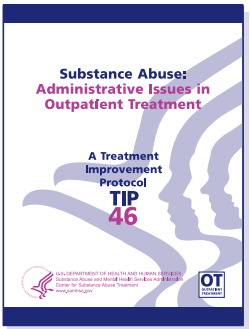
Quick Guide

For Administrators

Based on TIP 46

Substance Abuse: Administrative Issues in Outpatient Treatment



OT
OUTPATIENT TREATMENT

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Contents

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Based on TIP 46

Substance Abuse: Administrative Issues in Outpatient Treatment

This Quick Guide is based entirely on information contained in TIP 46, published in 2006. No additional research has been conducted to update this topic since publication of TIP 46.

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Abuse: Administrative Issues in Outpatient Treatment,* Number 46 in the Treatment Improvement Protocol (TIP) series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). This Quick Guide is based entirely on TIP 46 and is designed to meet the needs of the busy administrator for concise, easily accessed how-to information.

The Quick Guide is divided into eight sections (see *Contents*) to help readers quickly locate relevant material. It will help administrators operate in the rapidly expanding and increasingly complex field of outpatient treatment.

For more information on the topics in this Quick Guide, readers are referred to TIP 46.

WHAT IS A TIP?

The TIP series has been in production since 1991. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest.

TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment,* surveys topics relevant to administrators working in the changing environment of outpatient treatment:

- Strategic planning, starting a program, working with partners, and public relations;
- Hiring and retaining staff, continuing education and training, and formulating guidelines and policies for staffing;
- Preparing a program to treat diverse clients, assessing the cultural competence of a program, and implementing program changes based on the findings;
- Strengthening the financial position of a program, working with managed care organizations (MCOs), and understanding contracts; and
- Improving performance, monitoring outcomes, and using performance data to promote a program.

See the inside back cover for information on how to order TIPs and other related products.

INTRODUCTION

This Quick Guide can help administrators address the following issues:

- **Financial pressures.** Funding limitations and shrinking State budgets require increasing creativity and resourcefulness of outpatient treatment (OT) administrators;
- **Human resources challenges.** Substance abuse counselors have a high rate of turnover, skilled counselors are hard to find, and the scarcity of diverse counselors is acute;
- **Diverse clients.** Improving cultural competence can enhance a program's services and help it meet funding and accreditation requirements;
- **Emergence of behavioral health funding.** Some entities fund mental health and substance abuse treatment separately from other health care, making strategic alliances necessary;
- **Emphasis on outcomes.** The Federal Government now ties funding to performance outcomes, and program monitoring is increasingly important; and
- **Community relationships.** Accrediting bodies and potential funders look at community outreach and partnerships when evaluating a program.

For more detailed information, see TIP 46, pp. 1–6.

MANAGEMENT ISSUES

Strategic Planning

Strategic planning includes—

- Conducting a community needs assessment
- Identifying program strengths
- Clarifying program mission
- Developing and evaluating goals
- Identifying strategies to attain goals.

Implementing the strategic plan entails—

- Incorporating goals and strategies into an annual operating plan
- Assigning personnel and timelines
- Developing a marketing plan, based on the community needs assessment.

Board of Directors

Board members have three main responsibilities.

General Responsibilities—

- Appoint and evaluate the executive director
- Attend all meetings of the board of directors
- Set organizational policy
- Approve and monitor the budget and plan
- Develop a mission statement, and review it periodically
- Establish a strategic plan

- Evaluate effectiveness in accomplishing board-approved objectives
- Serve on at least one board committee
- Become informed and educated about the program and the industry of which it is a part
- Be familiar with the program's bylaws

Fundraising Responsibilities—

- Participate in special events sponsored by the program
- Raise funds using creative strategies
- Optional: Make an annual personal donation

Public Relations Responsibilities—

- Act as a sounding board for community feedback
- Serve as a liaison to community organizations
- Support the services of the program, and speak out on its behalf

Boards should comprise—

- People who have knowledge of or experience with substance abuse treatment
- Representatives from the local community, the client population, and the program's referral sources
- Men and women of various races, cultural backgrounds, and sexual preferences
- People with expertise in State and local politics, insurance, managed care, financial management, legal matters, and nonprofits and foundations.

Orientation for new board members includes—

- Program history, mission, and services
- Data on service delivery
- Board composition and responsibilities
- Board committee structure
- Program administrator's job description
- Budget
- Bylaws
- Short- and long-term plans.

Board members should be evaluated at least every 5 years, either by an outside consultant or by self-evaluation.

Program Policy Management

Licensing and accreditation standards require that programs establish written policies and procedures that govern—

- Program mission statement and philosophy
- Client care (screening, assessment, and treatment and discharge planning)
- Recordkeeping (security of clients' records)
- Organizational structure (governance committees and staff positions)
- Personnel (procedures for hiring, evaluating, and termination)
- Program structure and staffing
- Clients' rights and the program's grievance process

- Performance improvement (setting standards and monitoring performance)
- Facility, health, and safety standards (first aid, emergency planning, and disaster management).

Suggested steps toward accreditation include—

- Forming an alliance with a larger organization that can provide support
- Hiring a consultant who has experience with the accreditation process
- Visiting **www.jcaho.org, www.carf.org, www.ncqa.org, www.coanet.org,** or **www.ncchc.org** for more information.

Relationships With Strategic Partners

Potential sources of new client referrals include—

- Managed care companies
- Employers
- Mental health treatment providers
- Employee assistance programs (EAPs)
- Schools
- Hospitals
- Welfare agencies
- Criminal justice agencies
- Religious leaders.

Referring Clients to Services Outside the Program

Programs should have contact and other information for services not provided on site, including—

- Name of organization
- Address
- Telephone number
- Services available
- Hours of operation
- Proximity to public transportation
- Contact person
- Eligibility criteria
- Costs
- Client capacity
- Waiting lists
- Staff qualifications.

Program files should include information about the following types of services and organizations:

- Social services;
- Child welfare;
- Preventive health care;
- Inpatient and outpatient medical and mental health services;
- Recovery support groups;
- Faith-based institutions;

- Food banks and clothing distribution centers;
- Recreational facilities and programs;
- Credit counseling programs;
- Adult education programs (including English as a second language);
- Child care;
- Parent training programs;
- Family therapists and couples counseling;
- Housing resources (including U.S. Department of Housing and Urban Development [HUD] Section 8 housing, homeless and battered women's shelters, and recovery houses);
- Legal assistance;
- Volunteer transportation services; and
- Public transportation.

Administrators should consider formal agreements with service providers. Case managers should be involved in writing such agreements; the program's attorney should review legal contracts.

Financial Management

Suggestions for reducing program costs follow:

- Eliminate noncore services that are not self-supporting after 6 months;
- Evaluate staffing and consolidate positions;
- Save staff time by reducing paperwork; and
- Increase the program's buying power by teaming up with other human service providers.

Outreach

Outreach can include—

- Cultivating relationships with officials and funders at conferences or in meetings
- Inviting officials and funders to program functions (e.g., program graduations)
- Allowing officials and funders to observe program activities and become familiar with staff members and the client population
- Providing regular mailings about program achievements.

Neighbors, businesses, and landlords often do not welcome substance abuse treatment programs. Providing basic information about the prevalence, impact, signs and symptoms, methods of prevention, and treatment options of substance abuse destigmatizes substance abuse and brings potential clients into the program.

For more detailed information, see TIP 46, pp. 7–26.

MANAGING HUMAN RESOURCES

Challenges in employing and retaining skilled and caring staff members include—

- Dearth of experienced staff
- High demand for counselors
- Low pay, long hours, and difficult schedules
- Stressful client population
- Demands on time (e.g., completing paperwork and maintaining linkages with EAPs, social service agencies, mental health care providers, and the criminal justice system)
- Limited community resources.

Policy Issues and Guidelines

New staff members should sign forms indicating that they have read and agree with the program's policies and procedures and the program's treatment philosophy, including the following:

- Addiction is a biopsychosocial and spiritual disorder, best treated by multidisciplinary approaches, which may include medication;
- Recovery is possible; and
- Recovery support groups play a vital role in treatment and recovery.

Counselors should demonstrate—

- Familiarity with reporting requirements
- Adherence to professional standards and scope of practice

- Willingness to use supervision and peer assessments to gain insights into deficiencies
- Awareness of current addiction research and trends
- Involvement in professional organizations
- Respect for clients from diverse backgrounds
- Recognition of the effect that personal bias toward other cultures and lifestyles can have on treatment
- Understanding of personal recovery and its effect on the provision of treatment
- Capacity to conduct self-evaluation
- Participation in regular continuing education.

Program guidelines should address the following:

- **Conflicts of interest.** Referrals and treatment decisions are based solely on the client's needs, not on potential benefits to a staff member;
- **Staff–client relationships.** Clear guidelines are needed about contact with clients outside the program, including guidelines for staff members who participate in recovery groups; and
- **Grievance procedures.** Programs should have clear procedures for handling complaints of sexual harassment and other violations of professional conduct.

Overview of Staffing

OT staff should include—

- **Core clinical staff** (provides assessment, counseling, and crisis intervention; includes medical staff for OT-based detoxification programs)
- **Clinical management** (case managers and certified supervisors with clinical experience)
- **Specialized services staff** (psychologists, psychiatrists, social workers, vocational counselors, family therapists, and medical staff)
- **Administrative and support staff** (provides program planning, fiscal management, quality assurance, information management, regulatory compliance, and contract management).

Administrators should build a multidisciplinary team. By using program staff and consultants or by collaborating with other agencies, programs should be able to address—

- Medical services
- Counseling
- Case management
- Family services
- Social services
- Psychological services
- Psychiatric services
- Liaison with criminal justice, child welfare, and other agencies.

Programs should consider providing or referring clients for—

- Vocational rehabilitation
- Recreational therapy
- Art, music, and dance therapy
- Nutrition counseling
- HIV/AIDS counseling
- Spiritual counseling
- Literacy instruction
- General equivalency diploma preparation.

Staff in Recovery

Program policy should specify how long a counselor needs to be in recovery before being considered for employment, usually 1 year. The Federal Rehabilitation Act and the Americans with Disabilities Act (ADA) protect individuals who are in recovery from discrimination in employment.

Programs should maintain a drug-free workplace by—

- Considering preemployment and for-cause drug testing for employees (see **workplace.samhsa.gov/home.asp**)
- Integrating job descriptions, personnel policies, and policies on staff substance use
- Drafting policies for relapse by program staff members.

Staff relapse policies include the following:

- Decisions about whether to treat relapse involving illegal drugs the same as relapse that involves alcohol or legal drugs;

- Written job requirement that specifies staff abstinence;
- Incentives for relapsing employees to seek treatment; and
- How long an employee who has had a relapse must be abstinent before returning to work.

Staff Structure

Staff-to-client ratios of from 1-to-8 to 1-to-15 are common. Factors to consider when establishing counselor caseloads include—

- State regulations
- The type of care the program provides
- Linkages to auxiliary services
- The amount of work employees can accomplish, given their work schedules.

Staff Communications

Regular meetings help facilitate good communication among team members:

- General staff meetings provide a venue to address staff members' concerns, provide training, and review and adjust treatment plans;
- Case reviews examine client progress, allowing staff members to assess progress, brainstorm treatment strategies, and coordinate services; and
- Impromptu meetings address crises as they arise and maintain continuity of care.

Managers should inform staff members about—

- Program performance
- Competitive status
- Policymaking
- Finances.

Counselors and administrators benefit when counselors are involved in—

- Discussions and negotiations with MCOs
- Case reviews
- Utilization reviews
- Educational events with MCOs.

Selecting Qualified Clinical Staff

The following qualities are desirable in OT program staff members:

- Emotional maturity;
- Adaptability;
- Creativity;
- Ability to relate effectively with others;
- Capacity to confront and resolve internal personal difficulties;
- Willingness to learn about and understand people with different backgrounds; and
- Ability to benefit from constructive criticism and mentorship.

All treatment professionals should have a basic understanding of addiction that includes knowledge of—

- Evidence-based practices
- Pharmacology
- Biological bases of addiction.

When hired, clinicians should be certified, licensed, or working toward certification or licensure. Staff members should obtain credentials in addictions treatment from credentialing bodies such as the American Society of Addiction Medicine (ASAM).

Clinical Competence

Clinical staff should meet counselor standards established by the International Certification and Reciprocity Consortium and by State certification boards. Clinicians should be able to demonstrate competence in the following areas:

- **Clinical evaluation.** To perform diagnostic functions, clinicians need to be knowledgeable about—
  - Use of current screening and assessment instruments
  - Effect of cultural diversity on information gathering and client assessment
  - Symptoms of intoxication, withdrawal, and toxicity for psychoactive substances
  - Physical, pharmacological, and psychological implications of substance abuse
  - Mental status assessment criteria
  - Treatment matching and placement criteria, including DSM-IV diagnostic standards
  - Confidentiality requirements
  - Theories about how behavior changes
  - Assessing clients' readiness for changes.

- **Treatment planning.** To plan treatment well, counselors need to—
  - Communicate with clients and their significant others
  - Work with clients to define and prioritize their needs
  - Understand available treatment modalities and community resources
  - Develop individualized treatment plans with clients.
- **Referral and service coordination.** Many clients require referrals for social services, mental status examinations, and medication assessment. Coordinating services calls on clinicians to manage cases, advocate for clients, marshal community resources, and work with MCOs.
- **Counseling.** To be a successful counselor, an individual should be able to—
  - Establish rapport and engage with clients (Counselors should be direct and nonjudgmental.)
  - Recognize whether counseling and other therapeutic interventions are working
  - Integrate therapy with events occurring in the client's life (Counselors should be comfortable working with client's family, employer, and community if permission is granted.)
  - Recognize when to seek help from other professionals
  - Educate clients about addiction and recovery

  - Help clients build and practice recovery skills.
- **Family education and counseling.** Clinicians who provide family counseling should have—
  - Supervised experience with family therapy
  - Thorough knowledge of the functioning and availability of family support groups (e.g., Al-Anon, Nar-Anon)
  - Knowledge of strategies that support clients in recovery and improve family communications.
- **Documentation and ethical responsibilities.** Clear documentation of client cases serves important clinical goals and is required by regulatory and funding agencies. Staff members have access to sensitive client information (e.g., criminal justice or employment status). All staff must adhere to professional responsibilities.

Recruiting and Hiring

Some questions to consider when making staffing decisions include—

- Does the applicant have experience in the program's treatment modality?
- Does the applicant have experience working with the client population the program serves?
- Does work experience suggest that the applicant will be able to function competently with all the program's clients? Can the applicant prevent personal assumptions and biases from affecting outcomes?

- Is the applicant knowledgeable about addiction, recovery, and the maintenance of therapeutic alliance?

Recruiting Applicants

Programs may need to make special efforts to recruit ethnically diverse staff:

- Recruit young candidates and train them;
- Offer higher salaries or sign-on bonuses to counselors who are in high demand (e.g., multilingual counselors); and
- Take advantage of funds set aside for training counselors from minority groups (contact the Single State Agency [SSA] for information).

Interviewing and Assessing Candidates

To ensure that a candidate can work on a clinical team, the program's staff should participate in the selection process:

- Staff members interview candidates before they meet with the clinical director;
- The candidates role play a counseling session with staff to give a sense of how they will work with clients; and
- The clinical director interviews the candidates recommended by the staff.

Background checks should be run on all employees hired for drug and alcohol treatment programs. Asking knowledge-based questions (e.g., "If a client tells you she is having trouble with the Third Step, what might

her issues be and how would you respond?") provides important information about how the candidate will perform as a counselor and avoids discrimination based on recovery status, real or feigned.

Staff Supervision

Supervisors should be particularly attentive to the following issues:

- Relationships between recovering staff and clients;
- Professional credibility;
- Cultural bias and unfair treatment;
- Staff performance evaluations;
- Liability concerns; and
- Impaired counselors.

Administrators should consider using a variety of supervisory methods, including case studies, chart reviews, presentations by outside experts, and videotapes and audiotapes. Two supervisory formats that should be used are—

- **Group supervision,** in which a clinician presents a difficult case and the group discusses the course of treatment
- **Individual supervision,** in which supervisors meet one-on-one with clinicians, establishing a climate of learning and inquiry and encouraging clinicians to head off crises.

Medical Staff

Physicians and nurses need to be supervised by peers in the medical profession. If the program

does not employ anyone qualified to supervise medical staff, a peer review can be arranged.

Part-Time Staff

Suggestions for supervising part-time staff members include—

- Allow 1 hour of paid supervision for every 40 hours of work
- Be flexible so that supervisory hours vary as the person's work hours increase or decrease
- Schedule shorter, more frequent supervisory meetings
- Assign part-time staff members to work with particular clients whose counselors become the staff members' de facto supervisor
- Allow full-time staff members to supervise senior part-timers who carry their own caseloads
- Address any conflicts of interest that arise from part-time staff members' private practices or affiliations with other agencies.

Peer Extenders

A peer extender is a noncredentialed paraprofessional (e.g., a recovering program alumnus) who acts as a "temporary sponsor" for clients and works as cotherapist if supervised and trained with regard to confidentiality and professional boundaries.

Continuing Education and Training

A program can support education and training for staff by—

- Encouraging staff members to be assertive about identifying education and training needs
- Helping staff members locate the resources to carry out their individual development plans
- Being flexible with staff members in negotiating education and training opportunities
- Tying financial and other rewards to the attainment of staff members' education or training goals.

Exhibit 3-5 on p. 46 of TIP 46 lists resources for staff education and training.

Onsite training for clinical staff should include—

- **Multicultural awareness.** Staff members should understand how their underlying cultural biases and assumptions affect client treatment.
- **Crisis management.** Staff members should be able to—
  - Exercise sound judgment
  - Assess situations and respond appropriately
  - Understand their personal limitations
  - Stabilize a psychological, social, or medical crisis
  - Defuse volatile situations with clients.
- **Documentation skills.** Training should cover—
  - Regulations about client records
  - Essential components of client records (release forms, assessment instruments,

treatment plans and revisions, progress notes, and discharge summaries)
  - Client rights
  - How to analyze, synthesize, and summarize information
  - Clinical terminology and the practice of objective recording.
- **Confidential and legal requirements.** Clinical staff members need to understand program, State, and Federal confidentiality regulations, in addition to ethical standards governing client confidentiality.
- **Requirements of service purchasers.** Clinical staff members need training to meet the data requirements of purchasers, such as MCOs.

Exhibit 3-6 on p. 48 of TIP 46 presents a list of clinical training manuals and curricula.

Motivating and Retaining Staff

Programs can increase staff members' commitment and reduce turnover and burnout by—

- Paying competitive salaries
- Acknowledging the stressors and challenges of substance abuse treatment jobs
- Providing emotional and structural supports to help staff members address them
- Offering special project work.

Administrators should encourage and mentor staff by—

- Using clinical teams to share the responsibility for treatment planning and service delivery
- Encouraging cooperation and conflict resolution
- Including team members in decisionmaking
- Contracting with an EAP to provide stress management, brief counseling, and referrals
- Permitting flexible work schedules
- Praising and encouraging staff.

For more detailed information, see TIP 46, pp. 27–51.

PREPARING A PROGRAM TO TREAT DIVERSE CLIENTS

Understanding Cultural Competence

Cultural competence is—

- The capacity to increase knowledge and understanding of cultural differences
- The ability to acknowledge cultural assumptions and biases
- The willingness to make changes in thought and behavior to address those biases.

Cultural diversity applies not only to ethnic and racial groups but also to—

- Gender
- Age
- Sexual identity and preference
- Spiritual beliefs
- Socioeconomic status
- Physical and mental capacities
- Geographic location.

Culturally competent treatment is characterized by—

- Staff knowledge of or sensitivity to the first language of clients
- Staff understanding of the cultural nuances of the client population
- Staff with backgrounds similar to those of the client population

- Treatment methods that reflect the culture-specific values and treatment needs of clients
- Inclusion of the client population in program policymaking and decisionmaking
- An open-minded, inquisitive attitude toward other cultures.

Why Cultural Competence Matters

The percentage of minority clients in treatment is much larger than the percentage of minority substance abuse treatment counselors. By understanding a client's culture, staff can tap into treatment strategies based on the personal and social strengths of each individual. Enhancing the capacity to treat clients from other cultures improves a program's ability to treat all clients. Cultural competence is increasingly a requirement of funding and accrediting bodies.

Administration's Attitude Toward Cultural Competence

Many Federal agencies and academic centers offer information to assist in planning, implementing, and evaluating culturally competent service delivery systems. Appendix 4-A on pp. 68–70 of TIP 46 lists resources on educating staff and preparing for culturally competent treatment; chapter 10 of TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment,* lists culture-specific resources for many diverse groups.

Preparing for Cultural Competence Assessment

Before performing a cultural competence assessment of their programs, administrators should—

- Discuss what staff members have learned from their experiences with clients from diverse backgrounds
- Educate and motivate staff by having them read and conduct research in cultural competence
- Establish a cultural competence task force with representation from all levels of the program and community members to plan and lead the cultural competence assessment
- Network with programs that have developed culturally competent service delivery systems and with diverse groups in the community
- Learn about the six stages of cultural competence.

Six Stages of Cultural Competence

Stage 1. Cultural Destructiveness—

- Makes people fit the same cultural pattern; excludes those who do not fit
- Uses difference as barriers

Stage 2. Cultural Incapacity—

- Supports segregation as a desirable policy; enforces racial policies and maintains stereotypes
- Maintains a paternalistic posture toward "lesser races" (e.g., discriminatory hiring practices,

lower expectations of minority clients, subtle messages that they are not valued)
- Discriminates based on whether members of diverse groups "know their place"
- Lacks the capacity or will to help minority clients in the community
- Applies resources unfairly

Stage 3. Cultural Blindness—
- Believes that color or culture makes no difference and that all people are the same
- Ignores cultural strengths
- Encourages assimilation; isolates those who do not assimilate
- Blames victims for their problems
- Views ethnic minorities as culturally deprived

Stage 4. Cultural Precompetence—
- Desires to deliver quality services; has commitment to civil rights
- Realizes weaknesses; attempts to improve some aspects of services
- Explores how to serve minority communities better
- Often lacks only information on possibilities and how to proceed
- May believe that accomplishment of one goal fulfills obligations to minority communities; may engage in token hiring practices

Stage 5. Cultural Competence—

- Shows acceptance of and respect for differences
- Expands cultural knowledge and resources
- Provides continuous self-assessment
- Pays attention to the dynamics of difference to meet client needs better
- Adapts service models to needs
- Seeks advice from and consults with minority communities
- Is committed to policies that enhance services to diverse clientele

Stage 6. Cultural Proficiency—

- Holds all cultures in high esteem
- Seeks to add to knowledge base
- Advocates continuously for cultural competence

Performing Cultural Competence Assessment

A cultural competence assessment answers the following questions:

- What is the composition of the local population?
- Are all those who need care being served in the program?
- What is the level of satisfaction with the program among minority groups?
- How prepared is the program to meet the treatment needs of the diverse groups in the community?

Community Assessment

Local census data allow administrators to assess—

- The percentage of minority and ethnic individuals in the area
- The extent to which individuals from ethnic groups are accessing services
- Underrepresented groups that need targeted outreach
- The makeup of the staff and board with respect to the diversity in the community.

Assessment by Clients

Programs should survey clients when they are discharged or drop out of the program to assess the accessibility, sensitivity, and effectiveness of the program. Client feedback can be analyzed by gender, race, ethnicity, religion, and physical ability.

Program Self-Assessment

Self-assessment of a program's cultural competence should include—

- Administration policies
- Physical facility
- Staff diversity
- Staff training
- Screening and assessment methods
- Program design.

A cultural competence self-assessment should—

- Take place in a supportive environment
- Involve the entire program, including board members and volunteers

- Include a formal review in which all who were involved learn the results
- Culminate in a decision to develop a long-term plan that includes goals and objectives.

Implementing Changes Based on Cultural Competence Assessment

The following actions will improve a program's cultural competence:

- Incorporate cultural competence in the mission statement;
- Demonstrate cultural diversity in the program's philosophy, outreach activities, staffing, and client services;
- Make ability to work sensitively with people from other cultures a criterion for evaluating performance and encourage staff members to pursue continuing education in cultural competence;
- Add board members from groups that are not represented;
- Seek input from diverse local community members on new interventions and services;
- Hire diverse staff; and
- Ensure the décor promotes inclusivity and reflects cultural openness.

Developing a Long-Term Cultural Competence Process

Administrators should consider making changes to improve cultural competence.

Steps To Take—

- Obtain screening instruments that are translated into the language of the client population or designed to be administered orally in English or in other languages
- Open a dialog with staff to explore attitudes about cultural diversity
- Develop training programs around staff members' cultural competence
- Fund workshop and conference attendance for staff members to further cultural competence

Staff Selection—

- Assess the barriers to hiring clinical staff from specific ethnic and cultural groups
- Tap into State and national recruiting sources (e.g., the SSA, employment Web sites)
- Use internships and training to encourage potential counselors to enter the treatment field
- Recruit diverse candidates from local colleges; grant fellowships to advanced students
- Rate more highly applicants who include religion, physical ability, sexual preference, age, and gender as part of diversity

Training Topics—

- The meaning of substance abuse and addiction in a client's culture
- Self-assessment of cultural biases and attitudes
- Sources of cross-cultural misunderstanding

- Sources of social or psychological conflict for bicultural clients
- Strategies for clinical and cultural assessment of individual clients

Program Planning

Criteria for Types of Programming

The following questions help determine whether a specialized program is warranted to address the needs of diverse clients:

- Is the potential volume of clients sufficient to support a specialized program?
- Is financial support available for these clients?
- Will treatment goals of the specialized services fit into the program?
- Will there be training on the special needs of the population?
- Are links and referrals to other service providers possible for this population?

Specialized Treatment Programs

Clients for whom specialized programs are recommended include—

- Foreign-born clients who need bilingual counselors
- Minority groups with identity, self-esteem, and cultural alienation problems that can be addressed by ethnocentric programming
- Clients who are disabled.

Specialized programs for a particular group should include—

- Staff members at all levels with backgrounds similar to those of the clients
- Assessment instruments with norms for the ethnic and cultural groups being treated
- Input from the community and other providers.

Clients With Disabilities

ADA guarantees equal access to treatment for clients with disabilities, which may entail altering the building that houses the program and eliminating physical barriers to accommodate people with disabilities. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities,* contains information about screening and treating these populations.

Clinics are required to accommodate clients who are deaf, such as by providing an American Sign Language interpreter during sessions. The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals offers resources and training for treating this population (**www.mncddeaf.org**).

For more detailed information, see TIP 46, pp. 53–72.

OUTPATIENT TREATMENT FINANCING OPTIONS AND STRATEGIES

Planning and Developing a Program

New programs can approach the following groups for startup funding or other resources:

- Potential strategic partners;
- Community organizations; and
- Local foundations and businesses.

During program development, planners should work closely with potential referral and payment sources to determine their needs. Potential sources of referral and payment include—

- Contacts made during focus group meetings
- Public-sector payers and planners
- Private insurance plans
- Contracting agents for private insurance
- Local employers that have EAPs or managed behavioral health plans
- Other treatment providers for referrals and continuum of care.

Funding Streams and Other Resources

Substance abuse treatment is financed through a mix of public and private sources with their own approval and reporting requirements.

Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the primary mechanism for Federal funding of substance abuse treatment programs. Funds are distributed through SSAs.

The Children's Health Act of 2000 mandates a transition from SAPT Block Grants to require the implementation of performance measures identified as the National Outcome Measures (NOMs). Providers should track this transition through their SSA; likely effects include—

- **Changes in reimbursement.** Managed care arrangements and utilization review are increasingly common
- **Performance outcome data.** NOMs require reporting of outcomes and other performance data; payers such as CSAT and the States are beginning to utilize such performance measures in their evaluation and planning of service activities.

Medicaid

Medicaid provides financial assistance to States to pay for medical care of—

- Low-income children
- Pregnant women
- Elderly persons
- People who are disabled, including those who are blind.

Medicaid expenditures vary greatly by State because substance abuse treatment is an optional benefit. States choose the services and levels of care they reimburse; OT, as a new form of treatment, may not be covered.

Medicaid offers the following advantages to substance abuse treatment programs:

- It can provide funding for high-risk groups (e.g., low-income mothers, adolescents);
- Client copays usually are not required, so the program receives the entire negotiated fee;
- Its contracts can provide a useful lower limit for rate negotiations with commercial payers;
- Certification as a Medicaid provider can position a program to receive clients from other public-sector referral sources; and
- Criminal and juvenile justice systems typically favor Medicaid-eligible providers because some States permit treatment of offenders to be billed to Medicaid.

Medicaid Link to Supplemental Security Income

Supplemental Security Income (SSI) recipients automatically qualify for Medicaid coverage. SSI benefits are payable to adults or children who meet the following criteria:

- They are blind or otherwise disabled;
- They have limited income and resources;

- They meet the living arrangement requirements; and
- They are otherwise eligible.

A primary substance use disorder diagnosis does not qualify as a disability. However, if a person is otherwise qualified for SSI benefits, a secondary substance use disorder does qualify.

Medicare

Medicare provides coverage for people ages 65 and older and people with certified disabilities or end-stage renal disease. Medicare may provide Part A coverage to clients in hospital-based OT programs and Part B coverage to clients in OT programs with Medicare-certified practitioners (however, clients reimbursed under Part B must pay half of Medicare-approved charges). More information is available from the Social Security Administration, Medicare provider enrollment department, State Medicare services, or Centers for Medicare and Medicaid Services (**www.cms.gov/medicare**).

Medicare Link to Social Security Disability Insurance

Recipients of Social Security Disability Insurance (SSDI) are covered by Medicare after a 2-year waiting period. As with SSI, a primary substance use disorder does not qualify a person for SSDI coverage, but if a person qualifies under a separate diagnosis, a secondary substance use disorder diagnosis is acceptable.

State Children's Health Insurance Program

In many States, the State Children's Health Insurance Program provides funds for substance abuse treatment of children and adolescents of low-income families that are not eligible for Medicaid.

TRICARE

TRICARE is a health care program for active duty and retired members of the uniformed services and their families, supplementing the health care resources of the military. TRICARE Extra (preferred provider) and TRICARE Standard (fee-for-service, formerly known as CHAMPUS) include benefits for substance use disorders, subject to preauthorization (**www.tricare.osd.mil**).

Indian Health Service

The Indian Health Service (IHS) operates a comprehensive health service delivery system for American Indians who live on or near reservations. The IHS behavioral health program supports substance use disorder prevention, treatment, and rehabilitation (**www.ihs.gov/MedicalPrograms/Behavioral**).

Department of Veterans Affairs

Medically necessary substance abuse treatment is covered by the Civilian Health and Medical Program of the Department of Veterans Affairs (**www.va.gov/hac/forbeneficiaries/champva/champva.asp**).

Social Services

Temporary Assistance for Needy Families. Temporary Assistance for Needy Families funds services and treatment for unemployed persons and their families, usually women with dependent children. Funds often are distributed through State or local Private Industry Councils, Workforce Investment Boards, and Workforce Development Boards (**www.acf.hhs.gov/programs/ofa**).

Welfare-to-Work Initiatives. Nonmedical substance abuse treatment is funded through Welfare-to-Work (**www.doleta.gov/wtw**).

Social Services Block Grant. The Administration for Children and Families provides a block grant to States that can be used for nonmedical substance abuse treatment services, with the exception of initial detoxification (**www.acf.hhs.gov/programs/ofa**).

Public housing. HUD's Public Housing Drug Elimination Program funds substance abuse treatment for public housing residents. Special housing programs are available for people who are homeless and abuse substances (**www.hud.gov/grants/index.cfm**).

Vocational rehabilitation. The U.S. Department of Education supports treatment for substance use disorders through State agencies (**www.ed.gov**).

Children's protective services. Funds are available for substance abuse treatment for parents who have been ordered by the courts to receive treatment to retain custody of their children (**www.acf.hhs.gov/programs/cb/index.htm**).

HIV/AIDS resources. The Ryan White Comprehensive AIDS Resources Emergency Act provides funds for people affected by HIV/AIDS. This money can be used for substance abuse treatment (**www.hab.hrsa.gov/programs.htm**).

Criminal and Juvenile Justice Systems

State corrections system. Funds may be provided for treatment of offenders who are returning to the community.

Community corrections. This system includes drug courts that may mandate substance abuse treatment in lieu of incarceration.

Correctional residential facilities. Programs may contract with these facilities to provide substance abuse treatment to prevent relapse.

Juvenile court system. Programs with experience treating adolescents can provide treatment in juvenile correctional facilities and in the court system.

TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System;* TIP 21, *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System;*

and TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community,* provide more information.

Byrne Formula Grant Program

The Byrne Formula Grant Program funds programs that meet the treatment needs of adult and juvenile offenders who are drug or alcohol dependent (**www.ojp.usdoj.gov/BJA/grant/byrne.html**).

County and Local Governments

In States with strong county systems (e.g., California, New York, Washington), county and local governments often contract for delivery of substance abuse treatment services.

Schools and Colleges

Local schools may fund assessment but usually do not fund treatment. Schools sometimes provide outpatient programs with rent-free space for counseling services.

Private Payers

Contracts with MCOs, health plans, and managed behavioral health care organizations (MBHOs). Substance abuse treatment may be covered under mental health benefits or medical coverage.

Direct service contracts with employers. Some employers whose health plans offer inadequate benefits may contract with local providers for treatment services.

Contracts with EAPs. EAPs provide direct service contracts for an OT program.

Clients with indemnity or out-of-network coverage. These clients pay out of pocket and are reimbursed by their insurance company for eligible services.

Contributions

Fundraisers can help a program develop a campaign. Groups soliciting charitable donations often are required to register with the State (**www.labyrinthinc.com/index.asp**). Contributions can be sought from—

- Foundations and local charities (**www.fdncenter.org**)
- Alumni
- Local colleges, which can supply interns
- Faith-based and retirement organizations
- Community centers, which may provide rooms for classes and group meetings
- Local businesses.

Research Funding

SAMHSA (**www.samhsa.gov**), the National Institute on Drug Abuse (**www.nida.nih.gov**), and the National Institute on Alcohol Abuse and Alcoholism (**www.niaaa.nih.gov**) fund research on best practices in substance abuse treatment.

Grants

Writing successful grant applications entails—

- Hiring a consultant, if the program does not have qualified planning and research staff
- Involving program staff members in the development of the proposal
- Establishing links with other resources and services in the community.

The following Web sites provide information on grant availability and grant writing:

- **www.grants.gov.** Information on Federal Government grants;
- **www.samhsa.gov/grants/index.html.** Information about SAMHSA grants;
- **www.cybergrants.com.** Information about corporate foundations;
- **www.cdpublications.com.** Subscription-only newsletters that detail funding strategies and opportunities; and
- **www.grantsandfunding.com** and **www.tgci.com.** Commercial Web sites that offer tips and strategies for writing grant applications.

Self-Pay Clients

Some clients will pay out of pocket and not seek reimbursement either because their insurance does not cover substance abuse treatment or because of concerns over confidentiality. Some

programs institute sliding-scale fees based on clients' ability to pay.

Working in Today's Managed Care Environment

Most MCOs separate (or carve out) mental disorders from other health care services. Substance use disorders often are covered in a medical MCO. The carve-in approach, which integrates medical services with substance use disorder treatment services, is reemerging but still rare; in this approach, MCOs often subcontract for specialty services.

Contracts Are Primary Tools in Managed Care

Administrators should be familiar with the following aspects of managed care arrangements:

- Contracts specify the obligations of each party;
- By signing a managed care contract, a program becomes a member of an MCO's network;
- Performance must be measured and reported; and
- MCO staff determines which services are eligible for reimbursement.

Elements of Financial Risk in Managed Care Contracts

To manage financial risk, administrators need to understand the three major types of financial arrangements in managed care contracts.

Fee-for-Service Agreement

These programs are the least risky to providers and generally require precertification and utilization

management for at least some or all services. A rate is received for the services provided—a standard program session with other services (e.g., urine testing and group, family, or individual counseling).

Cautions/risks for programs. When negotiating a contract, administrators must ensure that the rate will cover the actual costs of services. All services should be costed out before negotiation.

Capitation Agreement

The MCO and the provider negotiate a fixed amount that the provider is paid per subscriber per month. The provider agrees to provide all or some treatment services for an expected number of "covered lives" (e.g., $70,000 per month to provide OT and IOT services for 200,000 subscribers).

Cautions/risks for programs. The per member/per month rate and the utilization rate are critical. Reliable information on the historical use rates of the MCO's enrollees is key: if more people than predicted require service, the provider may be unable to cover service delivery costs. Programs may agree to a speculative rate and then renegotiate after they have collected data.

Case Rate Agreement

The case rate is a fixed, per-client rate paid for delivery of specific services; the provider covers all services a client requires for a specified period.

Unlike capitation, in a case rate agreement all the clients are anticipated to receive some service.

Cautions/risks for programs. A case rate removes some of the utilization risk from the provider. But clients may need more intensive services than predicted. Administrators should track costs by client to assess the adequacy of the proposed rate.

Cost of Services

To assess a managed care contract, an administrator must know what it costs the program to deliver each service. The cost of services includes—

- Staff time spent with clients
- Administrative time spent on meetings and paperwork
- Capital and operating expenses.

Exhibit 5-2 on pp. 89–90 of TIP 46 lists resources on costs of services.

Networks, Accreditation, and Credentialing

Each MCO has criteria for the credentials of network providers, often including academic degrees, levels of licensure, and minimum levels of malpractice insurance. MCOs are sometimes unfamiliar with substance abuse treatment, which means they are more likely to contract with programs that are licensed by the State than with individual substance abuse treatment providers. Providers often must help MCOs understand the treatment environment.

Programs may have to be accredited by a national health care accrediting organization, such as—

- CARF (**www.carf.org**)
- National Committee for Quality Assurance (NCQA) (**www.ncqa.org**)
- JCAHO (**www.jcaho.org**).

Organizational Performance Management

The results of MCO performance evaluations can affect a program's financial success and its ability to remain a network provider. Administrators should consider implementing internal performance measures in their programs. These measures should include—

- Percentage of clients who complete a treatment that meets their individual needs
- Percentage of clients who drop out of treatment in the first 7 days
- Percentage of clients who remain in less intensive treatment 30 days after discharge
- Percentage of clients who are employed or attending school 6 months after discharge.

NCQA has developed four domains for substance abuse treatment measures that are used in the MCO accrediting process:

- Prevention or education;
- Recognition or identification of substance abuse;

- Treatment—Initiation of plan services, linkage of detoxification and drug and alcohol plan services, treatment engagement, and interventions for family members and significant others; and
- Maintenance of treatment effects.

Recordkeeping and Management Information Systems

MCOs require detailed records of services provided. Failure to document clinical services adequately can result in nonpayment and jeopardize a contract. Clients' private information and identity must be handled confidentially in accord with the Health Insurance Portability and Accountability Act (**www.hhs.gov/ocr/hipaa**).

Managing multiple contracts requires a sophisticated management information system (MIS). The program's MIS needs to be capable of two-way data transfer (e.g., membership, benefits, copays, deductibles) between the MCO and the program.

Managing Payment From Multiple Funding Streams

Multiple funding streams and payers may be used to support services for a single client. The various contracts should specify order of payment, but the program needs to manage the funds carefully to be in compliance. One strategy is to draw first on reimbursement from those payers with the most restrictive services, with more flexible funds used to cover the remaining services.

Utilization and Case Management

Utilization management focuses on a single type of service; case management focuses on the coordination of an array of client services. Utilization and case management staffs at an MCO authorize specific services for payment, usually based in part on criteria such as ASAM patient placement criteria. Program staff members should understand what their MCO counterparts do and be familiar with the criteria and protocols used by the MCOs.

Strengthening the Financial Base and Market Position of the Program

Achieving recognition for high-quality and effective services entices managed care enrollees and other clients to use a program. Providing treatment to a population no other program serves can result in client referrals from a large geographic area and from multiple sources.

Adding clinic sites may allow programs to spread some fixed costs (e.g., management, information, financial systems) among a larger number of clients.

Including government and community leaders on the board can raise the program's profile. Collaborating with or forming a coalition of local providers may be useful in working with MCOs.

For more detailed information, see TIP 46, pp. 73–94.

PERFORMANCE IMPROVEMENT AND OUTCOMES MONITORING

Performance improvement uses objective information to improve outcomes by—

- Identifying opportunities for improvement
- Testing innovations
- Reporting the results to relevant stakeholders.

Measuring Outcomes

Performance can be measured using both objective and subjective data.

Objective Measures

$$\textbf{Engagement rate} = \frac{\text{Total number of clients attending their x scheduled session}}{\text{Total number of clients admitted}}$$

$$\textbf{Attendance rate} = \frac{\text{Total number of sessions attended}}{\text{Total number of sessions scheduled}}$$

$$\textbf{Retention rate} = \frac{\text{Total number of weeks clients remained in treatment}}{\text{Total number of clients admitted}}$$

Step 1. For each client admitted during the period under study (e.g., the first quarter of the year), calculate the total number of weeks in active treatment (e.g., the client attended at least one or more treatment sessions within 2 weeks).

Step 2. Add the total number of weeks clients remained in the treatment and divide by the total number of clients admitted.

$$\text{Abstinence rate} = \frac{\text{Total number of negative test results}}{\text{Total number of tests administered}}$$

Subjective Measures

Quality of life indicators. Client participation in support groups (e.g., 12-Step programs, other mutual-help groups) is another way to monitor program effectiveness. Followup calls to former clients can determine—

- The number of support group meetings a client has attended in the last month
- Whether the client has spoken with his or her sponsor in the last month
- Whether the client has a home group.

Client satisfaction. Client satisfaction data may help increase treatment engagement, attendance, retention, and abstinence by pointing to improvements that can be made by individual staff members and the clinic as a whole. Appendix 6-A on p. 113 of TIP 46 presents a client satisfaction form designed for use with OT clients. Client satisfaction forms usually are divided into three sections:

- Client satisfaction with clinic services, such as education materials and sessions, counseling

groups, individual attention, adequacy of the facility, and overall benefit of treatment;
- Client satisfaction with the counselor, including feedback on counselor's warmth, empathy, insight, knowledge and competence, and responsiveness; and
- Confidential demographic information about the client, including age, gender, ethnicity, and sexual orientation.

Satisfaction of referral sources. Conducting a structured telephone interview with key referral and funding sources can—
- Establish whether the program is providing referral sources with appropriate, timely information
- Identify complaints before they escalate into problems
- Help the program expand or refine services.

Client dropout. Phone interviews using open-ended questions with clients who dropped out of treatment can determine what factors prompted the departure and guide changes in the program. Every person contacted in a dropout study should be invited to return to treatment.

The more a program is able to document the positive effects of its efforts, the better it will be able to justify its funding. The following may be important to funders and the public:

- Improvements in clients' employment, education, and family relationships;
- Reductions in arrests, convictions, and incarcerations;
- Reductions in hospitalization for mental illness;
- Increased participation in afterschool programs;
- Decreases in school dropout rates;
- Reductions in use of welfare benefits;
- Reductions in emergency room visits;
- Increases in birth rates of healthy, drug-free babies; and
- Increases in wages and number of days worked.

Outcomes Measuring Instruments

Addiction Severity Index

The Addiction Severity Index (ASI) can be used to collect information for comparison across sites and at different points in time, for example—

- On client intake, to provide baseline status and aid in treatment planning
- At meaningful intervals (e.g., after 3 months) during treatment, to measure progress
- At discharge, to assess outcomes in key areas of a client's life
- At 3 months after discharge, to measure long-term change in client's status and behavior.

Treatment Services Review

The Treatment Services Review (TSR) (**www.tresearch.org**) is a brief, structured interview that elicits the number and frequency of services delivered and yields a rating of the services.

Risk Assessment Battery

The self-administered Risk Assessment Battery (RAB) assesses a client's risk for infectious disease. Monitoring of risk reduction for infectious diseases might involve administering the RAB—

- At intake
- After 2 months of treatment
- At discharge
- 1 to 3 months after discharge.

Program Monitoring for Special Purposes

Program management may be particularly interested in monitoring rates of attendance, engagement, and abstinence before and after implementing new service components or treatment approaches. Referral sources also provide valuable feedback.

When administrators notice a problem or receive a complaint, they might begin monitoring key indicators to learn how to respond. If a clinic experiences a disruption in operations (e.g., a move to a new location, a period of high staff turnover), monitoring might be particularly helpful.

Working With Staff on Performance and Outcomes Improvement

Before beginning performance monitoring, administrators should tell staff members that this process will identify program needs (e.g., training, policy changes). Performance monitoring will not be used to punish employees but will enable them to improve service to clients.

Case Mix Effect

Performance outcomes may vary from clinic to clinic and from counselor to counselor—and for the same clinic and counselor over time—as a result of case mix. Clinics and counselors who work with more challenging clients (e.g., clients who are homeless, have co-occurring disorders) likely will have poorer outcomes. Staff members must know case mix will be taken into account when evaluating performance data.

Dissemination of Study Findings

The following are important considerations when disseminating study findings:

- Administrators should monitor outcomes for a few months before drawing any conclusions because initial results of performance studies can be misleading;
- Data should be handled confidentially. Individual performance data should not be reported in clinicwide meetings but should be released in one-on-one meetings with counselors; and

- Feedback should address only things that counselors can control. Interventions resulting from feedback are more effective if the feedback is objective and focused on tasks.

Taking Action To Improve Performance

After data have been collected and disseminated, all staff members can suggest interventions and strategies for improvement. Staff should focus on—

- Resource allocation
- Conditions causing differences in counselor outcomes
- Improvements in program structure
- A retrospective study.

Funding of Outcomes Improvement

Simple performance improvement studies can be conducted cheaply by—

- Making time in counselors' schedules for followup calls to collect client data
- Using graduate students or faculty researchers for assistance in conducting studies.

Results of a performance improvement study can be used as a fundraising and public relations tool. Even poor results identify areas for work and set a baseline against which later improvements can be compared.

For more detailed information, see TIP 46, pp. 95–114.

Ordering Information

TIP 46

Substance Abuse: Administrative Issues in Outpatient Treatment

Easy Ways to Obtain FREE Copies of All TIP Products:

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**;
2. Visit NCADI's Web site at **www.ncadi.samhsa.gov**; or
3. Access TIPs online at **www.kap.samhsa.gov**.

Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:

TIP 44: *Substance Abuse Treatment for Adults in the Criminal Justice System* (2005) **BKD526**

TIP 45: *Detoxification and Substance Abuse Treatment* (2006) **BKD541**

TIP 47: *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (2006) **BKD551**

See the inside back cover for ordering information for all TIPs and related products.

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