

NATIONAL TREATMENT CENTER STUDY

SUMMARY REPORT (NO. 5)

THIRD WAVE ON-SITE RESULTS

A report detailing the findings from the third wave of on-site interviews with a nationally representative sample of private alcohol and drug problem treatment programs participating in the National Treatment Center Study conducted by the University of Georgia and the Georgia Institute of Technology.

August 2002

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Overview of the National Treatment 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 initially by the National Institute of Alcohol Abuse and Alcoholism and later by the National Institute on Drug Abuse, this study was developed in response to the critical shortage of research in this area.

Between June 1995 and August 1996, our first wave of 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 was organizational survival and adaption over time, participating centers were re-contacted at 6-month intervals. During these brief telephone calls, we inquired as to whether any changes had 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.

The second wave of data took place between September 1997 and February 1999, following the same procedures and timeline as the initial interviews. The third wave of the study examines how private-sector substance abuse treatment centers respond to uncertainty and change, specifically their adoption and implementation of pharmacological and therapeutic treatments. We also integrate data regarding the centers' organization and management, creating a fuller depiction of how centers change over time.

Data for this most recent wave were collected between July 2000 and May 2002. About two-thirds of the initial study participants were included in this third wave--305 of 450 cases. By the end of Wave 3, 111 of the centers that had previously participated in the study were closed. Nineteen centers were unable to participate during this wave of data collection, and seven centers were no longer eligible for this study. Thus, 75 more substance abuse centers that met eligibility requirements were randomly selected to augment the existing cases. This report summarizes data obtained during on-site interviews of those 397 privately funded substance abuse treatment centers.

I. Technical Guide to the Report

A) Cases Included in this Report

The data described in the following report is derived from 397 cases. All of the centers, whether part of the initial sample or added during Waves 2 and 3, met specific eligibility requirements (i.e., more than 50% of funds come from private source; center is primarily involved in substance abuse treatment; at minimum, the center offers a level of care equivalent to ASAM level III).

B) Comparison by Center Type

In a number of the tables that follow, comparisons will be made among four different types of treatment centers. The 397 cases included in this report fall into these four types as follows: 187 non-profit hospital-based programs, 87 non-profit nonhospital-based programs, 23 for-profit hospital-based programs, 100 for-profit nonhospital-based programs.

C) 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% probability that these findings could have occurred by chance. In other words, we can be almost certain that the differences among these types of centers are present in the population and not specific to this sample.

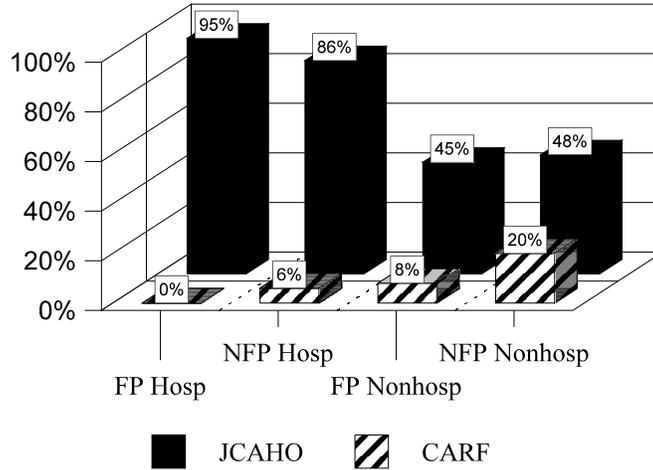
II. General Center Information

A) Accreditation Status

On average, about 97% of the centers in our study were accredited by the state. All for-profit hospital-based administrators claimed that state accreditation was required for their centers to remain open, while about 94% of the remaining administrators reported that it was necessary for their respective centers. There were no significant differences in the percentage of centers that were required to receive or had already received state accreditation across center types.

While 73% of the centers reported JCAHO accreditation, only 10% had received CARF accreditation. Hospital-based centers were significantly more likely to be JCAHO accredited than their nonhospital-based counterparts. Not-for-profit nonhospital-based centers were more likely to obtain CARF accreditation than any other center type; 20% of not-for-profit nonhospital-based centers were accredited by CARF.

Accreditation by Center Type

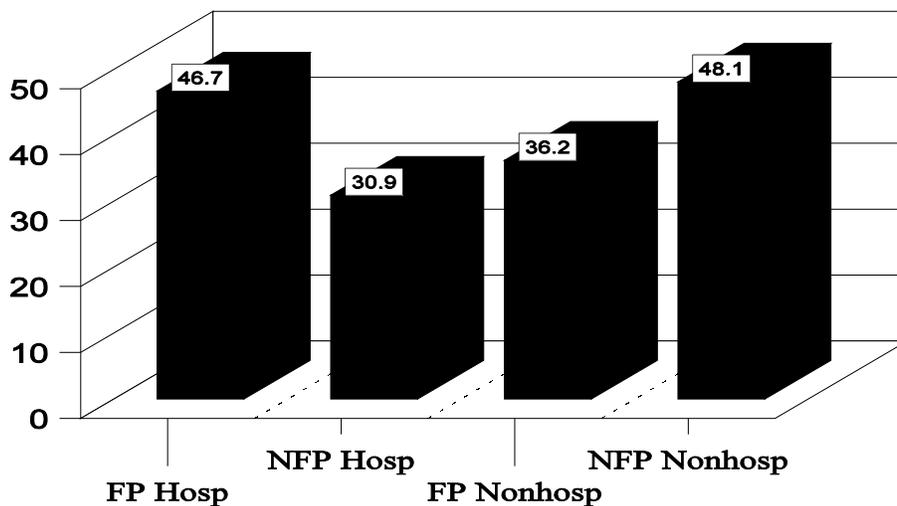


III. Human Resource Management

A) FTEs and Total Employees

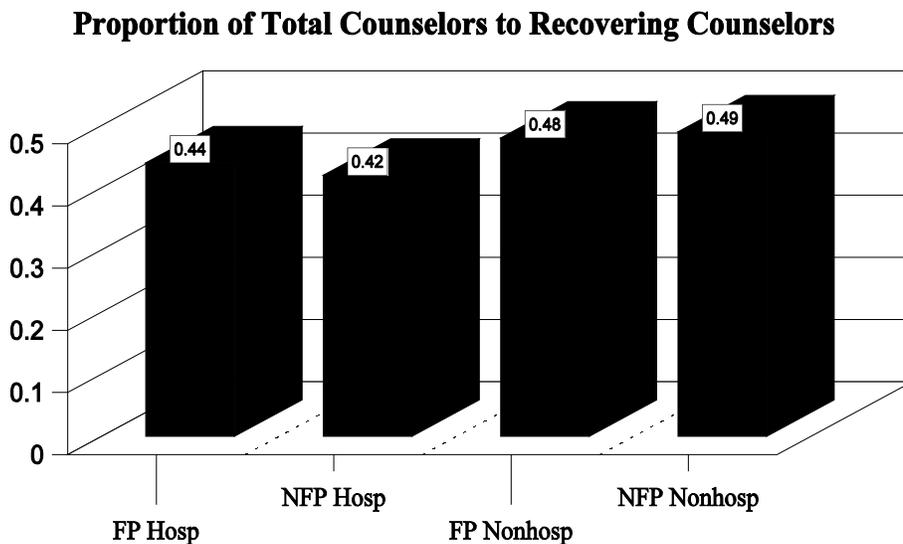
Our current data indicate that centers have an average of 37 full-time employees. As the following table illustrates, there is a wide variation in the average number of FTEs across center types. Specifically, not-for-profit nonhospital-based centers employ a significantly greater number of FTEs than not-for-profit hospital-based centers. The number of FTEs at all other center types are comparable.

Average Number of FTEs by Center Type



B) Counselors

During the third wave of data collection, participating centers reported an average of 13 counselors on staff. Of these, about half are certified. Centers also employed an average of 5 recovering counselors. Although there were no significant differences in the average number of counselors employed across center type, not-for-profit nonhospital-based centers employ a significantly greater number of recovering counselors than not-for-profit hospital-based centers. In addition, the proportion of counselors in recovery to total counselors differs by center type with the lowest recovering counselor/total counselor proportion found in for-profit hospital-based centers and the highest proportion in not-for-profit nonhospital-based centers. The actual proportions are shown in the chart below.

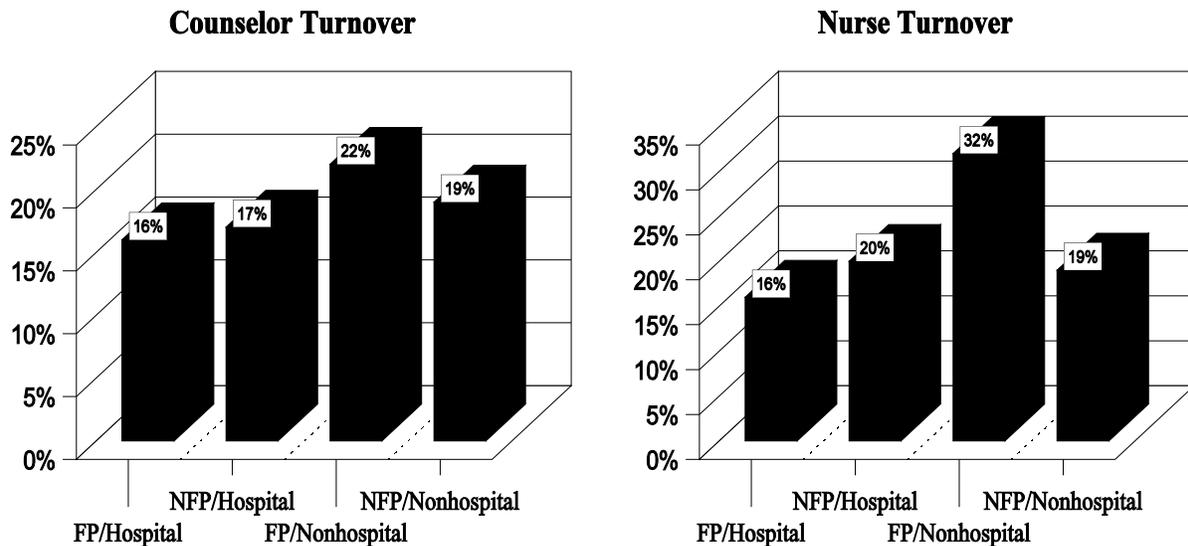


C) Counselor Salaries

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 \$12,000 to \$52,000, with a mean starting salary of \$28,219. Maximum salaries ranged from \$15,000 to \$95,000, with a mean maximum salary of \$41,797. The average salary for all counselors was \$34,266.

D) Nurse and Counselor Turnover

To determine the counselor and nurse turnover within a center, we asked the administrator to report the number of counselors and nurses who voluntarily quit over the past year. On average, 18.5% of counseling staff and 21.5% of the nursing staff have to be replaced each year. The average turnover rates for each center type are shown in the graphs below.



E) Level of Education of Counselors

Administrators at each center were asked to report the percentage of counselors who had achieved specific levels of education, ranging from less than a bachelor's degree to an Ph.D. or M.D. On average, over half (54.0%) of all counselors held at least a master's degree. For-profit hospital-based centers employed the greatest percentage of counselors with at least a master's degree (64.3%), while not-for-profit nonhospital-based centers employed the fewest (49.7%). For-profit nonhospital-based centers and not-for-profit hospital-based centers reported that 50.1 and 56.7 percent, respectively, of their counselors had earned at least a master's level degree. There are no significant differences in these percentages across center types.

F) Staff Benefits

In addition to health insurance coverage, participating centers offered a variety of benefits to their employees. Nearly 70% of centers have developed health/wellness programs for employees. Over half (56%) have established stress reduction programs, while 86% offer family leave options. Nearly a quarter (22%) of the centers that we interviewed offered child-care facilities for their employees. In general, hospital-based centers provide a wider range of benefits to their employees than do nonhospital-based centers.

G) Employee Assistance Programs

In addition to the aforementioned benefits, nearly 70% of these centers have an Employee Assistance Program available. The likelihood of a center having an EAP available varies by center type. For-profit nonhospital-based centers are significantly less likely to have an EAP than the other three center types. Only 27% of such centers report having an EAP. The percentages of for-profit hospital, not-for-profit hospital, and not-for-profit nonhospital centers with EAP are 68, 93, and 60 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; thus, establishing an Employee Assistance Program in these small centers may be seen as prohibitive in terms of cost.

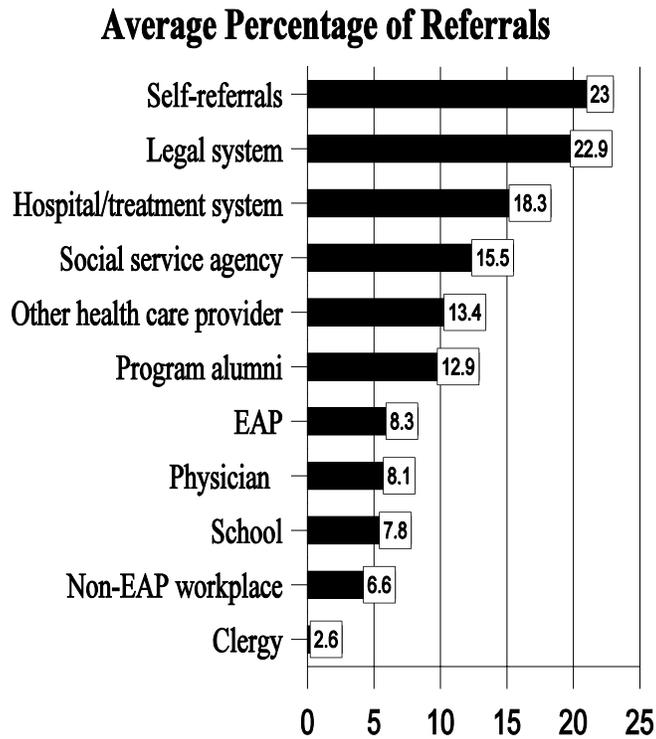
H) Organizational Professionalization

An indicator of good management practice within substance abuse treatment is the percentage of centers with formal employee appraisal programs. 94% of our participants utilize formal appraisal programs when evaluating employee performance.

IV. Patient Data

A) Referral Sources

During the most recent wave of data collection, administrators and clinical directors asked to provide the approximate percentage of referrals their center received from the sources listed below. The following chart shows the range in importance of different referral sources. Self-referral and legal system referrals were the most frequent referral sources, comprising 23.0 and 22.9 percent of the total referrals, respectively.



B) Patient Caseloads

Clinical respondents at all centers were asked to estimate the composition of their typical caseload by different population subgroups. The following table shows the average percentage of each type of clientele within each center type. There are no significant differences in the caseload proportions of adolescents, minorities or relapsers across the four center types. Not-for-profit hospital-based centers were more likely to treat women clients than for-profit nonhospital-based centers. Both not-for-profit and for-profit nonhospital-based centers were significantly more likely to treat probationers/parolees than for-profit hospital-based centers.

Average Percentage of Subgroups Served by Center Type

<u>SUBGROUP</u>	For-profit Hospital	Not-for-profit Hospital	For-profit Nonhospital	Not-for-profit Nonhospital
Women	36.6%	39.5%	33.6%	36.0%
Adolescents	13.1%	8.9%	11.4%	13.1%
Minorities	36.0%	27.4%	31.1%	30.3%
Relapsers	46.4%	51.7%	46.7%	50.6%
Parolees/Probationers^A	15.7%	26.3%	35.9%	31.8%

^A- Nonhospital-based centers treat a significantly higher proportion of clients in this subgroup than do for-profit hospital-based centers.

C) Census

Respondents (both administrators and clinical directors) were asked to provide both the 12-month average daily census and total capacity (i.e., number of beds and/or number of slots) for each level of care. To determine the average capacity for each center type, we divided the total capacity by the average daily census. In some cases, the average daily census was greater than the total capacity, indicating that the demand for a certain level of care exceeded the allotted number of beds or openings. This was a particularly common phenomenon for inpatient care. The table below shows the percentage of available beds or slots that are occupied, on average, on a daily basis over the course of a year. The average number of available beds and slots for each center type is also included. (Averages are based only on those programs offering a given level of care, not the entire sample.)

With the exception of intensive outpatient, not-for-profit nonhospital-based centers offer, on average, a larger number of beds and outpatient slots than the other three center types. Not-for-profit hospital-based centers tend to have fewer inpatient beds and outpatient slots than other center types. Though for-profit hospital-based inpatient programs appear to operate at a higher percent capacity than other center types, these differences are not statistically significant. By contrast, the highest average percent capacity among intensive outpatient and outpatient programs is in not-for-profit nonhospital-based centers.

Average Percent of Capacity by Level of Care and Center Type

<u>SUBGROUP</u>	For-profit Hospital	Not-for-profit Hospital	For-profit Nonhospital	Not-for-profit Nonhospital
Inpatient Care^A	88.3%	70.9%	72.6%	79.7%
<i>Average number of beds</i>	(57)	(35)	(68)	(73)
Partial Hospitalization	54.3%	50.4%	46.8%	50.9%
<i>Average number of slots</i>	(21)	(17)	(23)	(28)
Intensive Outpatient	65.8%	63.4%	56.9%	70.0%
<i>Average number of slots</i>	(36)	(31)	(44)	(31)
Outpatient	53.7%	62.8%	61.0%	69.0%
<i>Average number of slots</i>	(107)	(75)	(95)	(133)

^A Although different centers offer different combinations of inpatient treatment programs, inpatient care may include any or all of the following: residential, inpatient detox, inpatient adult CD, inpatient adolescent CD, inpatient adult psychiatric and inpatient adolescent psychiatric treatments.

D) Success Rates

From centers conducting follow-up studies of former clients, we requested estimates of success rates. Just under half (45%) of the centers reported some level of contact with former clientele. The frequency of follow-up ranged from one month to a year, indicating that some centers conduct monthly follow-ups, while others administer only annual follow-ups. The length of time clients were followed ranged from only one month to five years. Based on the responses to these questions, we asked them to report the percentage of clients remaining clean and sober at the specified interval (i.e., if a respondent reported follow-ups every six months for a year, we would request the success rate at 6 and 12 months). The results of these queries are listed in the table below. Note that the range of reported success rates are highly variable.

Percentage of Clients Remaining Clean Following Treatment

FOLLOW-UP INTERVAL	Average Success Rate	Range Across Centers
1-month interval	66.8%	5% -100%
3-month interval	61.9%	0% - 100%
6-month interval	63.1%	25% - 100%
12-month interval	56.5%	20% - 100%

E) Payor Mix

Administrators were asked to estimate the percentage of clients paying for services via the following methods: Medicaid, Medicare, private insurances, HMOs, PPOs, self-pay (100% out-of-pocket), and charity. Only about two-thirds of the centers accept Medicaid and about 60% accept Medicare. Not surprisingly, hospital-based centers are significantly more likely to accept Medicaid and Medicare clients than are nonhospital-based centers. Those accepting Medicaid patients report an average of 22.5% Medicaid clients, and those accepting Medicare report that Medicare patients make up approximately 9.7% 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 hospital-based centers, both for-profit and not-for-profit, reporting a significantly higher percentage of Medicare clients.

Self-paying clients and those utilizing private insurance comprise a sizeable proportion of many centers' caseloads, with an average of 16.2% and 13.4%, respectively, recorded across all center types. Nonhospital-based centers, both for-profit and not-for-profit, report a significantly higher proportion of self-paying clients than their hospital-based counterparts. Private insurance is used more often in not-for-profit hospital-based centers than in not-for-profit nonhospital-based centers.

On average, 14% of centers' clients are covered by PPOs, EPOs or POSs and a little over 16% use HMOs. In general, hospital-based centers see a significantly greater proportion of clients who are using either PPOs, EPOs, POSs or similar insurance options. The proportion of clients covered by HMOs is generally comparable across center types.

Finally, many centers receive charity cases. On average, 5.2% of cases in each center are considered charity cases. Not-for-profit nonhospital-based centers receive a significantly higher proportion of these clients than any of the other three center types.

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. In general, not-for-profit nonhospital-based centers tend to charge less for most types of treatment than the other three center types.

Comparison of Average Daily “Retail” Charges by Center Type

SUBGROUP	Whole Sample	For-profit Hospital	Not-for-profit Hospital	For-profit Nonhospital	Not-for-profit Nonhospital
Inpatient Detox^A	\$665.13	\$777.80	\$711.19	\$664.80	\$479.18
Inpatient Adult CD^A	\$537.63	\$713.00	\$582.29	\$535.11	\$336.42
Inpatient Adolescent CD^A	\$624.44	\$1045.00	\$692.95	\$629.93	\$357.50
Inpatient Adult Psych	\$797.04	\$943.08	\$763.20	\$790.43	\$943.33
Partial Hospitalization^B	\$293.16	\$356.35	\$290.44	\$314.26	\$238.41
Intensive Outpatient^C	\$156.85	\$182.85	\$170.86	\$155.17	\$119.17
Outpatient	\$85.34	\$103.50	\$89.37	\$88.17	\$65.57

^A- Not-for-profit nonhospital-based centers charges are significantly less than the other three center types.

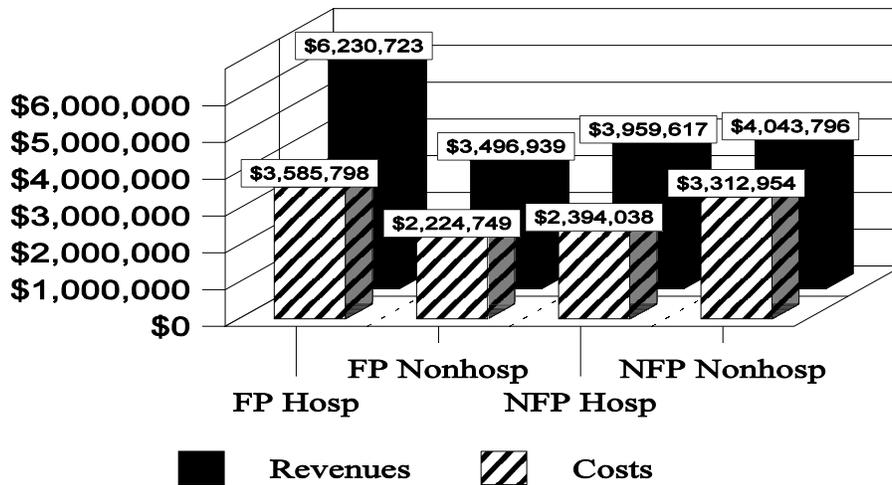
^B-Not-for-profit nonhospital-based centers charges are significantly less than both for-profit center types.

^C-Not-for-profit nonhospital-based centers charges are significantly less than not-for-profit hospital-based centers.

B) Annual Costs and Revenues

Administrators were asked to provide approximate total revenues and expenditures for their respective centers for the most recent fiscal year. Overall, 76.2% of these respondents reported that their revenues met or exceeded expenses. Over half (52.7%) of the not-for-profit nonhospital-based centers reported revenues that met or exceeded expenses; 83.8% of for-profit nonhospital-based centers reported profits; 77.9% of not-for-profit hospital-based centers had greater revenues than costs; and, 93.3% of for-profit hospital-based centers received profits. Despite the seemingly wide variation in these percentages, none of these differences are statistically significant. The following chart shows the average annual costs and revenues for each center type. As illustrated in the chart, not-for-profit nonhospital-based centers report the smallest average difference between revenues and expenses.

Average Cost and Revenue by Center Type



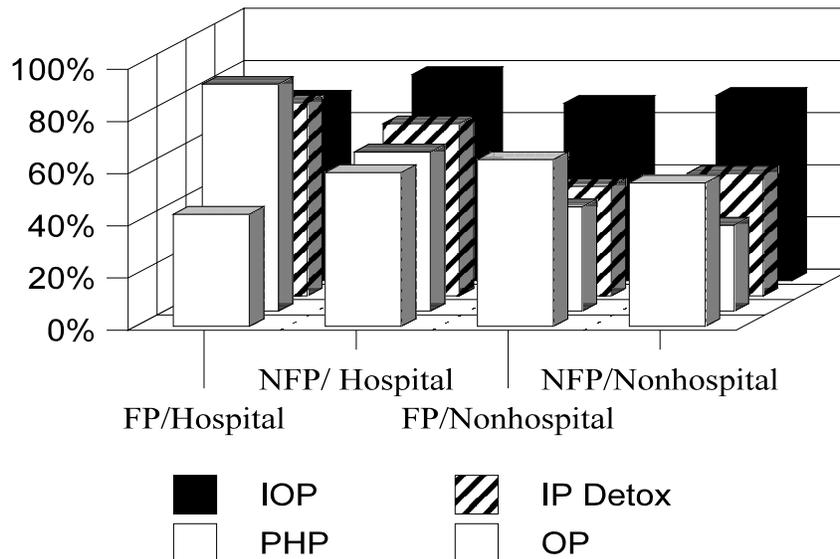
VI. Clinical Programs

A) Chemical Dependency Treatment Services

During the third on-site visit, we asked respondents if they offered specific types of inpatient and outpatient treatments. Intensive outpatient, outpatient, inpatient detox, and partial hospitalization were the most commonly offered levels of care for substance abuse treatment. The percentage of centers offering these levels of care is represented in the chart below, separated by center type. In general, hospital-based centers were more likely to offer inpatient detox than their nonhospital-based counterparts. For-profit hospital-based centers were significantly more likely to offer partial hospitalization than any other center type. The percentage of centers that offered intensive outpatient and outpatient treatments was relatively even across center type.

Less commonly offered treatments include residential, outpatient detox, adult inpatient, adolescent inpatient, and adult and adolescent psychiatric care. Adult-focused treatments tended to be offered more frequently than adolescent-focused care in all center types. For-profit hospital-based centers were the most likely to offer inpatient adult care, outpatient detox, and psychiatric treatment for adults and adolescents.

Types of Treatment by Center Type



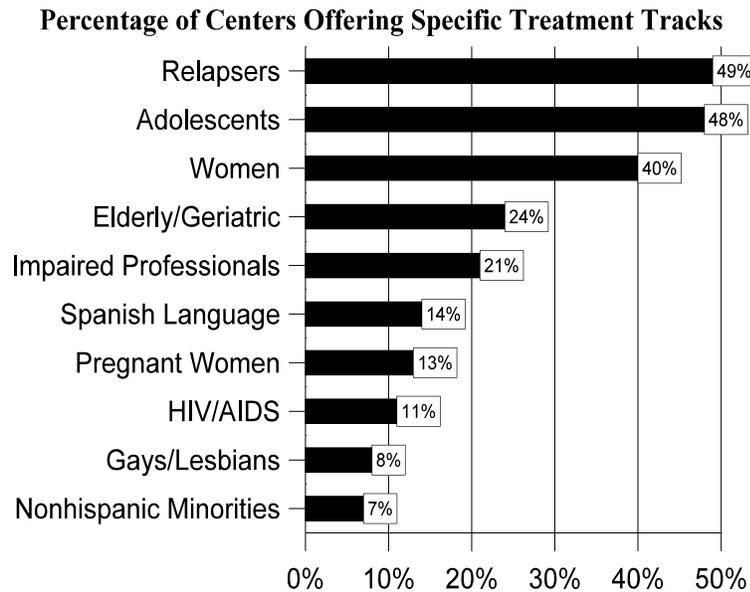
B) Other Services

In addition to offering treatment for chemical dependency, many of the centers in our study provide a number of other treatment services. Our data show that 65% of these centers also offer programs to treat clients with psychiatric disorders. Hospital-based centers are significantly more likely to have programs that treat psychiatric disorders than nonhospital-based centers. While 54% of the centers offer codependency treatment programs, only one-third treat clients with eating disorders.

Many centers also offer programs to treat a number of addictions. Gambling and nicotine addiction are the most common forms of addiction treated in our study's centers, with 37% and 39% of the centers offering treatments for these respective addictions. Approximately 29% of the centers treat sex addiction, while 12% have programs to treat Internet addiction. The likelihood of offering these non-substance-related addiction services does not differ significantly by center type.

C) Treatment Tracks

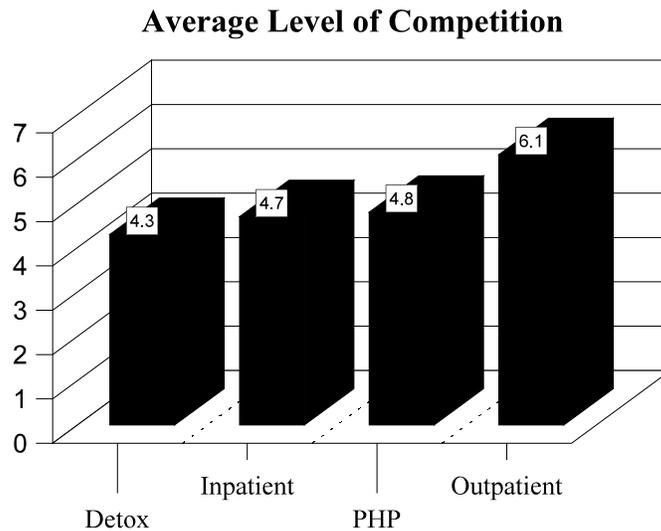
Many of our study's centers offer specialized treatment tracks designed to meet the needs of specific demographic groups. Not surprisingly, the most common groups for whom separate treatment tracks are developed are relapsers, adolescents and women. In general, not-for-profit nonhospital-based centers are significantly more likely to offer specialized treatment tracks for women than not-for-profit hospital-based centers. With the increasing number of elderly, many centers have also developed treatment tracks designed specifically for the needs of elderly or geriatric clients. Both not-for-profit and for-profit hospital-based centers are significantly more likely to offer treatments that accommodate the specific needs of elderly than their nonhospital-based counterparts. The increased presence of Latino/Latina populations has also motivated many centers to offer treatments in Spanish; a smaller proportion of treatment tracks are devoted to other non-Hispanic minorities. The percentage of centers that offer specialized tracks for these demographic groups are listed below.



VII. Marketing Information

A) Competition

Respondents from each center 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 shows the average competition rating across each level of care. Not unexpectedly, centers report more intense competition for outpatient services than any other service. The average level of competition did not vary significantly by center type.



B) Competitive advantages

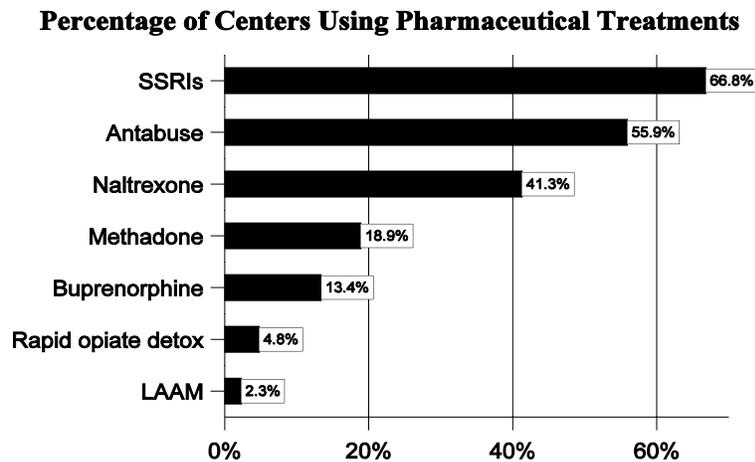
For the purposes of this study, we identified a variety of center characteristics that might allow a particular treatment center a competitive advantage over its competition; these characteristics included a center's location, reputation, medical and behavioral treatment offerings, costs to center and to clients, flexibility and innovation. Respondents to the marketing interview were asked which of these aspects gave their respective centers a competitive advantage over the other centers with whom they competed, with 0 representing to no extent and 5 being a very great extent. Their average results are as follows:

Center/hospital reputation:	4.5
Center longevity:	4.4
Client satisfaction:	4.3
Staff reputation/name recognition:	4.3
Flexibility of treatment programming:	4.2
Accessibility of medical services:	4.1
Ability to respond to census changes:	4.0
Comprehensiveness of services:	4.0
Location/appearance/setting:	4.0
Cost of services:	3.6
Ability to respond to funding changes:	3.5
Nontraditional/innovative programming:	3.3
Success rate/outcome studies:	3.2
Affiliations with other facilities:	3.0
Operating costs:	3.0

VIII. Treatment Innovations

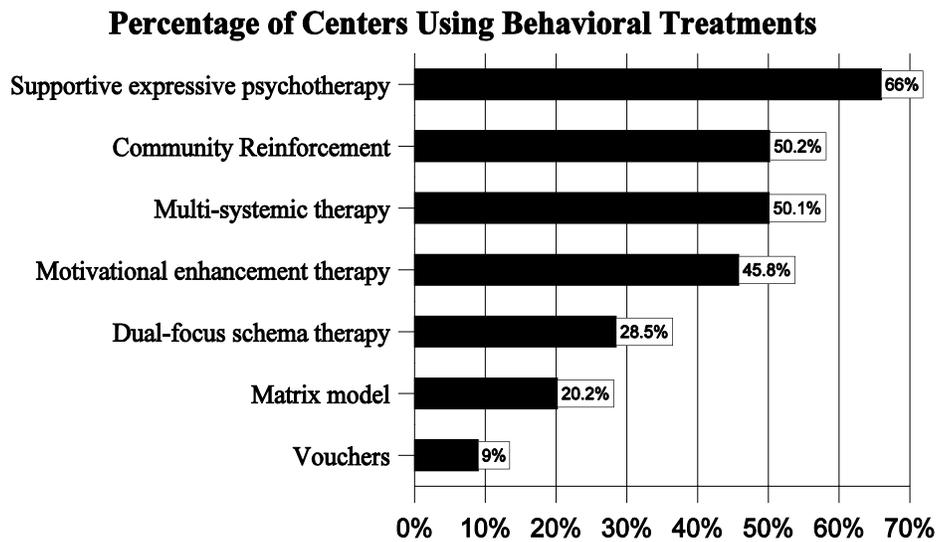
A) Pharmaceutical

Respondents were asked whether their center used specific pharmaceutical treatments, and if so, what percentage of their clients received that medication. Many of these medications were prescribed in conjunction with some form of psychosocial therapy. SSRIs, antabuse and naltrexone are the three most commonly used pharmaceutical treatments in our study's centers. For-profit hospital-based centers are significantly more likely to use antabuse than any of the other center types. Both not-for-profit and for-profit hospital-based centers reported prescribing SSRIs more often than their nonhospital-based counterparts. Methadone, LAAM, buprenorphine and rapid opiate detox were used in fewer than 20% of our study's centers.



B) Behavioral:

Substance abuse treatment centers utilize a much wider range of behavior based treatments than pharmaceutical treatments. While supportive expressive psychotherapy (SEP) was used nearly two-thirds of our sample, community reinforcement and multi-systemic therapy were also provided by over half of the centers. Motivational enhancement therapy (MET) was another widely used method, with nearly half of the centers reporting its use. Dual-focus schema therapy, the matrix model and vouchers were adopted by fewer than 30% of the centers. The actual percentage of centers using these behavioral based treatments is shown in the chart below.



C) Alternative:

Many of the centers in our study offer treatments that depart from the traditional pharmaceutical and behavioral approaches. Art and music therapy are the most common forms of alternative therapy, with these methods being used in 51.4 and 34.2 percent of our study's center, respectively. Acupuncture is used in approximately 9% of the centers. Around 10% of the respondents reported prescribing hypnosis, another form of alternative therapy. The use of alternative therapies was evenly distributed across center types.

