National Treatment Center Study

Summary Report

A comprehensive report detailing findings from on-site interviews at 450 alcohol and drug addiction treatment programs nationwide

January 1997

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National Treatment Center Study

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National Treatment Center Study, Summary Report, 1997
I. Regional Distribution of Participating Programs

We visited 450 programs in 38 states, distributed as follows:

![Distribution by Region](chart)

Regions were defined as follows (parentheses show number of programs in each state):

**Northeast:** Connecticut (9), Delaware (1), Massachusetts (20), New Hampshire (4), New Jersey (16), New York (27), Pennsylvania (15)

**Southeast:** Alabama (5), Florida (30), Georgia (20), Kentucky (13), North Carolina (8), South Carolina (6), Tennessee (8), Virginia (3), West Virginia (5)

**Great Lakes:** Illinois (23), Indiana (15), Michigan (15), Minnesota (16), Ohio (22), Wisconsin (20)

**Central:** Colorado (11), Kansas (1), Louisiana (10), Iowa (9), Missouri (10), Nebraska (7), Oklahoma (3), Texas (26)

**West:** Arizona (8), California (29), Idaho (8), Montana (5), New Mexico (3), Oregon (5), Utah (3), Washington (12)

*National Treatment Center Study, Summary Report, 1997*
II. Description of Participating Programs

A. Profit status: Among participating programs, 37.4% were for-profit facilities, while 62.6% were not-for profit programs.

B. Physical location of programs:
Roughly 39% of programs are located in self-contained units that are not on a hospital campus; 23% of programs are located within self-contained units on a hospital campus; 29% are located within general hospitals; and 8% are located in psychiatric hospitals.
C. Administrative Location:
We classified programs as "hospital-based" if they were owned by a hospital or had administrative ties to a hospital, regardless of whether the program itself was located "on campus" or "off campus." (Programs located on a hospital campus but sharing no administrative ties to the hospital were considered freestanding. Likewise, programs administered by hospitals but not located on the hospital campus are classified as hospital-based in this report.) Using this definition, 65.8% of programs are hospital-based, while 34.2% are classified as freestanding.

D. Distribution of profit status across organizational type:
The following chart shows the results of cross-tabulating hospital location by profit status. (Note: bar labels indicate the number of programs in each category.)

National Treatment Center Study, Summary Report, 1997
### E. Perceived Organizational Advantages: Hospital-based vs. Freestanding Programs

We asked administrators of hospital-based programs and freestanding facilities to describe the advantages and disadvantages (if any) that they attribute to their organizational type. The table below depicts (in descending order) the most common responses mentioned. (Multiple responses were permitted.)

What are the advantages and disadvantages of being...

<table>
<thead>
<tr>
<th>Hospital-based Advantages</th>
<th>Hospital-based Disadvantages</th>
<th>Freestanding Advantages</th>
<th>Freestanding Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>on-site medical services</em></td>
<td><em>CD treatment seen as &quot;stepchild&quot; to med/surg focus</em></td>
<td><em>can shape program's culture/philosophy</em></td>
<td><em>lack of financial resources to fall back on</em></td>
</tr>
<tr>
<td><em>administrative support services</em></td>
<td><em>higher overhead, higher treatment charges</em></td>
<td><em>less bureaucracy, can make changes more quickly</em></td>
<td><em>limited medical or administrative support services</em></td>
</tr>
<tr>
<td><em>referral networks</em></td>
<td><em>limited space, or unappealing treatment setting</em></td>
<td><em>focus on more &quot;personalized&quot; service</em></td>
<td><em>smaller referral base</em></td>
</tr>
<tr>
<td><em>legitimacy associated with hospitals reputation or credentials</em></td>
<td><em>must comply with strict hospital standards and regulations</em></td>
<td><em>offer more affordable programming</em></td>
<td></td>
</tr>
<tr>
<td><em>reimbursement issues, eligibility for Medicare/Medicaid</em></td>
<td></td>
<td><em>appealing physical location or treatment setting</em></td>
<td></td>
</tr>
</tbody>
</table>

*National Treatment Center Study, Summary Report, 1997*
F. Corporate Ownership

We classified programs as "corporate-owned" if either the treatment facility itself, or the hospital in which a program was based, was owned by a corporate entity. In all, 44.7% of programs were classified as being owned by a larger corporation.

G. Advantages and Disadvantages of Corporate Ownership

We asked administrators of corporate-owned programs to describe the advantages and disadvantages (if any) that they attributed to corporate ownership. The table below depicts (in descending order) the most common responses mentioned. (Multiple responses were permitted.)

What are the advantages and disadvantages of being...

<table>
<thead>
<tr>
<th>Corporate-Owned Programs</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>*financial resources</td>
<td>*red tape; slow to implement changes</td>
<td></td>
</tr>
<tr>
<td>*administrative support services</td>
<td>*treatment program gets &quot;low&quot; in other projects/initiatives</td>
<td></td>
</tr>
<tr>
<td>*referral networks</td>
<td>*concern with the &quot;bottom line&quot;</td>
<td></td>
</tr>
<tr>
<td>*employee benefits</td>
<td>*stigma attached to &quot;big business&quot; in health care</td>
<td></td>
</tr>
<tr>
<td>*strategic planning</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

National Treatment Center Study, Summary Report, 1997
H. Age of programs:

Across all participating programs, average age at the time of our on-site interview was 15.2 years (median=12 years). Programs ranged in age from 1 year old to more than 75 years old, although most are between 6 and 15 years old.

I. Changes since founding:

Given the age of programs in our sample, they show remarkable stability in ownership over time. Of the total, 103 programs (22.9%) changed owners in the time since they first opened. Among these, 36 changed their profit status, with 24 for-profit programs becoming non-profits, and 12 non-profit programs becoming for-profits.

J. Threats of Closure:

Among all administrators interviewed, 142 (31.6%) reported that, at some time since their founding, their program had been seriously threatened with being closed. 50 administrators (11% of total) reported that they were currently faced with a threat of closure at the time of our on-site interview.

Having undergone a major organizational change (in ownership and/or profit status) since founding was not significantly related to whether programs had experienced a threat of closure.
K. Likelihood of Closure:

We asked administrators to rate the likelihood that their program would close within the 12 months following our on-site interview. 65% of respondents said their program had "no likelihood" of closing in the next 12 months; 24.2% rated their center's likelihood of closure as low (2.4 on a scale of 1 to 10); 9.5% rated likelihood of closure as moderate (5-7 on a scale of 1 to 10); and only 0.2% rated their chance of closing as high (8-10 on a scale of 1 to 10). The average rating across all centers in the study was 1.97.

L. Reported closures:

We track all of our participating centers to ascertain whether any have closed since the time of our last contact. To date, we have found that 20 of our 450 participating centers have closed. Among these closures, 13 programs were greater than 10 years old, and all but one were more than 5 years old, arguing against a "liability of newness" among these programs. Twelve of the programs had rated their threat of closure as moderate or high. However, eight of the now-closed programs rated their threat of closure as low; among these, 6 programs were hospital-based and/or corporate owned, suggesting that these unanticipated closures may have been the result of actions taken at other levels of the organization.

Additional closures will be reported as each wave of follow-up calls are completed. We are currently analyzing closure data to determine which, if any, organizational factors are most helpful in predicting organizational failure. Such data will be made available in future reports.
M. Accreditation:

The vast majority (94.9%) of the programs are licensed or accredited. Of these, 391 (91.6% of accredited programs; 96.8% of total sample) are accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).

N. Expansion Plans:

At the time of our on-site interview, 253 centers (56.2%) told us that they were seriously considering expanding some portion of their services. Among the plans being considered (multiple responses were permitted):

- 241 (53.6% of total) programs were seeking to increase the number of clients served
- 214 (47.6%) planned to increase their outpatient capacity
- 193 (42.9%) planned to increase the number of employees
- 57 (12.7%) planned to increase the number of beds

If programs did not report any expansion plans, we then asked if they were seriously considering any reductions or cutbacks in their services, staff, or programs. Of the 157 administrators asked, only 36 were seriously considering making any such alterations.
III. Human Resource Management

A. FTEs and Total Employees

Administrators at the 450 participating centers reported that their program employed an average of 38.18 full-time equivalent employees (FTEs; median=20), with 36 centers (8%) having more than 100 FTEs. On average, administrators reported having 48 total employees in their treatment programs (median=25), with 55 centers (12%) having more than 100 total employees on staff.

Number of Staff
(FTEs and total staff)

B. Volunteer staff:

247 facilities (54.9%) use volunteer staff to assist in their programs

C. Staff shortages:

We asked respondents whether there was a shortage of particular skills in their labor market (i.e., whether certain qualifications were hard to find when hiring staff). 227 respondents (50.4%) mentioned an ongoing need for some particular skill or credential. Among the specific skills most often mentioned:

27% mentioned clinical skills/credentials
10% mentioned nurses
5% mentioned needing staff of various racial/ethnic/cultural backgrounds
4% mentioned administrative skills
4% mentioned M.D.s
4% mentioned bilingual staff

(Note: multiple responses were permitted. Numbers reflect percentage of all programs.)

National Treatment Center Study, Summary Report, 1997
D. Counselors:

Across the entire sample, centers employed an average of 10 counselors. Centers had an average of 8 licensed/certified counselors, and an average of 5 recovering counselors on staff.

Hospitals employed significantly more counselors than other programs (an average of 14 in hospitals, 9 in all other programs). Interestingly, hospitals did not differ significantly from other programs in terms of the number of licensed/certified counselors employed. However, hospital programs had significantly fewer recovering counselors on staff.

E. Counselor Salaries:

Administrative respondents at each facility reported their approximate minimum and maximum salaries for counselors. (All hourly rates were converted to annual equivalents.) Across all centers providing data, the average minimum (starting) salary was $23,741 and the average maximum salary was $36,042.

Comparisons by organization type: Counselor minimum and maximum salaries show no statistically significant differences when we compare facilities based on their profit status or ownership type. Hospital-based programs show significantly higher starting salaries than other programs, but there was no statistically significant difference in maximum salaries between these two groups.

Comparisons by staff size: We also correlated minimum and maximum counselor salaries with staff size (both FTEs and total employees) as well as with number of counselors to see if these variables were related. Maximum counselor salaries were significantly and positively correlated with all three staff size variables — that is, centers with more FTEs, more total employees, or more counselors were also likely to have higher maximum salaries. However, staff size had no significant relationship to minimum (starting) salaries for counselors.

Comparisons by region: There were no significant differences in counselor minimum or maximum salaries when compared across geographic regions.
F. Drug Testing of Staff, and Employee Assistance Programs:

We asked administrators whether they use drug testing of their job applicants and current employees. Additionally, we asked whether employees had access to an employee assistance program. As depicted below, 59.8% of centers utilize pre-employment drug testing of job applicants; 10.9% utilize random drug testing of current employees; 73.1% utilize drug testing when there is reasonable suspicion of employee drug use ("for-cause" testing); and 68.9% of programs utilize breathalyzer tests when employees are suspected of drinking on the job. Overall, staff at 72% of treatment centers have access to an employee assistance program.

Drug Testing & EAPs
prevalence across centers

Pre-employment  For-cause (drug)  EAPs
IV. Patient Data: Referral Sources, Caseloads, and Census

A. Catchment areas:
Overall, centers receive an average of 7% of their patients from out-of-state (median=2%), with a range in our sample of 0%-95%. Breaking down these numbers, we find:

% patients from out-of-state

- 31.1%
- 20.6%
- 9.8%
- 9.4%
- 3.9%

B. Referral Sources:
We asked respondents to indicate their single most important source of patient referrals, as well as which referral sources contributed significant numbers of patients to their programs. The following chart shows the proportion of centers indicating each source as their most important (black bar), as well as the proportion indicating each source as significant (gray bar).

Referral Sources

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C. Employee Assistance Program Referrals:

Overall, respondents reported receiving clients from an average of 7 EAPs per center, with a range of zero to 60 EAPs providing patients. Only 42 centers (9.3%) reported receiving no referrals from EAPs.

D. Criminal Justice System Referrals:

The vast majority of programs (80.9%) report that they receive referrals from the criminal justice system.

E. Patient Caseloads:

We asked clinical respondents to estimate the breakdown of their typical caseloads in terms of demographic composition. Across all participating centers average caseloads were comprised of the following:

- 35.4% women
- 17.5% adolescents
- 29.9% minorities
- 3.2% pregnant women
- 21.8% parolees/persons on probation
- 40.0% relapsers (persons previously in treatment in this or another center)

F. Census:

We asked respondents at each center to compare their census in each level of care to the average census over the past year. (Note, inpatient dual diagnosis is included with adult CD in the table below. Data are expressed as percentage of centers reporting census figures for each level of care.)

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>% with higher than avg census</th>
<th>% with same as avg census</th>
<th>% with lower than avg census</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox</td>
<td>42.9</td>
<td>37.3</td>
<td>19.8</td>
</tr>
<tr>
<td>IP adult CD</td>
<td>54.4</td>
<td>27.0</td>
<td>18.6</td>
</tr>
<tr>
<td>IP adolescent CD</td>
<td>54.9</td>
<td>32.2</td>
<td>12.9</td>
</tr>
<tr>
<td>IP adult psych</td>
<td>55.2</td>
<td>28.4</td>
<td>13.4</td>
</tr>
<tr>
<td>PHP/Day Tx</td>
<td>43.3</td>
<td>35.2</td>
<td>21.5</td>
</tr>
<tr>
<td>IOP</td>
<td>39.2</td>
<td>28.9</td>
<td>31.9</td>
</tr>
<tr>
<td>Outpatient</td>
<td>24.5</td>
<td>58.3</td>
<td>17.2</td>
</tr>
</tbody>
</table>

National Treatment Center Study, Summary Report, 1997
G. Primary Problems:
Among patients in these programs, it was estimated that an average of 51% have a primary problem with alcohol dependence, whereas 43.4% have a primary problem with drug dependence.

H. AMA Rates:
Across all centers, average estimated proportion of patients leaving treatment against medical advice (AMA) was 13.9%. (This is an average across all levels of care offered at each center.)

I. Waiting Lists:
Among participating facilities, 36 (8%) had waiting lists on the day of our visit. An additional 38 programs (8.4%) need to use waiting lists at least occasionally for some portion of their programs. Overall, however, the majority of programs have services immediately available for patients who need them.

J. Payor Mix:
We asked program administrators to estimate their "payor mix," or the various methods by which patients pay for their treatment services. Below are the six payment categories used, and the average proportion of patients paying with each.

![Pie chart showing payor mix: Medicare 16.8%, Medicaid 17.3%, Commercial Insur. 44.8%, Charity 4.7%, Public funds 8.6%, Self-pay 10.7%]
We also obtained the following information regarding reimbursement sources:

**Medicaid/Medicare:**
- 115 centers (25.5%) receive no Medicare payments
- 171 centers (38%) receive no Medicaid payments
- 4 centers are entirely dependent upon Medicaid and/or Medicare

We asked administrators if Medicare and Medicaid reimbursement rates were sufficient to cover the costs of providing treatment services. Among facilities receiving Medicare payments, 44.8% said Medicare reimbursement rates were not sufficient to cover their program's treatment costs; among facilities receiving Medicaid payments, 61.7% said Medicaid reimbursement rates were not sufficient to cover their program's treatment costs.

**Self-paying patients (cash):**
At 248 centers (55%), 5% or fewer of the patients are typically self-paying.
At 8 centers (1.6%), 70% or more of the patients are self-paying.

**Charity care:**
160 facilities (35.6%) reported accepting no charity cases (or a negligible amount each year)

The following table provides a further analysis of the payor mix data. The first column provides aggregated responses across all centers; the following columns show comparisons between for-profit and non-profit programs, as well as between hospital-based and freestanding programs.

<table>
<thead>
<tr>
<th>Payor Type</th>
<th>All Centers</th>
<th>Non Profit</th>
<th>For Profit</th>
<th>Hospital</th>
<th>Freestanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Insurance</td>
<td>44.8%</td>
<td>44.8%</td>
<td>42.9%</td>
<td>43.5%</td>
<td>44.6%</td>
</tr>
<tr>
<td>Medicaid*</td>
<td>17.3%</td>
<td>18.7%</td>
<td>15.0%</td>
<td>19.8%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Medicare**</td>
<td>16.9%</td>
<td>14.4%</td>
<td>21.1%</td>
<td>19.5%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Self pay*</td>
<td>10.7%</td>
<td>9.3%</td>
<td>13.2%</td>
<td>7.4%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Public funds*</td>
<td>5.6%</td>
<td>7.1%</td>
<td>3.3%</td>
<td>4.4%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Charity*</td>
<td>4.7%</td>
<td>5.4%</td>
<td>3.6%</td>
<td>5.1%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Note: * denotes statistically significant differences between non-profit and for-profit centers within payor type; + denotes statistically significant differences between hospital programs and other facilities within payor type.

*National Treatment Center Study, Summary Report, 1997*
V. Financial Data

A. Retail Charges:

We asked administrators to provide their "retail charges" for each of their levels of care. The following chart provides detailed information on these charges across all participating programs. (We should emphasize that these are average retail charges for services, not negotiated, discounted, or contracted rates. Weekly or monthly rates, when given, were converted to their daily or "per session" equivalents for the purposes of these analyses. Also note that inpatient dual diagnosis is included with inpatient adult CD in the tables below.)

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Range</th>
<th>Mean</th>
<th>1st quartile cutoff</th>
<th>2nd quartile cutoff</th>
<th>3rd quartile cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox</td>
<td>$50 - $2000</td>
<td>$585.65</td>
<td>$420</td>
<td>$525</td>
<td>$700</td>
</tr>
<tr>
<td>IP CD, adult</td>
<td>$47 - $1700</td>
<td>$509.03</td>
<td>$339</td>
<td>$459</td>
<td>$550</td>
</tr>
<tr>
<td>IP CD, adolescent</td>
<td>$135 - $1500</td>
<td>$591.59</td>
<td>$348</td>
<td>$466</td>
<td>$663</td>
</tr>
<tr>
<td>IP Psych, adult</td>
<td>$185 - $1300</td>
<td>$726.89</td>
<td>$550</td>
<td>$700</td>
<td>$900</td>
</tr>
<tr>
<td>PHP / day program</td>
<td>$75 - $700</td>
<td>$266.71</td>
<td>$200</td>
<td>$260</td>
<td>$323</td>
</tr>
<tr>
<td>OP</td>
<td>$22 - $400</td>
<td>$136.29</td>
<td>$97</td>
<td>$135</td>
<td>$162</td>
</tr>
<tr>
<td>OF</td>
<td>$10 - $280</td>
<td>$70.32</td>
<td>$45</td>
<td>$65</td>
<td>$90</td>
</tr>
</tbody>
</table>

*Note: Quartile cutoffs are provided to indicate relative distribution of charges across facilities, and may be interpreted as follows: 1st quartile cutoffs indicate the point below which 25% of all centers fall; 2nd quartile cutoffs indicate the median charge, or the point below which 50% of all centers fall; 3rd quartile cutoffs indicate the point below which 75% of all centers fall. Conversely, the 3rd quartile cutoff also defines the most expensive 25% of all programs. Interpreting the Detox charges given in the above table, we see that 25% of all centers have daily charges between $80 and $420; 50% have charges at or below $525; 75% have charges at or below $700 per day; and 25% of all centers have daily detox charges exceeding $700 per day.
B. Retail Charges: Comparative Data

The following 4 tables show comparisons of retail charges across various groups within our sample. In each table, the average for the overall sample is also provided, in order to permit comparison of each sub-group to the whole.

1. **Average Daily Charges, Hospital-based vs. Freestanding programs**

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Whole Sample</th>
<th>Hospital-based</th>
<th>Freestanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox</td>
<td>$565.68</td>
<td>$603.92</td>
<td>$542.80</td>
</tr>
<tr>
<td>IP CD, adult</td>
<td>$509.03</td>
<td>$529.99</td>
<td>$467.93</td>
</tr>
<tr>
<td>IP CD, adolescem</td>
<td>$591.59</td>
<td>$594.03</td>
<td>$589.42</td>
</tr>
<tr>
<td>IP Psych, adult</td>
<td>$726.89</td>
<td>$698.48</td>
<td>$791.30</td>
</tr>
<tr>
<td>PHP / day program**</td>
<td>$269.71</td>
<td>$266.88</td>
<td>$292.53</td>
</tr>
<tr>
<td>IOP</td>
<td>$136.29</td>
<td>$137.56</td>
<td>$122.99</td>
</tr>
<tr>
<td>OP</td>
<td>$70.32</td>
<td>$73.61</td>
<td>$63.01</td>
</tr>
</tbody>
</table>

**Note: Differences in average daily charges between hospital programs and freestanding programs are statistically significant for this level of care.**

2. **Average Daily Charges, Corporate-owned vs. Non-corporate programs**

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Whole Sample</th>
<th>Corporate-owned</th>
<th>Non-Corporate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox**</td>
<td>$585.68</td>
<td>$643.81</td>
<td>$533.00</td>
</tr>
<tr>
<td>IP CD, adult**</td>
<td>$509.03</td>
<td>$571.67</td>
<td>$449.62</td>
</tr>
<tr>
<td>IP CD, adolescent**</td>
<td>$591.59</td>
<td>$716.06</td>
<td>$497.13</td>
</tr>
<tr>
<td>IP Psych, adult**</td>
<td>$726.89</td>
<td>$794.75</td>
<td>$612.98</td>
</tr>
<tr>
<td>PHP / day program**</td>
<td>$266.71</td>
<td>$291.38</td>
<td>$242.39</td>
</tr>
<tr>
<td>IOP</td>
<td>$136.29</td>
<td>$137.83</td>
<td>$135.13</td>
</tr>
<tr>
<td>OP</td>
<td>$70.32</td>
<td>$65.46</td>
<td>$71.75</td>
</tr>
</tbody>
</table>

**Note: Differences in average daily charges between corporate-owned and non-corporate owned programs are statistically significant for these levels of care.**

*National Treatment Center Study, Summary Report, 1997*
### 3. Average Daily Charges, For-Profit vs. Not-For-Profit Programs

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Whole Sample</th>
<th>For-Profit</th>
<th>Non-Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox**</td>
<td>$595.68</td>
<td>$711.76</td>
<td>$515.57</td>
</tr>
<tr>
<td>IP CD, Adult**</td>
<td>$509.93</td>
<td>$633.18</td>
<td>$429.41</td>
</tr>
<tr>
<td>IP CD, Adolescent**</td>
<td>$591.59</td>
<td>$760.91</td>
<td>$440.58</td>
</tr>
<tr>
<td>IP Psych, Adult**</td>
<td>$726.89</td>
<td>$846.92</td>
<td>$635.29</td>
</tr>
<tr>
<td>PHP**</td>
<td>$265.71</td>
<td>$324.05</td>
<td>$234.17</td>
</tr>
<tr>
<td>IOP</td>
<td>$136.29</td>
<td>$145.07</td>
<td>$131.78</td>
</tr>
<tr>
<td>OP</td>
<td>$70.32</td>
<td>$74.04</td>
<td>$96.29</td>
</tr>
</tbody>
</table>

**Note:** Differences in average daily charges between for-profit and not-for-profit programs are statistically significant for these levels of care.

### 4. Average Daily Charges, All Participating Centers, By Region

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Northeast</th>
<th>Southeast</th>
<th>Great Lakes</th>
<th>Central</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox</td>
<td>$499.18G</td>
<td>$693.33K</td>
<td>$609.98G</td>
<td>$532.22</td>
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<td>IP CD Adult</td>
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<td>$583.66G</td>
<td>$443.01G</td>
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<td>$489.77</td>
</tr>
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<td>IP CD Adol.</td>
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<td>$837.30G</td>
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<td>$243.45G</td>
<td>$300.46G</td>
<td>$261.66S</td>
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<td>IOP</td>
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<td>$127.02</td>
<td>$143.69</td>
<td>$143.43</td>
<td>$125.57</td>
</tr>
<tr>
<td>OP</td>
<td>$74.04</td>
<td>$76.16</td>
<td>$70.51</td>
<td>$58.86</td>
<td>$57.96</td>
</tr>
</tbody>
</table>

**Note:** Statistically significant differences in average daily charges are denoted by superscript symbols referencing comparison group. For example, average daily charges for detox among centers in the Southeast are significantly different from average daily detox charges at centers in the Northeast (N) and Great Lakes (K) regions.

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*National Treatment Center Study, Summery Report, 1997*
C. Annual Revenues

We asked administrators to provide approximate total revenues and expenditures for the treatment program in the most recent fiscal year. Of the 325 facilities providing data, we find that revenues met or exceeded expenses in 285 facilities (81.5% of those providing data); in the remaining 60 facilities, expenses exceeded revenues.

Comparing organizational types, we find:

Revenues met or exceeded expenses in 82.5% of hospital-based programs (vs. 70.5% of non-hospital programs); 87.2% of for-profit facilities (vs. 78.2% of non-profits); and 83.9% of corporate-owned programs (vs. 79.6% of non-corporate programs). (Note that only the for-profit / non-profit difference is statistically significant.)

![Annual Revenues Chart]

D. Revenue Trends:

We asked administrators whether their revenues had been in a period of decline, stability, growth, or fluctuation over the past few years. Among those responding, 27.3% reported that their revenues were in a period of decline; 21.3% reported stable revenues; 24.9% reported increased revenues; and 11.1% reported fluctuating revenues over the past few years.

![Revenue Trends Chart]

National Treatment Center Study, Summary Report, 1997
VI. Clinical Programs

A. Treatment Services:

In addition to treatment for alcohol and drug problems, centers in our study offered the following treatment services:

- 270 (60%) have psychiatric services available
- 254 (56.4%) offered treatment programs for codependency
- 133 (29.6%) offered treatment services for eating disorders

**Dual Diagnosis Treatment:**

Most programs (79.8%) have a dual diagnosis treatment component. Across all programs, 39 (6.7% of 450) were entirely dual diagnosis facilities; 71.1% offered dual diagnosis tracks/groups in addition to other services. However, in the vast majority of cases, respondents said they must refer patients with severe psychiatric conditions to other programs or facilities. As expected, the need to refer patients is much more prevalent among facilities without on-site access to full-service psychiatric units.

B. 12-Step Models:

- 419 facilities (93.1%) offer treatment programming based on a 12-step model.
- 375 facilities (83.3%) hold 12-step meetings on-site. These include:

![12 Step Groups Offered](chart)

339 treatment programs (75.3%) offer 12-step groups which are open to community residents.

Not surprisingly, nearly all of the programs (98.6%) said they advocated abstinence from alcohol for all of their alcohol and/or drug dependent patients.

*National Treatment Center Study, Summary Report, 1997*
C. Pharmacological Approaches:

We asked clinical respondents whether medications were routinely prescribed for patients while in treatment. Among the most common medications mentioned:

![Medications used in Treatment Chart]

D. Family Programs:

419 centers (93.1%) offer a program for the families of patients.

Across all facilities offering family programs, an average of 54% of patients’ families get involved in these programs. Only 27 of the 419 centers with family programs (6.4%) said that fewer than 10% of the patients’ families get involved, while 85 of the 419 centers with family programs (20.3%) said that family participation exceeded 80%.

E. Other Services:

174 programs (38.7%) also are involved in DUI assessment services.

291 programs (64.7%) arrange interventions.

National Treatment Center Study, Summary Report, 1987
F. Admission / Treatment Criteria:

Clinicians at 307 of the 450 facilities (68.2%) reported using the American Society of Addiction Medicine (ASAM) patient placement criteria in their patient intake process. Another 46 centers (10.2%) model their own criteria after ASAM guidelines.

G. Treatment Programming:

Only 11 of the 450 programs (2.4%) offer segregated treatment programming for patients with alcohol problems and patients with drug problems.

Of the 270 programs offering psychiatric treatment services, 114 programs offer completely segregated treatment tracks for substance abuse and psychiatric patients, with the remaining 156 programs offering integrated treatment for these groups.

We asked respondents to identify any clinical reasons (i.e., reasons other than managed care decisions or patients’ inability to pay) why patients might be denied admission to their treatment program. Among the most common reasons cited:

- patient requires more intensive level of care than is offered at the center
- patient requires less intensive level of care than is offered at the center
- patient is too violent / threat to self or others
- patient is unwilling/unable to understand or cooperate with treatment regimen
- patient has history of relapse/noncompliance in previous treatment episodes

Overall, respondents estimated that an average of 7.5% of patients seeking treatment were denied admission for reasons such as those cited above. However, respondents at 260 centers (97.8% of total) said that they denied admission to fewer than 5% of patients seeking treatment.

H. Drug Testing of Patients:

The vast majority of treatment programs (94.4%) use some form of drug testing to monitor patients in their program. Of these, 33.7% use drug testing for probable cause (including after off-campus leave for inpatients); 7.9% require drug tests at regularly scheduled intervals (for example, once per week for all patients, or at each weekly outpatient visit); 23% perform random drug tests; and 34% have multiple policies or conditions concerning drug tests (e.g., different policies for patients in different levels of care).

Distribution of drug testing practices is shown in the chart on the following page.
More than 91% of respondents said that continued treatment for patients testing positive to drug tests would be decided on a case-by-case basis; in many instances, programs would recommend "stepping patients up" to a more intensive level of care. Only 9% of programs said that positive drug tests would result in immediate discharge or transfer to another facility.

I. Utilization Review:

Among our participating centers, 50.3% have at least one staff member formally assigned full-time to perform utilization review activities. Another 23.8% have at least one person formally assigned part-time to utilization review. In 4.9% of the centers, there is a department or individual in the larger hospital which handles all such activities. In the remaining 21% of centers, there is some informal division of labor involving utilization review, with such activities shared among counselors, case managers, nurses, and/or various administrative staff.

National Treatment Center Study, Summary Report, 1997
J. Use of the Addiction Severity Index:

The most widely used addiction/dependence measure among clinicians at participating programs was the Addiction Severity Index, utilized by 141 programs (31%). The ASI is designed to assess a number of problems in various life spheres (e.g., employment, legal, financial, relationships) which may pose barriers to patients’ successful recovery. Once problems are identified, programs may then establish their treatment plan accordingly.

Interestingly, regardless of whether clinicians use or are familiar with the ASI, most facilities do some form of screening or assessment which includes components of the Addiction Severity Index. For instance,

- 78.4% of programs assess whether patients have financial problems, and 23.1% of all programs offer counseling for such problems in conjunction with addiction treatment
- 82% of programs assess whether patients have legal problems, and 20.4% of all programs offer counseling for such problems in conjunction with their addiction treatment program
- 82.2% of programs assess whether patients are having problems finding or keeping a job, and 30.9% of all programs offer some form of vocational counseling in conjunction with their addiction treatment program
- 87.8% of programs assess whether patients have family or other social relationship problems, and 75.1% of all programs offer counseling for such problems in conjunction with their addiction treatment program

VII. Marketing Activities

A. Respondents:

329 facilities completed interviews regarding their marketing activities. (53 of the 450 programs [11.8%] had no marketing function at all. At another 30 programs, all marketing activities were handled through the larger hospital or corporate offices, and these programs were unable to provide us with data on marketing activities specifically for the chemical dependency treatment program. The remaining 58 facilities were unable or unwilling to schedule marketing interviews.) This gives us a response rate of 89% among eligible participating centers.

Among the 53 programs which had no marketing function at all, 60% were non-profit facilities, 72% were hospital-based programs, and 50% were corporate-owned facilities. This distribution suggests that the absence of marketing function is not related to these organizational characteristics.

National Treatment Center Study, Summary Report, 1997
D. Advertising:

281 treatment programs (71.7%) use some form of advertising in their marketing strategy.

E. Referral Sources:

We asked marketing respondents to indicate which specific referral sources they targeted in their marketing efforts. Among the most common responses (more than one response was permitted):

- 79.9% mentioned physicians
- 80.5% mentioned counselors in private practice
- 72.9% mentioned community mental health center staff
- 89.7% mentioned employee assistance programs
- 70.2% mentioned personnel managers or other workplace representatives
- 65% mentioned program alumni
- 60.8% mentioned schools
- 76.3% mentioned courts/police/other criminal justice
- 62.6% mentioned clergy

Among other marketing strategies:

- 292 programs (88.6%) sponsor seminars or lectures for various audiences
- 252 programs (76.6%) sponsor regular open houses or tours of their facilities
- 278 programs (84.5%) exhibit at meetings/conferences

F. Unique features:

We also asked marketing respondents which, if any, of their programs' unique features they emphasize in their marketing efforts. Among the most common features mentioned:

- 19.1% mentioned the availability of medical services on-site
- 23.1% mentioned the quality of their treatment programming
- 8.8% mentioned client satisfaction, outcome studies, proven results
- 36.2% mentioned comprehensiveness of available behavioral health services
- 32.5% mentioned flexibility/individualization of programming

*National Treatment Center Study, Summary Report, 1997*