NATIONAL TREATMENT CENTER STUDY

SUMMARY REPORT (NO. 3)

SECOND WAVE ON-SITE RESULTS

A report detailing the findings from the second wave of data collection with a nationally representative sample of private alcohol and drug problem treatment centers participating in the National Treatment Center Study conducted by the University of Georgia and the Georgia Institute of Technology

December 1998

Suggested Citation: Roman, Paul M., Johnson, J.A. 1998. National Treatment Center Study Summary Report: Private Treatment Centers. Athens, GA: Institute for Behavioral Research, University of Georgia.

The National Treatment Center Study is funded by Research Grant R01-AA-10130 from the National Institute on Alcohol Abuse and Alcoholism, a component of the National Institutes of Health, U.S. Public Health Service. The contents of this report are solely the responsibility of the project staff, and do not necessarily reflect the official views of the funding agency.

Table of Contents

National Treatment Center Study Project Staff

Principal Investigators: Paul M. Roman, Ph.D.
University of Georgia

Terry C. Blum, Ph.D.
Georgia Institute of Technology

Project Coordinator: J. Aaron Johnson, M.A.

Fieldwork Coordinators: Stacey James
Allison J. Ohl
Cristin E. Rollins, M.A.

Field Interviewers:

James Awbrey	Hannah Knudsen
Gabrielle Blair	Sara Mason
Fernando Charvet	Stuart Milne
Amy Alice Chastain	Beth Montemurro
Christopher Foster	Marybeth Stalp
Claire Giannasi	Diana Wall
Heath Hoffman	Janey Ward

Support Staff: Amanda Abraham
Brooke Abraham
Samuel Hunt
Jennifer Swint

Project Offices: Institute for Behavioral Research
101 Barrow Hall
University of Georgia
Athens, GA 30602-2401

Phone: (800) 742-0694
Fax: (706) 542-6436

Overview of the National Treatment Center Study

In 1994 the Institute for Behavioral Research at the University of Georgia and the School of Management at Georgia Institute of Technology launched a major national study of private treatment for alcoholism and substance abuse. Funded by the National Institute of Alcohol Abuse and Alcoholism, this project is directed by Paul M. Roman (the University of Georgia's Institute for Behavioral Research) and Terry C. Blum (Georgia Institute of Technology's School of Management). It came about as a response to the critical shortage of research in this area. The study is focused on how the managements of private substance abuse treatment centers cope with a turbulent and uncertain environment.

Between June 1995 and August 1996, on-site interviews were conducted with 450 private-sector treatment facilities nationwide. Every effort was made to meet with the program administrator, a lead member of the clinical staff, and (when available) a member of the marketing staff. The administrative interview covered general topics about the history and operation of the center, including its ownership, plans for expansion, number and type of staff, linkages with managed care, payor mixes, and retail charges for treatment services. The clinical interview covered very general topics about the clinical program, including the various levels of care offered, and the patient capacity and census. The marketing interview inquired about the center's marketing strategy and the competitiveness of the center's environment.

Since our primary interest lies in organizational survival and adaptation over time, participating centers were re-contacted at 6-month intervals. During these brief telephone calls, we inquired as to whether any changes have taken place in the center's administration or services since our last time of contact. We also collected that day's census figures and asked a few additional questions about such topics as managed care and competition with other programs.

In September 1997 we began a second wave of on-site data collection. It is these data that are the basis for the current report. Like the first wave of this project, this wave involved interviews with program administrators, clinical coordinators and a member of the marketing staff (if applicable) at each of the centers in our original sample. To date, at least 46 centers of the original 450 have closed their doors or are no longer offering substance abuse treatment. To assure a dynamic profile of alcohol and drug treatment, we have utilized a split-panel design method to randomly sample 30 "new centers" (programs opening since 1994). The addition of these centers enables the identification of new adaptive trends occurring in the substance abuse treatment industry. Like those in the original sample, these new centers must meet specific eligibility criteria.

While the second wave of on-site data collection is on-going, this report summarizes data obtained during on-site interviews at 291 centers including 13 of our "new centers." This represents about two-thirds of the total number of centers expected in the final Wave Two sample. As soon as possible, we will release a final report on this wave as data collection, coding, and cleaning are completed.

I: Technical Guide to the Report

A) Cases Included in this Report

While data collection for the second wave of on-site data collection is nearly complete, the data described in the following report is derived from 291 cases that have been coded, entered and cleaned. A final report on the entire sample will be released in the coming months.

B) Comparisons by Center Type

In a number of the tables that follow, comparisons will be made among four different types of treatment centers. The 291 cases included in this report fall into these four types as follows: 45 for-profit hospital-based programs, 67 for-profit nonhospital-based programs, 148 non-profit hospital-based programs, and 31 non-profit nonhospital-based programs.

C) Comparisons to Earlier Results

In some of the tables and text that follows, references and comparisons will be made to earlier results. In each case, this refers to results obtained from our initial on-site visit with participating centers in 1995-1996.

D) References to Statistical Significance

In some of the results reported, we refer to types of centers as having significantly different characteristics than other types. In all cases, statistical significance has been set at .05, meaning that there is less than a 5% chance that these results are invalid.

II. General Center Information

A) Reported Closures

Since the beginning of our study in 1995, we have been tracking participating centers to ascertain which ones have closed since the time of our last contact. At the time of the first progress report in January 1997, 20 of the 450 participating centers had closed. The second report in November 1997 revealed that an additional 14 had closed for a total of 34. At the time of this printing, 46 (10.2%) of our participating centers have now closed their doors. By center type, the closures are as follows: 10 for-profit hospital-based programs, 10 for-profit nonhospital based programs, 23 nonprofit hospital based programs, and 3 nonprofit nonhospital based programs.

These figures can be misleading. While the number of nonprofit hospital based closures far exceeds the closures among other types of centers, it is important to point out that these centers are over-represented among study participants. When this is taken into account, there are no significant differences in the percentages of closures across the different types of centers.

B) Accreditation Status

Since 1995 there has been a slight increase in the percentage of centers licensed or accredited by some accrediting group from 94.9% to 98.6%. However, the percentage of centers with JCAHO accreditation has actually decreased from 86.9% of the total sample to 83.5%. Most of this decline can be attributed to the new panel of centers which are now a part of the study. These centers are primarily nonhospital based programs and are therefore less likely to have JCAHO accreditation. The decline is not the result of participants losing JCAHO accreditation.

C) Expansion Plans

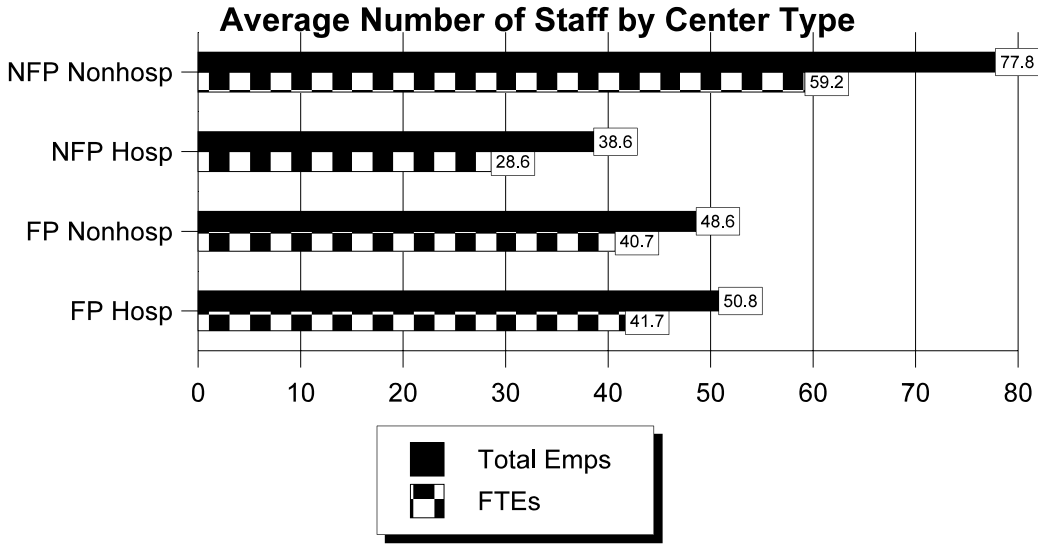
Plans for expansion may be a sign of organizational well-being. During our first visit with participants, we asked respondents to decribe in detail any plans they had for the future expansion of their respective programs. More than half (56.2%) told us that they were seriously considering expanding some part of the services. On our second visit, we reminded respondents of what they had told us and asked if these plans had been realized. Notably, more than three fourths of the centers reported that they had successfully expanded their existing services. In addition to inquiring about past expansions, respondents were again asked if there were future plans for expansion. Again more than half (55.3%) responded in the affirmative. Plans included the following (percentages are based on 283 valid responses):

140 (49.5%) centers are planning to increase the number of clients served
117 (41.3%) centers are planning to increase their outpatient capacity
110 (38.9%) centers are planning to increase the number of employees
32 (11.3%) centers are planning to increase the number of beds

III. Human Resource Management

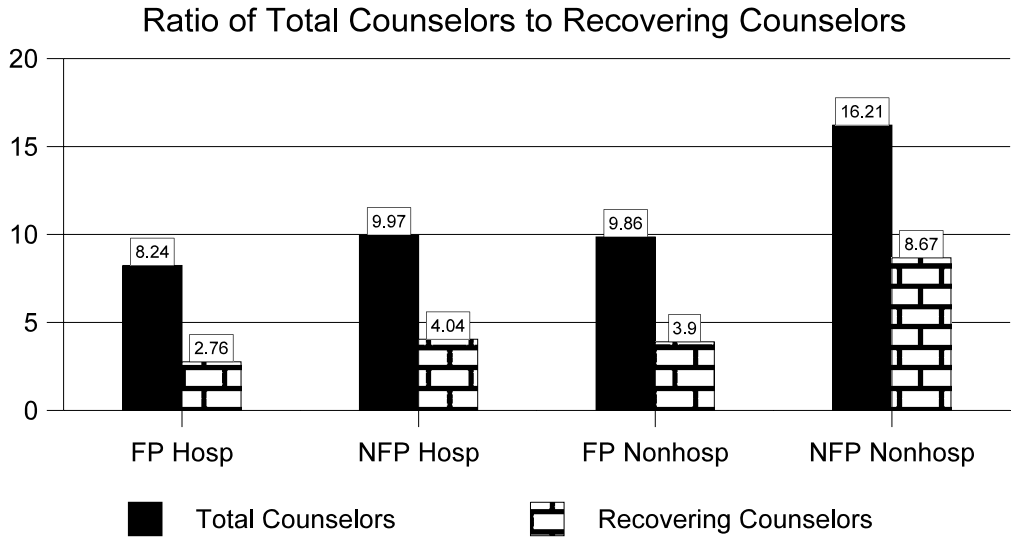
A) FTEs and Total Employees

There is indirect evidence of an overall improvement in management efficiency. While a sizeable percentage of our participants reported expanding their services over the past two years, this has not translated into an increase on the number of employees. In fact, there has been a slight though non-significant decrease in both FTEs and total employees. In 1995-96 participants reported an average of 38.2 FTEs and 48 total employees. Our current data indicate that this number has since declined to an average of 36.8 FTEs and 46.8 total employees. As the following table illustrates, there is wide variation in the average number of FTEs and total employees across different center types. Generally speaking, nonhospital-based centers have more employees than their hospital-based counterparts. This is primarily because support staff and occasionally nurses are supplied by the hospital.



B) Counselors

The average number of counselors has changed very little since our initial visit. During both periods of data collection, participating centers reported an average of 10 counselors on staff. Surprisingly, the average number of counselors who are licensed or certified has decreased slightly. During wave one, centers reported an average of 8 licensed/certified counselors on staff. Our more recent data indicate an average of only 6 licensed/certified counselors per center. The average number of counselors per center does vary by center type with non-profit nonhospital-based centers employing significantly more than other center types. In addition, the ratio of counselors in recovery to total counselors differs by center type with the lowest recovering counselor/total counselor ratio found among for-profit hospital-based centers. The following chart illustrates these differences.



C) Counselor Salaries

Administrators at each center were asked to report the range of counselor salaries as well as the average counselors salaries for their respective centers. Minimum (starting) salaries ranged from $10,753 to $41,760 with a mean starting salary of $24,312. Maximum salaries ranged from $15,598 to $88,000 with a mean maximum salary of $38,084. The average salary for all counselors was $30,733. There were no significant differences in counselor salaries across center types.

D) Staff Benefits

In addition to health insurance coverage, participating centers offered a variety of benefits to their employees. Over half (55.2%) have established health/wellness programs for employees. One trend that seems to be increasing, particularly among the larger centers, is the availability of on-site child care. More than 20% of our participating centers (primarily hospital-based centers) now offer child-care programs for their employees.

E) Employee Assistance Programs

In addition to the aforementioned benefits, nearly three fourths of these centers have an Employee Assistance Program available. The likelihood of a center having an EAP available to its employees does vary by center type. For-profit nonhospital based centers are significantly less likely to have an EAP than the other three center types. Only 30% of for-profit nonhospital based centers report having an EAP. The percentages of for-profit hospital, nonprofit hospital, and nonprofit nonhospital centers with EAPs are 87, 87, and 97 percent respectively. The primary reason for the absence of EAPs among for-profit nonhospital based centers is size. Many of these centers are single proprietor centers with fewer than 10 employees. Establishing an Employe Assistance Program in these small centers would not be cost-effective.

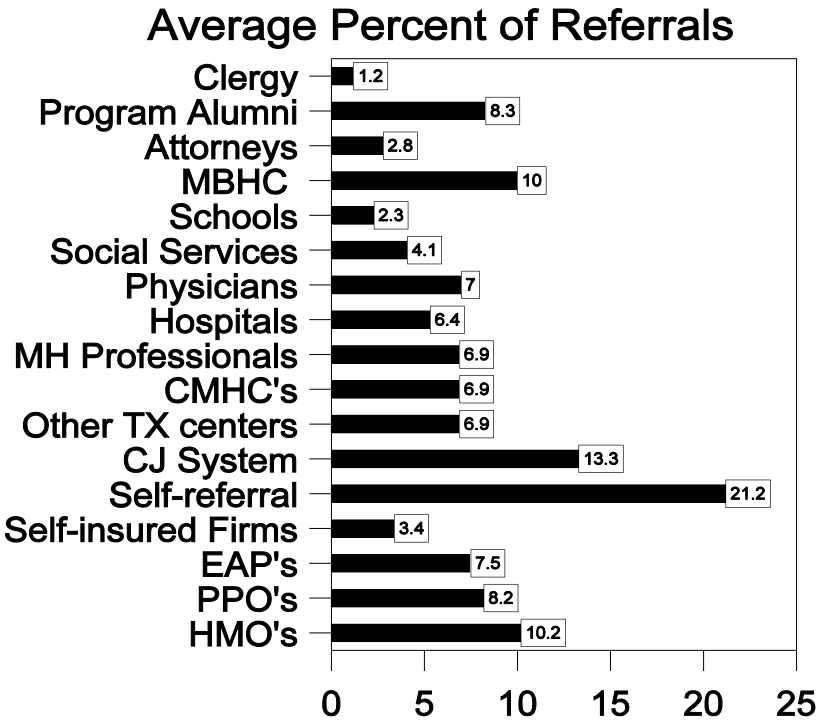
F) Organizational Professionalization

A strong indicator of the professionalization of substance abuse treatment is the percentage of centers with formal employee appraisal programs. 91% of our participants utilize formal appraisal programs when evaluating employee performance.

IV. Patient Data: Referral Sources, Census, etc.

A) Referral Sources

During wave one, respondents were asked to identify the single most important source of referrals for their respective centers. Results revealed that the most important referral source was self-referral, followed by program alumni and physicians. During the most recent wave of data collection, administrators and clinical directors were each given a list and asked to provide the approximate percentage of referrals their center received from the sources listed below. The following chart shows the results of this request. As before, self-referral and program alumni continue to be among the most important sources of referral. However, using this method reveals the emergent importance of the criminal justice system, health maintenance organizations, and managed behavioral healthcare firms, all of which exceed the relative importance of alumni referrals. (Note: In the chart below MBHC refers to managed behavioral healthcare firms and CMHC refers to community mental health centers.



B) Patient Caseloads:

Clinical respondents at both waves of data collection were asked to estimate the composition of their typical caseload by different population subgroups. The following table illustrates the changes, in terms of caseload composition, that have occurred since our initial on-site visit. While the percentage of women and minorities in treatment has changed very little since 1995-96, there seems to have been an overall increase in the percentage of probationers/parolees and relapsers. This increase in relapsers may be indicative of the decreased lengths of stay in treatment imposed by managed care.

SUBGROUP	WAVE ONE	WAVE TWO
Women	35.4%	35.1%
Minorities	29.9%	28.2%
Relapsers	40.0%	52.0%
Probationers/parolees	21.8%	27.5%

C) Census:

Respondents (both administrators and clinical directors) were asked to provide, for each level of care, their current census as well as their average daily census for the past twelve months. The following table shows the average daily census for each level of care across the different types of centers. Note that almost without exception, nonhospital based programs report a higher average daily census than hospital based programs. (Averages are based only on those programs offering a given level of care, not the entire sample)

Average Number of Persons (Census) by Level of Care and Center Type

LEVEL OF CARE	For-profit Hospital	For-profit Nonhospital	Nonprofit Hospital	Nonprofit Nonhospital
Detox	5.2	8.0	3.8	10.4
Inpatient Adult CD	13.6	22.1	7.6	27.8
Inpatient Adolescent CD	6.7	6.7	3.1	9.6
Inpatient Adult Psych	16.2	12.6	11.6	12.3
Partial Hospitalization	6.1	17.5	8.4	10.8
Intensive Outpatient	15.8	31.6	19.9	24.2
Outpatient	24.9	70.5	52	38.9

D) AMA Rates:

Across all centers, average estimated proportion of patients leaving treatment against medical advice (AMA) was 14.16%. This estimate is not significantly different from the 13.8% AMA rate at Wave One.

E) Success Rates:

One of the new items we requested from our centers during this wave was an estimate of their success rate. For the purposes of this study, the success rate was defined as the percentage of clients remaining clean and sober for at least six months following treatment. While fewer than half of our centers have been able to provide us with this rate, those for whom we have data report that an average of 55.7% of clients remain clean and sober for at least 6 months.

F) Payor Mix:

Administrators were asked to estimate the percentage of clients paying for services via the following methods: Medicaid, Medicare, private insurance, self-pay (100% out-of-pocket), and charity. While nearly all of our centers accept private insurance clients, only about two-thirds accept Medicaid and about three-fourths accept Medicare. Not surprisingly, hospital-based centers are significantly more likely to accept Medicaid and Medicare clients than are nonhospital-based centers. For those accepting medicaid and medicare clients, these clients comprise a sizeable proportion of their caseloads. Those accepting Medicaid report an average of 31% Medicaid clients and those accepting Medicare report Medicare patients make up approximately 21% of their caseloads. There are no significant differences in the percentage of Medicaid clients across center types. However, the percentage of Medicare clients does vary by center type with for profit centers, both hospital and nonhospital, reporting a significantly higher percentage of Medicare clients.

Turning to the other payment sources, about 40% of centers' clients are covered by private insurance, 15.5% are self-paying clients, and 7% are charity cases. While the percentage of clients covered by private insurance does not differ by center type, there are significant differences among self-pays and charity cases. Nonhospital-based center, both for profit and nonprofit, report a significantly higher percentage of self-paying clients than their hospital-based counterparts. Not surprisingly, nonprofit centers report significantly higher percentages of charity cases than for profits.

G) Managed Care:

Managed care continues to make significant in-roads into substance abuse treatment. While most private insurance now has some sort of managed care component, over the past 3-4 years states have increasingly introduced managed care components for both Medicaid and Medicare. In addition to asking administrators to identify their payor mix, they were also asked to identify the overall percentage of patients covered by managed care. Across all centers, the average percentage of clients covered by managed care was 54.2% with nearly one-fourth of our centers reporting managed care clients in excess of 80%.

V. Financial Data

A) Retail Charges

Administrators were asked to provide their daily "retail" charges for each of their levels of care. By retail charges we mean rates that are not negotiated, discounted, or contracted rates. The following table shows the average retail charges across all centers for Wave One as compared to Wave Two. These data indicate a general increase in charges for inpatient levels of care over the past two years, but little change in the average retail charge for outpatient services.

Comparison of Wave One and Wave Two Average Daily "Retail" Charges

LEVEL OF CARE	Wave 1 Range	Wave 1 Mean	Wave 2 Range	Wave 2 Mean
Detox	$80-2000	$585.68	$100-2000	$653.68
Inpatient Adult CD	$47-1700	$509.03	$125-1475	$551.43
Inpatient Adol. CD	$135-1500	$591.59	$145-1450	$681.49
Inpatient Adult Psych	$186-1300	$726.89	$300-1475	$775.00
Partial Hospitalization/ Day Program	$75-700	$266.71	$32-650	$275.85
Intensive Outpatient	$22-400	$136.29	$27-510	$138.76
Outpatient	$10-280	$70.32	$15-200	$67.30

B) Retail Charges: Comparative Data

As was true in wave one, the average retail charges differ significantly among the different center types. The following table compares charges for each level of care across the four center types. Generally speaking, for-profit centers' charges are significantly greater than the charges of nonprofit centers.

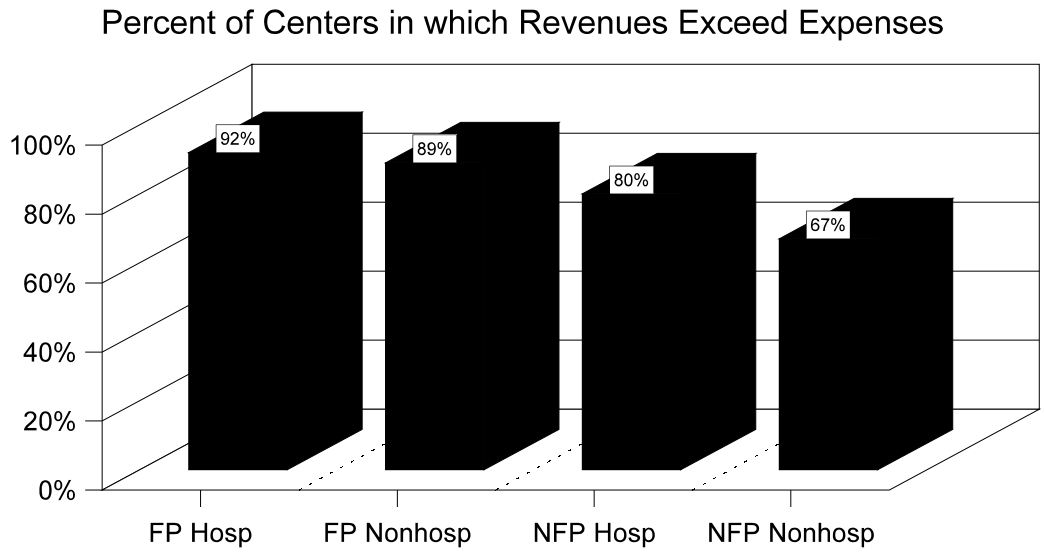
Comparison of Average Daily Charges by Center Type

LEVEL OF CARE	Whole Sample	For profit Hospital	For profit Nonhospital	Nonprofit Hospital	Nonprofit Nonhospital
Detox[A]	$653.68	$846.62	$634.26	$628.71	$422.72
Inpatient Adult CD[A]	$551.43	$796.10	$538.09	$519.12	$352.09
Inpatient Adol. CD[B]	$681.49	$927.50	$686.77	$590.76	$451.86
Inpatient Adult Psych[B]	$775.00	$974.33	$823.69	$698.78	$574.25
Partial Hospitalization/ Day Program[B]	$275.85	$346.06	$285.97	$259.29	$214.67
Intensive Outpatient	$138.76	$146.03	$118.89	$147.48	$113.65
Outpatient	$67.30	$80.46	$53.52	$70.55	$73.62

[A] - For profit Hospital-based center charges significantly greater than other three center types.
[B]- For profit Hospital-based center charges significantly greater than nonprofit hospital and nonprofit nonhospital-based centers.

C) Annual Revenues

Administrators were asked to provide approximate total revenues and expenditures for their respective centers for the most recent fiscal year. Overall, 82% of these respondents reported that their revenues met or exceeded expenses. The following chart show the percentages of centers in which revenues exceed expenses by center type. Despite the seemingly wide variation in these percentages, none of these differences are statistically significant.



VI. Clinical Programs

A) Chemical Dependency Treatment Services:

Since the beginning of our study in 1995-96 we have remained in contact with our centers to learn of any changes occurring in the provision of substance abuse treatment services. The summary report released in November 1997 revealed that 8.6% of participants had discontinued some level of care while nearly 30% had added a new level of care. As we reported at that time, outpatient detox was the most likely new addition.

During the second on-site visit, we again asked respondents about the discontinuation and addition of levels of care. This time, 18% reported discontinuing some level of care, and 30% reported the addition of some level of care. These findings suggest that our centers are continuing to diversify in order to maintain their competitive advantage in a constantly difficult environment.

One of the major changes we have seen since initiating this study is a move away from inpatient chemical dependency treatment. The 1995-96 data revealed that 74% of our centers offered some form of inpatient treatment. Since that time, the percentage of centers offering inpatient treatment has declined to 64%. Given most centers' heavy reliance upon third party payment sources and managed care's restriction on length of stay, we believe this trend away from inpatient treatment will continue into the future.

B) Corollaries to Chemical Dependency Treatment:

Despite the ever-changing face of chemical dependency treatment, three of its corollaries remain static. Aftercare and family programs continue to be offered by the overwhelming majority of our participants, 86.1% and 92.7% respectively. Similarly uneffected, approximately 65% of centers continue to arrange pre-treatment interventions.

C) Other Services:

In addition to offering treatment for chemical dependency, many of the centers in our study provide a number of other treatment services. Treatment programs for codependency are offered by 45.7% of our centers. This is down from the 56.4% of center offering this form of treatment at wave one. At 28%, the percentage of centers offering eating disorders programs remains unchanged since wave one.

Two services which have experienced a wide degree of diffusion since our initial on-site interview are DUI assessments and pathological gambling treatment. Since wave one, the percentage of centers performing DUI assessments has increased from 38.7% to 48.5%. Likewise, the percentage of centers offering treatment for pathological gambling has increased from 16.1% to 29.7%. The likelihood of offering these services does not differ significantly by center type.

D) 12-Step Models:

The 12-step model continues to be the dominant treatment modality in chemical dependency treatment with over 90% of our participants basing their treatment on this approach. The percentage of centers offering 12-step groups on-site also remains unchanged. The types of groups offered range from AA to Gamblers Anonymous to Emotions Anonymous. The majority of these groups (84.9%) continue to be open to community members. Clinical directors at centers offering open groups were asked the percentage of the total attendance non-clients or community members typically comprised. According to their reports, non-clients or community members usually comprise just over half (58%) of the total attendance.

E) Non 12-Step Programs

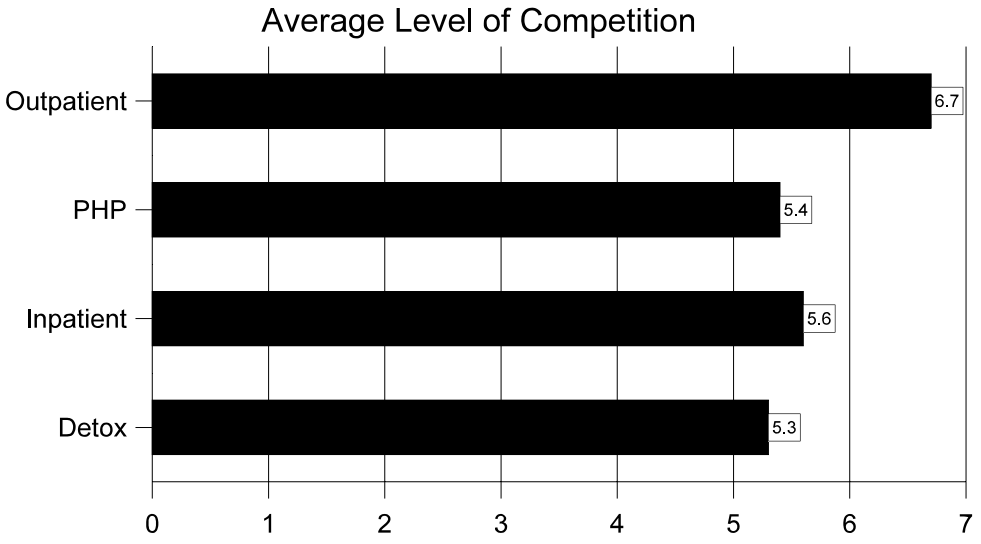
There are 33 centers in our study that are not based on the 12-step model. When asked to describe the model upon which the center is based, a majority (70%) of these centers reported basing their program on a combination of two or more types of models. Nearly one half of these centers incorporate the 12-step model in conjunction with other treatment modalities. In fact, 16 of the centers strongly encouraged their patients to attend 12-step meetings, and 15 held 12-step meetings at their respective centers.

Included among the alternatives to the 12-step approach are cognitive-behavioral, medical-behavioral, family system, rational recovery and ego-psychology models. The cognitive behavioral model is the most commonly described treatment modality found within this subgroup. This model was the primary treatment approach for 10 of the 33 non 12-step centers. Rational recovery, medical behavioral, and psychological models were mentioned by 4, 3, and 4 centers, respectively. Three centers also reported using motivational techniques (motivational therapy, motivational enhancement, and motivational interviewing). Less common models of treatment included the support group model, bio-psychosocial spiritual model, serenity support systems, relapse prevention psychotherapy, and secular organizations for sobriety. These models were each mentioned by a single center.

VII. Marketing Information

A) Competition

All three respondents (administrators, clinical directors and marketing directors) were asked to rate on a scale of 1 to 10 the amount of competition their center faced in the market area. Because competition can vary by level of care, they were asked to apply this rating across four levels of care: detox, inpatient, partial hospitalization, and outpatient. With 1 representing no competition and 10 being intense competition, the following chart show the average competition rating across each level of care. Not unexpectedly, centers report more intense competition for outpatient services than any other service.



When asked whether competition had increased, decreased, or stayed about the same over the past two years, 31% of respondents reported an increase in competition, 18% reported an overall decrease, and just over half reported competition remaining about the same. This same question was asked during the first wave of data collection and elicited the following response: 40% reported increased competition, 32% a decrease, and 29% reported no change in competition over the past two years. The fact that our most recent data collection revealed such a high percentage of respondents reporting no change in competition may indicate an overall "settling" of the substance abuse treatment environment.

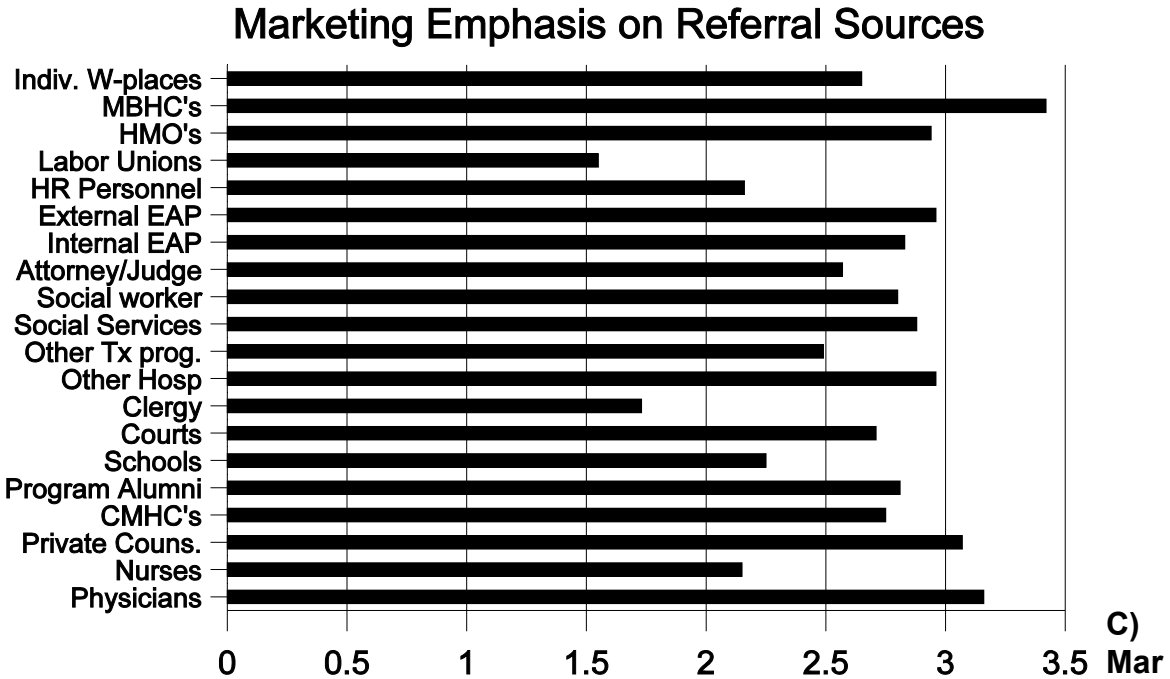
B) Marketing Effort

For the purposes of this study, we identify four potential audiences to which marketing personnel might communicate a given center's services: individuals and their families, practitioners in private practice, human resource personnel in workplaces or EAPs, and managed care organizations. Respondents to the marketing interview were asked what proportion of their time was spent marketing to these four audiences. There results are as follows:

Individuals/families	25%
Private practitioners	28%
HR personnel	21%
Managed Care	24%

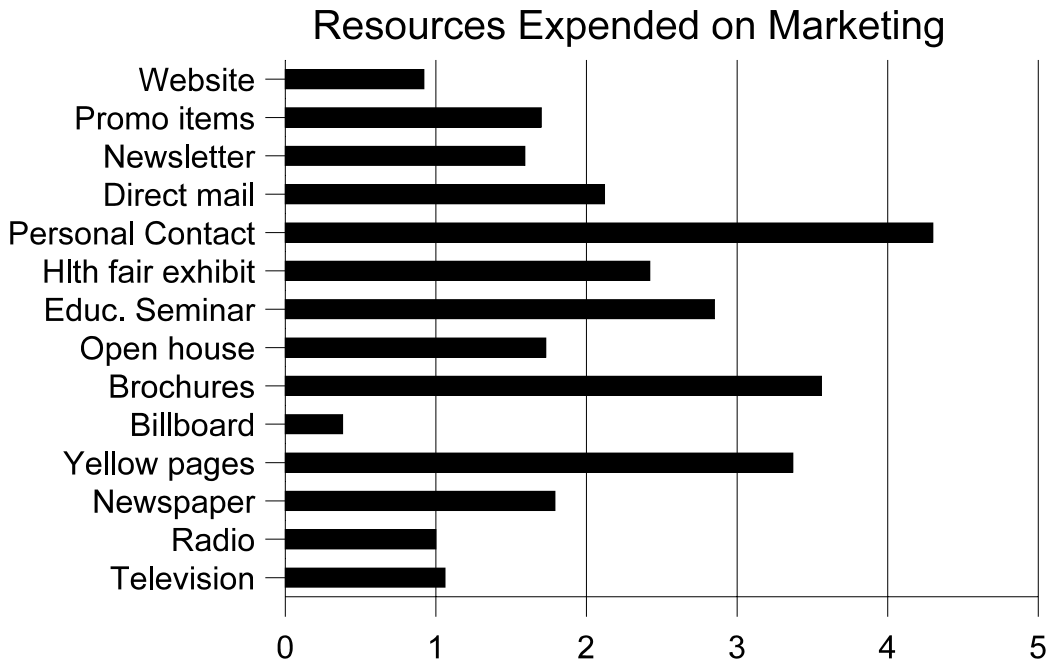
In terms of marketing efforts towards individuals and their families, respondents were asked if they targeted any specific demographic groups. More than half of the centers responded affirmatively. Among the most common groups targeted are professionals (targeted by 24% of participating centers), adolescents (19%), women (17%), and the elderly (17%).

We also inquired as to the level of effort expended toward marketing to various referral sources. Whereas the chart in the clinical section above shows the average proportion of patients referred by each referral source, the chart below shows the amount of emphasis marketers place on each referral sources. (Note: respondents were asked to rate this emphasis on a scale of 0 to 5 with 0 representing no emphasis and 5 representing great emphasis. The numbers in the chart represent the average amount of emphasis placed on each referral source and allow comparisons relative to other referral sources).



keting Resources

In addition to the effort put forth by marketing personnel towards referral sources, we were also interested in the amount of resources spent on various marketing areas. Since we knew it would be difficult for respondents to identify exact amounts spent on each area, we again asked respondents to rate on a scale of 0 to 5 the amount of emphasis placed on each. The following chart, like the previous chart, shows the relative emphasis placed on these areas. Personal contact, brochures, and the yellow pages stand out as sources receiving the highest emphasis in terms of marketing resources. The more costly sources such as radio, television, and billboard ads receive the least emphasis.



D) Innovations in Marketing

Although still in it infancy, one of the most interesting and innovative ways of marketing to potential clients if via internet website. Nearly one-third of participating centers maintain a website for marketing and informational purposes. More than 90% of these websites were established between the time of our initial on-site visit in 1995-96 and our most recent wave of on-site data collection.