement Medicaid funding. There is no requirement that any block grant money be used for OTPs or MAT for opioids. Block grant funds from SAMHSA require a state contribution through a complicated formula that varies state by state.

For Profit = Patient Self Pay

Today, some patients are paying for their OTP treatment. Many are going to private for-profit OTPs, a trend that started in the 1990s and has gathered speed in recent years. In 1994, Rick Harwood, now director of research for the National Association of State Alcohol and Drug Abuse Directors, wrote a definitive analysis of MM funding (http://www.nap.edu/openbook.php?record_id=4899&page=162). At that time, only 17 percent of the total estimated cost of MM treatment was funded by patient self-pay. Thirty percent was paid by the block grant, 31 percent by state funds, 12 percent by Medicaid, and 7 percent by local funds, for a total of 80 percent of MM paid by public funds. Only 2.5 percent was paid by private insurance.

Patient fees today definitely represent a bigger slice of the pie, and the pie itself has grown: $480 million a year was spent on MM in 1992, compared to Mr. Harwood's estimate of about $1 billion a year today.

But a lot has changed in the MM treatment field since then, and a much bigger portion is now paid by patients directly, Mr. Harwood says. "A whole wave of private for-profit clinics have opened, and their patients pay, often in cash," he tells *AT Forum*. Of the 286,000 patients in OTPs in 2008, approximately half attended private for-profit programs, and paid for their treatment out-of-pocket, at posted fees ranging from $13 to $25 a day or more. In fact, he says, due to sliding scales, the fees paid may be lower than advertised rates.

Mr. Harwood confirms that patient fees today definitely represent a bigger slice of the pie, and the pie itself has grown: $480 million a year was spent on MM in 1992, compared to Mr. Harwood's estimate of about $1 billion a year today. But he points out that nobody really knows, because the information isn't routinely collected. "It's disappointing, because this is an important and very understudied topic."

Only recently has SAMHSA resumed collecting financial data from a sample of its treatment programs. But there will be very few OTPs in

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this system, says Mr. Harwood. Furthermore, there will be no separate estimates for medication-assisted treatment.

Health Care Reform Will Increase Medicaid and Private Insurance Coverage

By 2014, the funding scenario will change once again. Under health care reform, virtually everyone in the country will be eligible to be covered by Medicaid, Medicare, or private insurance–at least, that is what the planners at SAMHSA say. In states that have health care reform now, such as Massachusetts, public funding has still been necessary for substance abuse treatment, since many people who need that treatment have not purchased health insurance. Payers know that MM is cost-effective when it's part of a system of health care and behavioral health care; using it reduces unnecessary hospitalizations, ambulance costs, mortality, and emergency department visits. Theoretically, OTPs will receive more funding from Medicaid and private insurance, and fewer patients will have to dig into their own pockets to pay. All OTPs, whether for-profit or not-for-profit, will have to be able to bill Medicaid and private insurance companies by 2014.

Resources available at ATForum.com.

What Is a Block Grant?

The Substance Abuse Prevention and Treatment block grant is administered by SAMHSA and is made available as an option for states to match and use for planning, carrying out, and evaluating substance abuse treatment and prevention services.

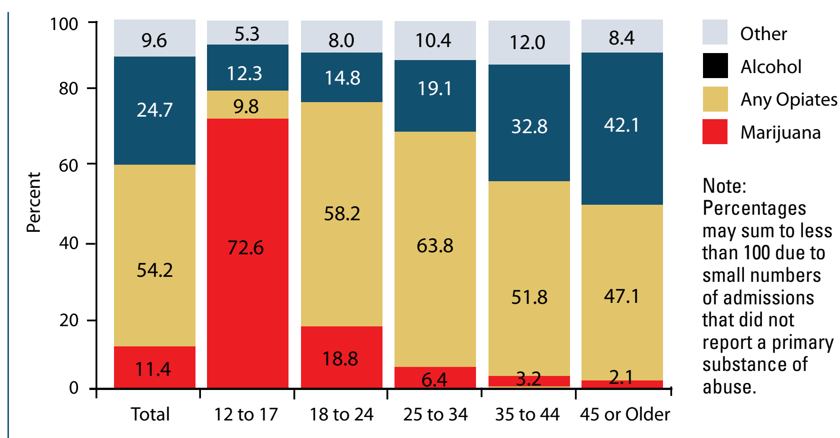
Substance Abuse Treatment Admissions for Benzodiazepine Abuse Triple

The number of patients admitted to *substance abuse treatment* who report benzodiazepine abuse tripled from 1998 to 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported in June. In 1998, benzodiazepines were involved—not necessarily as the primary drug of abuse—in 22,400 admissions. Ten years later, this number had grown to 60,200.

Benzodiazepines were rarely the only drug used, or even the primary drug. In 82.1 percent of the cases, benzodiazepines were the secondary drug of abuse, with opioids (54 percent) usually the primary drug—a pattern that roughly held true for nearly every age group except adolescents and those aged 45 and older (*see chart*).

One major public health concern with multiple drug abuse is the risk of overdose. The SAMHSA report notes that "abuse of benzodiazepines in combination with other substances can have severe and sometimes fatal consequences."

Primary Substance of Abuse Among Admissions Reporting Secondary Benzodiazepine Abuse, by Age at Admission: 2008



Source: SAMHSA Treatment Episode Data Set (TEDS), 2008.

The report, based on the Treatment Episode Data Set (TEDS), was released by SAMHSA in June 2011. The report collects information from providers on the primary substance of abuse, and up to two additional substances, at admission to treatment.

The TEDS Report, *Substance Abuse Treatment Admissions for Abuse of Benzodiazepines*, can be found at: http://atforum.com/addiction-resources/documents/TEDS028BenzoAdmissions.pdf.

Study: Benzodiazepine Use by OTP Patients May Indicate Untreated Anxiety

A recent study based on an anonymous survey of methadone patients in a Baltimore, Maryland opioid treatment program (OTP) found that more than half of benzodiazepine users attending group meetings had started using these drugs after entering methadone maintenance (MM) treatment.

The authors caution that their study results should not be used to make clinic policy, or to change operations. This article could be helpful to OTPs as they try to deal with the issue of benzodiazepine abuse.

"The study findings suggest that most methadone programs do not address co-occurring anxiety problems," the authors concluded. Further study is needed "to develop effective treatments that will simultaneously target addiction symptoms, anxiety disorders," and misuse of benzodiazepines.

The authors noted that benzodiazepine misuse increases the risk for relapse and overdose.

The study, Benzodiazepine Use and Misuse Among Patients in a Methadone Program, by Kevin W. Chen et al, is published in *BMC Psychiatry*, May 19, 2011. The article is available for free download at: http://atforum.com/addiction-resources/documents/Benzodiazepines.pdf.

Implementing EHR Systems in OTPs: Potential Roadblocks and Lessons Learned

An Interview with Lawrence S. Brown, Jr, MD, MPH

Despite government incentive programs and a 2014 deadline for establishing a fully electronic health record (EHR) system, most health care transactions continue to be carried out manually, on paper.

Among impediments to EHR implementation: Financial—What will it cost? Training—How to prepare employees for advanced technology? Selecting a program—Outside vendors, an in-house system, or a combination? Personnel issues—Possible conflicts between confidentiality, privacy issues, and legal provisions?

To answer these questions, the National Institute on Drug Abuse (NIDA) awarded a grant to Addiction Research and Treatment Corporation (ARTC), one of the nation's premier substance abuse treatment programs. A community-based, minority-operated, not-for-profit health care system with seven CARF-accredited opioid treatment programs (OTPs), ARTC serves more than 3,000 OTP patients each year in New York State, providing comprehensive methadone maintenance (MM) treatment, including HIV/AIDS services and primary medical care.

Lawrence S. Brown, Jr, MD, MPH, Interim executive director of ARTC, shares with us some challenges and opportunities ARTC encountered while implementing an EHR system under the NIDA grant. (*The Journal of the Evaluation of Clinical Practice* published a report; see citation at the end of this article.)

Setting up the ARTC EHR System

In 2006, ARTC began setting up EHRs for its general medical system, later interfacing it with the agency's basic administrative needs. "We quickly realized we needed an outside consultant, because of the way our operations and systems functioned," Dr. Brown says. "The project was beyond our in-house programmers' scope, and rapidly changing technology was dating our software and hardware.

"As a not-for-profit, we obtain over 90 percent of our revenue stream through public funds. Hiring a consultant wasn't an easy sell to our governing body, but we were successful, and the consultant began work in 2007. All staff received computer assessments, basic computer training, if needed, and specific program training."

As a large, multiple-site OTP, ARTC needed to choose between upgrading their entire system and continuing to use a largely decentralized system, based on security considerations and operations. "This is a decision OTPs will need to make. For smaller OTPs, that's less of an issue." ARTC decided to upgrade their desktop computers, servers, and network, while ensuring continuity of billing and fiscal processes.

In 2009, ARTC's general medical system went online. In 2010, behavioral data were integrated with the electronic medical system. Today, major challenges remain, as ARTC continues to integrate what was a largely paper-based information system with electronic clinical, administrative, and fiscal data.

Suggestions for OTPs Starting Out. Dr. Brown advises OTP staff to mentally prepare themselves before converting to an electronic system. "If you fight it, you'll just become more frustrated." Smaller OTPs considering starting a system internally need to carefully weigh the considerable start-up costs.

"Talk with your colleagues—OTPs who've set up a system, and those who haven't—to identify the challenges. Find out how consultants have worked out for your colleagues.

"Do an in-depth needs-assessment of your OTP. Identify strengths, and areas for improvement. Involve all stakeholders, even though that's a lot of work. Leaving out the governing body or clinicians would be a mistake."

Some Things ARTC Learned

Importance of Timely Reports. "We began to see the relationships between the quality and timeliness of our reports, and the impact to our bottom line and to patient care," Dr. Brown told *AT Forum*. "Before the electronic system, we couldn't tell if we were getting timely reports. Some clinicians took days to complete their clinical records, and until they did we couldn't submit bills. Now we are able to assess how promptly our clinicians carry out their clinical responsibilities.

"The electronic data also allow us to assess the quality of our patients' treatment plans, and to determine if our clinicians meet the treatment requirements of federal and state authorities and professional accreditation organizations.

EHRs allow OTPs to send electronic data to health departments and other providers without increasing their costs. For OTPs that have postponed going electronic, needing to send data electronically raises their personnel costs for data entry and quality control.

"Using the data, we've identified the items most important to our agency and field staff, leading to a hierarchy of objectives—our 5-point score card: 1) regulatory compliance; 2) financial health; 3) quality of care; 4) satisfaction of our patients and those we serve; and 5) satisfaction of our workforce. Whenever issues come up, we say, 'Where does this fit in our score card?' It helps us prioritize." These scorecards can help an agency evaluate how effectively it meets goals and objectives.

Patient Confidentiality Concerns. "Patient advisory committees conduct ongoing patient satisfaction surveys at each facility. Addiction treatment presents confidentiality concerns, because protections are set to a higher standard than those for general medical care.

"We've made it clear that patient care trumps everything else," Dr. Brown says. "We don't disclose anything without patients' permission, except what regulatory bodies require. We tell patients, 'If your care is funded by a third party, that party has a right to your information. In fact, they have access to it already.'

"Within our agency, every clinician–whether in behavioral health or in the general medical field—has access to patients' information. We will not allow patients to be harmed because a clinician lacks information."

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Implementing EHR Systems in OTPs – Potential Roadblocks and Lessons Learned

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Cost Concerns. "Implementing a major change like EHRs always involves a learning curve, with an initial drop-off in productivity. And there are upfront costs for software and hardware, and possibly a consultant. The cost savings—return on investment—will probably take several years, regardless of the size of the OTP.

"Startup costs may be a greater challenge for smaller OTPs, but, importantly, EHRs will allow them to send electronic data to health departments, regulatory agencies, and other providers for care coordination, without increasing their costs. When small OTPs that have postponed going electronic need to send this data electronically, it raises personnel costs for data entry and quality control, and involves programming costs."

Challenges ARTC Faced

Change Management. Various ARTC divisions had to collaborate in new ways—holding regular meetings for senior staff, formalizing strategic planning, agreeing on an integrated system, and coordinating software and hardware purchases: ensuring system compatibilities by planning installation under expert guidance, and well in advance.

Training Issues. ARTC evaluated all staff for basic computer skills and knowledge, and trained them to use software applications. "We assessed every employee's computer competency–not to exclude them, but to find out their needs. Some required basic computer training as the stepping-stone to software they needed to do their jobs," Dr. Brown says. "Over time, staff began to see technology as a way to improve their performance, rather than a threat to their employment."

ARTC Suggestions for OTP Staff

- Mentally prepare all staff before starting.
- Talk with colleagues at other OTPs; decide if you need an outside consultant.
- Do an in-depth needs-assessment of your OTP.
- Continue policy discussions at all phases of planning and implementation.

Electronic Security. Needs assessment revealed that ARTC was vulnerable to sabotage from within and without. To avoid database theft via flash drives, ARTC limited use of external media, disabled devices that write to media (with a few tightly controlled exceptions), changed the firewall, installed a spam blocker, and set up automatic locking at workstations. Updating electronic security remains a high priority at ARTC.

Conclusions

To successfully implement an EHR system, an OTP must carefully plan each step and involve all stakeholders in communication and collaboration throughout the development and implementation process. Studies suggest that the payoffs make EHRs worthwhile: better patient care and services, fewer medical errors, lower costs, better control over adverse effects of medications, a marked improvement in outcomes, and permanence of medical records during natural or wartime disasters.

Sources and resources available online at www.ATForum.com.