

*A Policy Research Partnership for  
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## **Assessing State Regulation of Outpatient Substance Abuse Treatment Programs in the U.S. along a Quality Continuum**

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# **Assessing State Regulation of Outpatient Substance Abuse Treatment Programs in the U.S. along a Quality Continuum**

## **ABSTRACT**

**Aims:** To assess the extent to which state outpatient substance abuse treatment program policies incorporate quality elements that may be related to program and client outcomes.

**Design:** A cross-sectional study of statutes and regulations effective as of February 1, 2004 in the 50 states and the District of Columbia in the U.S.

**Methods:** A framework for assessing the continuum of state outpatient substance abuse treatment program regulation was developed from the quality and performance measure indicator literature and applied to state policies. The continuum captures structural and process measures of quality related to program capacity and accountability and performance measures related to recognizing treatment need, treatment provision, and maintaining treatment effects (relapse prevention, aftercare, support groups).

**Findings:** Every state has some type of outpatient substance abuse treatment program policy; one state has yet to promulgate implementation regulations and two states' policies are entirely voluntary. Overall, state policies are significantly more likely to include ( $t=5.001$ ,  $p<.0001$ ) quality indicators most directly related to program capacity and accountability over performance measures more directly related to client outcomes. State policies are significantly more likely to include specific treatment components (e.g., counseling, testing, education) than they are to include provisions recognizing treatment need ( $t=4.46$ ,  $p<.001$ ) or maintaining treatment effects ( $t=5.48$ ,  $p<.001$ ).

**Conclusion:** This study provides a critical first step in categorizing the state outpatient substance abuse treatment policies along a quality and performance measure continuum. With this foundation, it will be possible to examine the relationship between state policies and treatment program practices.

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**Keywords:** Substance abuse, outpatient treatment, state policy, quality, performance measures

## **INTRODUCTION**

In 2003, 65.5 percent of standard outpatient substance abuse treatment programs received funding from government sources, excluding Medicare, Medicaid, and federal military health insurance (USDHHS 2004a). Thus, governments have a vested interest in seeing that the clients receive quality treatment services as well as ensuring that treatment programs are held accountable for their performance (McCorry et al. 2000; Hon 2004). While federal, state and local governments are the major payers of substance abuse treatment services (76%) in the United States (U.S.), the majority of substance abuse treatment services are paid for by state and local governments (56 %) (Mark et al. 2005). Yet, there is no national regulatory system for substance abuse treatment services. This, in turn, has led to a substance abuse treatment system that is governed by a patchwork of state policies with the states often serving as virtual experimental laboratories for each other and for the federal government (New State Ice Co. v. Liebmann, 1932). Through regulation, the states are uniquely positioned to affect the introduction of key quality and performance measurement indicators at the treatment program level that might directly and/or indirectly relate to client outcomes (Derose & Petitti 2003; McCorry et al. 2000; Hon 2004).

To date, no study has assessed the state policy context affecting substance abuse treatment program delivery. Without an understanding of the context within which treatment programs are operating, a potentially important component of the treatment delivery system will be overlooked. In this paper, we present new data on the extent to which states have incorporated key quality and performance measurement indicators into their laws governing outpatient substance abuse treatment programs in the U.S. We focus on outpatient programs because the vast majority of facilities in the U.S. offer standard outpatient (73%) or intensive outpatient

services (43%) as compared to residential (28%), day treatment (16%), detoxification (11%), methadone/LAAM maintenance (7%), or hospital inpatient (7%) (USDHHS 2004b).

The purpose of this paper is to develop and apply a conceptual framework for understanding the continuum of state regulation of substance abuse treatment programs drawing from the health care quality and the emerging substance abuse treatment performance measurement literature. As indicated below, our working premise for the framework is that the literature indicates that certain quality/performance measures are more likely to affect treatment program practices and, perhaps indirectly, relate to client outcomes. Many of these quality and performance measures are incorporated into state laws and regulations. To this end, in this paper we will: (1) assess the extent to which states have incorporated these quality and performance measures into their policies; (2) determine where on the continuum the states fall in terms of their policy emphasis (e.g., focusing more on quality rather than performance measures and *visa versa*); and (3) discuss the implications of our findings for the substance abuse treatment field and policy environment.

### **Quality Health Care from a Structural and Process Perspective**

The delivery of “quality” health care has been an area of extensive research, interest and concern for several decades (Donabedian 1966; 1980; 1982; 1985; Institute of Medicine [IOM] 1999, 2001). Yet, there is still a dearth of information linking the health care provided in the U.S. with basic quality standards (McGlynn & Brook 2001).

In 1990, the Institute of Medicine (IOM) defined *quality* as “...the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr 1990). One study has found that there

are quality deficiencies in the care that Americans receive in general (Schuster, McGlynn & Brook 1998), but for substance abuse treatment these deficiencies may be more profound. For example, Elizabeth McGlynn et al. (2003) documented levels of adherence to quality indicators for all phases of care for the 25 leading causes of morbidity, mortality, and health care utilization in the U.S., including alcohol dependence. Their results showed that alcohol dependence ranked lowest in terms of the percentage of recommended care received—only 11 percent.

In his classic works, Avedis Donabedian (1966, 1980, 1982, 1985), described a framework for assessing the quality of care comprised of structural and process measures as well as those related to outcomes.\* *Structural* measures address the capacity of the program to deliver quality care (IOM 1999, 2001); thus, from a substance abuse treatment program perspective, such measures might include policy provisions governing treatment program authorization as well as those related to resource availability such as maximizing the staff-to-client ratio. *Process* measures assess the processes of care such that emphasis is placed on the delivery of quality care and services (IOM 1999, 2001). State outpatient substance abuse treatment program policies seeking to emphasize the processes of care might focus on holding programs accountable and ensuring that they are complying with state standards through such mechanisms as inspections.

### *Structural Measures of Quality*

The regulation, or authorization, of the delivery of healthcare services by governments is important to safeguarding the public's health and safety (Gostin, Koplan & Grad 2003).

Requiring state authorization for a program to provide substance abuse treatment services is one

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\* In this paper, we did not examine state policies addressing outcomes of care as described by Donabedian because we chose, instead, to focus on potential substance abuse treatment-specific performance measures that are potentially related to substance abuse treatment client outcomes more directly than the “generic” health care outcomes included in the Donabedian model. (See below for further discussion.)

means by which states can attempt to ensure consistency in service offerings and provide oversight for ensuring the delivery of certain minimum standards.

The three primary approaches used by state governments to make determinations about the authorization of outpatient substance abuse treatment programs are licensure, certification and accreditation (Roa & Rooney 1999). Each one of these three approaches, alone or together with the others, has the potential to increase the availability and quality of healthcare services offered to the public (Nicholas 1999; Rooney & van Ostenberg 1999). While licensing seeks to ensure that minimal standards are met and provides a framework for the delivery of quality care, certification and accreditation attempt to ensure that certain optimal standards are met (Rooney & Van Ostenberg 1999; General Accounting Office [GAO] 1991). This important distinction may have a significant impact on treatment program practices that may relate to client outcomes.

Another type of authorization that may be found among state policies is that of deemed status. Deemed status is a term commonly used in the long-term care area for agencies seeking Medicare certification. For example, facilities that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are *deemed* under federal law to be compliant with Medicare requirements for patient safety and, therefore become eligible for Medicare payments. It is widely assumed that entities applying for national accreditation are committed to delivering high quality care because they must expend considerable resources in order to meet national accreditation standards (Joint Commission on Accreditation of Healthcare Organizations [JCAHO] 2004; Friedmann, Alexander & D'Aunno 1999a).

At the same time, by requiring (as compared to making authorization voluntary) that outpatient treatment programs at least meet certain state standards in order to receive

authorization, states are better positioned to ensure that such programs meet a certain minimum quality standard. Requiring state authorization in order for a program to operate ensures that the state has ultimate authority on the quality of care delivered by those programs (Rooney & van Ostenberg 1999). Also, using state funding as a “carrot” to ensure compliance with state requirements may be an effective means for ensuring the incorporation of quality assurance provisions and other quality indicators into outpatient substance abuse treatment programs (Friedman et al. 1999b).

As part of the program authorization/renewal process, states often conduct inspections of substance abuse treatment programs to determine whether standards intended to ensure health and safety are being violated (Gostin, Koplan & Grad 2003). Inspections are conducted in the health care sector (as well as other sectors) to determine whether service providers are conforming to “officially prescribed standards” (Anderson 2003). According to Anderson (2003, p. 222), “inspection is the most commonly used form of regulatory action.” Further, inspections of healthcare facilities and programs, which if conducted by a government agency, are one of the most basic tools available to health authorities to help ensure patient safety and quality of care (Grad 1990).

Having the capacity to adequately deliver care is a key structural measure of quality. One measure of capacity is reflected in staff-to-client ratios. Clients generally benefit from appropriate staff-to-client ratios because they are an indicator of the greater amount of attention provided to clients by the treatment program staff (Coleman and Paul 2001; Curtin 2003). For example, higher staff-to-bed ratios for veterans with severe substance use disorders who participated in a residential work therapy program resulted in more positive employment outcomes (Rosenheck & Seibyl 2005). D’Aunno and Vaughn (1995) found that clients in

outpatient drug abuse treatment units that had more clients per full time equivalent staff were less likely to receive services overall. Thus, by requiring that treatment programs employ higher staff-to-client ratios, states introduce a structural element of quality health care into the delivery system that is beyond the control of the treatment program itself unless it does not seek authorization from the state or a national accrediting body.

### *Process Measures of Quality*

Fundamentally, the organizational structure and capacity of a treatment program is meaningless unless the treatment program is held accountable for ensuring that it meets certain quality standards. Random, unannounced and follow-up/corrective action inspections are key potential indicators of quality because they indicate how closely the state monitors each program (as compared to structural indicators that simply determine whether the treatment program has the capacity to deliver care). The importance of random, unannounced inspections to the health care system has been well-documented. Until very recently when JCAHO announced the implementation of random, unannounced inspections beginning in 2006, JCAHO inspections were widely criticized as ineffective because the prior notice facilities received allowed temporary corrections in deficiencies (Dooley 2002; GAO 2004; SEIU 2003). As a result of the criticism and findings on announced inspections, random, unannounced inspections have become the norm rather than the exception.

While inspections may help ensure substance abuse quality and compliance, state required program quality assurance provisions also are important because they require the entity to periodically review its own functioning and effectiveness and assure accountability (IOM 2001; Shojania et al. 2004). According to the IOM (2001), "whatever the organizational

arrangement, it should promote innovation and quality improvement. Every organization should be held accountable to its patients, the populations it serves, and the public for its clinical and financial performance” (p. 116). A quality assurance program with clear standards and well defined processes for meeting those standards can play a major self-monitoring role in achieving and, more importantly, maintaining a quality program.

### **Performance Measurement: The Next Step**

While the Donabedian and IOM frameworks provide a firm foundation for assessing structural and process measures related to the delivery of quality health care services, they do not account for the unique nature of substance abuse disorders and the critical components of treatment that likely will affect client outcomes. The Washington Circle Group (WCG) has developed a set of core performance measures for alcohol and other drug services for public and private health plans that can be used to extend Donabedian’s original framework to more specifically target treatment program and client outcome performance (McCorry et al. 2000; Hon 2004). While the WCG performance measures were specifically developed from a health plan perspective, they also hold the potential to serve as benchmarks for state policies governing substance abuse treatment programs. The WCG’s core performance measures span four domains representing the continuum of alcohol and other drug services for adults: (1) prevention/education, (2) problem recognition, (3) treatment service provision (including linkages to other services and systems of care), and (4) maintenance of treatment effects (McCorry et al. 2000; Hon 2004).

The *prevention/education* domain is targeted less at individual treatment programs or individuals in treatment, but, rather at the primary care stage through the use of educational and other preventative measures (McCorry et al., 2000). Given that this domain falls outside of the substance abuse-specific treatment system, we do not continue to address it below.

The *recognition* domain seeks to assess the “efforts in all clinical settings, at case-finding, including screening and assessment, it also includes referral of affected individuals into treatment” (McCorry et al., 2000). While the WCG measure is at the health plan level, it also is relevant for treatment program provision and regulation because unless treatment programs are adequately assessing and diagnosing clients, the treatment program will be compromised from the outset. The treatment literature documents the importance of assessing an individual client’s drug use and health status at the time of admission to treatment so that an appropriate treatment plan can be developed from the beginning (Morgan et al. 2003; Thom et al. 1992). Tools such as the American Society of Addiction Medicine’s (ASAM) patient placement criteria, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and the Addiction Severity Index (ASI) are intended to guide the placement of patients presenting for addictive disorders and have been widely used by substance abuse treatment providers (American Psychiatric Association 1994; McLellan et al 1980; Mee-Lee et al. 2001). The use of ASAM patient placement criteria have been shown to reduce both detrimental under-treatment and cost-inefficient over-treatment when matching alcoholism patients to levels of care (Magura et al. 2003). Research also has shown the ASI to be a valid and reliable instrument for client screening, determining treatment needs, and assessing treatment outcomes (Calsyn et al. 2004; McLellan et al. 1985; Stoffelmayr, Mavis & Kasim 1994). In addition, the DSM-IV has been proven to be an effective tool in diagnosing substance use behaviors among patients and predicting improved

outcomes for patients (Carpenter, Miele & Hasin 2002; Dawson et al. 2005). In requiring treatment programs to use patient placement or diagnostic tools when assessing patients, the states are aiming to improve the accuracy of assessment or diagnosis (American Psychiatric Association 1994; McLellan et al 1980; Mee-Lee et al. 2001; Magura et al. 2003).

The third domain, *treatment*, encompasses the direct provision of care and spans the spectrum of services “associated with an episode of care, including medications, testing, counseling, medical services, psychiatric and social services, and coordination with other treatment resources” (McCorry et al., 2000). In fact, the standard of care today recognizes the need to integrate medications (if indicated by assessment), counseling, drug and infectious disease-related education, drug testing and testing for a variety of infections as well as the need to provide necessary ancillary health, education and human services (NIDA 1999; McCarty, 2000). Research has shown that treatment programs that include counseling services and incorporate appropriate pharmacological agents lead to improved outcomes (McLellan et al. 1993; Avants, et al., 2004; McCann, 2004). Education and testing programs also are critical components of an outpatient substance abuse treatment program. In fact, drug use has been linked to infectious diseases such as HIV, hepatitis C, tuberculosis, and sexually transmitted infections (Aktan, Calkins & Johnson 2001; Edlin 2005; Holmberg 1996; Nyamathi et al. 2004). According to NIDA (1999), because drug users are at increased risk for infectious disease, “participation in treatment also presents opportunities for screening, counseling, and referral for additional services” (p. 20). In fact, studies have documented the importance of HIV counseling/education and HIV testing components in substance abuse treatment programs (Batki & Ferrando 1996). One study concluded that HIV counseling and education services may have

contributed to reductions in HIV-related risk behaviors during treatment (Broome, Joe, Simpson 1999).

Researchers also have documented the importance of assessing and meeting the need for such ancillary services as employment training, transportation, housing or legal services. Analysis by Reif and colleagues (2004), using data from the nationally representative Alcohol and Drug Service Study, showed that those clients who had employment counseling needs met were significantly more likely to stay in treatment than those who did not receive this needed service. A comprehensive study of retaining HIV positive clients (including IDUs) in a primary care treatment program found that the provision of ancillary services such as transportation, housing and legal services played a significant role in retention especially for minorities and women (Lo, MacGovern, & Bradford 2002). In a study focused specifically on drug users, Orwin and his colleagues (2000) found that the provision of needed ancillary services significantly related to treatment retention and improved outcomes. In a summary of the state of the substance abuse field, McCarty (2000) noted that assessing and meeting the ancillary services needs of those in substance abuse treatment was crucial for success and a key part of developing high quality substance abuse treatment programs.

The final domain, *maintenance*, is critical to ensuring the long-term success of treatment and to maintaining abstinence (McCorry et al. 2000). Increasingly, researchers and clinicians have come to realize that addiction is a chronic reoccurring condition. Thus, it is crucial to provide continuing/after care for those enrolled in drug treatment in order to facilitate long term abstinence or reductions in drug use and related behaviors (Carroll, Rounsaville & Keller 1991; Marlatt 1985; McLellan 2002; NIDA 1999). Several studies have proven relapse prevention to be an effective method of improving substance abuse treatment outcomes (Carroll 1996; Irvin et al.

1999). Furthermore, research also has shown that relapse prevention, when combined with other components of treatment such as pharmacological agents, is associated with long-term improvements in treatment outcomes (Annis 1991). In examining the effectiveness of aftercare programs, Brown et al. (2002) indicated that aftercare is associated with better post-treatment outcomes and may be cost effective. While there is some disagreement in the literature as to whether aftercare programs are more or less effective than support groups such as 12 step programs, there seems to be general consensus that together, aftercare and treatment programs are more likely to increase abstinence from drug use than those who only attend treatment programs (Siegal, Li & Rapp 2002). Self-help or support groups (*e.g.*, alcoholics anonymous, narcotics anonymous) often are considered a complement to and may “extend the effects of professional treatment” (NIDA 1999, p. 20). In fact, research has shown that patients who participate in self-help groups upon completion of treatment tend to have lower rates of alcohol and cocaine use during follow-up (McKay et al. 1994). In addition, Moos and Moos (2004) found that the longer the participation in support groups, particularly for alcoholics anonymous, following treatment, the better the subsequent alcohol-related outcome.

### **A Conceptual Framework for Assessing Quality and Performance Measures included in State Substance Abuse Treatment Regulations**

The substance abuse treatment literature is replete with studies addressing the treatment system, treatment programs, and client outcomes. However, there has yet to be a clear framework for evaluating the continuum of regulation of substance abuse treatment programs that takes into account the extensive work that has gone into the development of quality and performance measurement indicators. Building off of the work of Donabedian, the IOM, and the

WCG presented in the preceding sections, we have conceptualized such a framework that is informed by what is known to work in clinical management and treatment program practices.

Figure 1 presents the conceptual framework that we have labeled to reflect the continuum of substance abuse treatment regulation. The figure categorizes the various components of the state statutes and regulations governing outpatient treatment programs according to the quality and performance measure domains and along the treatment regulation continuum.

**Insert Figure 1 about here**

Moving from left to right in the figure, we present the potential locations of direct to indirect regulatory impact. As indicated above, the structural and process quality measures (left side of the continuum) likely will most directly relate to the treatment program capacity and accountability and might potentially relate indirectly to client outcomes. On the right-hand side of the continuum, the performance measures, while still a reflection of state treatment program regulations, will likely have a more direct relationship with client outcomes because these indicators focus on the services that are actually being provided to individual clients. Consistent with the above literature review, the continuum includes linkages to medical and social services, collateral services, and medications/pharmacotherapies as part of the core components of treatment program provision because of their import to a comprehensive treatment program. As we note below, resource limitations precluded us from gathering the state policy data on these components so they are presented here as part of the overall conceptual framework. Future research will emphasize gathering these components so that we can assess the extent to which states have incorporated these provisions into their laws.

## **Applying the Framework to the State Laws**

Building off of the conceptual framework, we sought to explore the continuum of state outpatient substance abuse treatment regulation and the extent to which the states have incorporated the framework components into their laws. The study was exploratory in nature so as to provide initial insights into the state policy context that ultimately might relate to treatment program practices and/or client outcomes. Specifically, we will answer the following questions: (1) to what extent have the states incorporated quality and performance measures into their laws, and (2) are the states focusing more heavily on one end of the regulatory continuum as compared to the other?

## **METHODS**

### *Study Population*

The state policy information presented in this report is based on a systematic review of each state's policies (*i.e.*, statutes, regulations, and/or standards) governing standard and intensive outpatient substance abuse treatment programs in effect as of February 1, 2004. For purposes of this report, "state" refers to each of the 50 states in the U.S. and the District of Columbia. As indicated earlier, standard and intensive outpatient programs were emphasized since outpatient services are the primary treatment service offered in the U.S. (SAMHSA 2004). The standard and intensive outpatient programs were captured using the ASAM definitions for outpatient (ASAM Level I) and intensive outpatient (ASAM Level II.1) programs. ASAM standards require both outpatient and intensive outpatient programs to conduct "an assessment that meets the diagnostic criteria for a Substance-Related Disorder as defined in the current Diagnostic and Statistical Manual or other standardized and widely accepted criteria as well as

dimensional criteria for admission" (Mee-Lee et al. 2001). Both types of programs are staffed with appropriately credentialed treatment professionals. The outpatient definition requires the program to offer such services and therapies as individual and group counseling, family therapy, and educational groups. Frequency of these services is to be appropriate to the individual treatment plan. Intensive outpatient programs, in contrast, "generally provide 9 or more hours of structured programming per week" of the therapies mentioned above (Mee-Lee et al. 2001).

In order to ensure accurate capture of relevant provisions governing outpatient treatment programs in each state, it was important to understand how such programs were identified in each state's policy. To this end, the study captured the entity identified in the state policy as responsible for providing the actual services. For example, in some cases, a facility is responsible for providing the service and in others it is a program. Separate policies governing the physical structure (the physical facility) within which treatment services may be provided were not captured in this study. Similarly, specific, individual practitioner professional standards (detailing educational and credentialing requirements) were not captured in this study as they have been reported elsewhere (Mustaine, West & Wyrick 2003). For ease of reference, we have referred to the entities emphasized for this study as "programs."

State policy requirements applicable to program state authorization (i.e., licensure, certification, or accreditation) were the focus of this study. As such, any state-authorized program, regardless of whether it did or did not receive state funding including programs receiving funding under the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, would be governed by the policies included in this study. Policies contained specifically within Medicaid provisions or Medicaid provider reimbursement policies were not captured. While this is a limitation, we believe that we have captured the policies governing the majority

of the outpatient programs in the U.S. since according to the 2003 National Survey of Substance Abuse Treatment Services, 65.5 percent of regular outpatient substance abuse treatment programs received public funds from federal, state, or local sources excluding funds from Medicare, Medicaid, and federal military health insurance sources (USDHHS 2004a). Additional information about what was or was not captured is reported below under limitations.

### *Data Collection*

All policies were identified and collected from Westlaw, a subscription-based electronic legal research service, by research attorneys at The MayaTech Corporation using commonly accepted primary legal research methods (Mersky & Dunn, 2002). Westlaw contains electronic copies of all state statutes and regulations for the reference date of interest in this study (Thomson West 2005). Searches in Westlaw were conducted based on a comprehensive keyword search strategy developed by the first and second authors that emanated from an earlier pilot study of eight states' statutes and regulations where we had searched the hard copy paper indices and tables of contents of the pilot states' statutes and regulations. This keyword search strategy was then used in the Westlaw databases of the states' statutes and regulations to search: (1) the indices (if available), (2) the table of contents (if available), and (3) the entire text if both the Indices and the Table of Contents were not available.

Once a relevant statute or regulation was identified, a series of confirmatory checks occurred to ensure accurate policy capture: (1) the table of contents was reexamined to see if surrounding chapters were relevant; (2) the statutory authority cross-reference given in the regulation was examined; and (3) the annotations and references within the given statute and/or regulation were examined for relevancy.

During the data collection, all policies were reviewed to ensure that they were effective as of February 1, 2004. If the policy was found to be effective after that date, searches of historical databases on Westlaw were conducted to find those policies effective as of the February 1, 2004 date. For three states (i.e., California, Mississippi, and Kansas), the statutes and regulations did not provide enough detail to permit complete coding for the policy provisions of interest to this study. In these cases, we consulted the state web sites and were able to retrieve additional state standards that were not codified in statute or regulation so as to enable comparable coding across the states.

### *Data Coding*

Each state's policies were coded based on a predetermined coding scheme (see the Appendix) that captured most of the provisions presented in the regulation continuum framework (Figure 1). Due to resource limitations, we did not capture provisions related to linkages with medical and social services or collateral services; however, recognizing the critical importance of these components, we plan to incorporate these provisions in future studies.

Following is a brief summary of the provisions captured in the study by each category delineated in the regulatory continuum framework and defined in the Appendix:

### **Quality Measures**

- *Structural Measures*
  - Program authorization including the type of authorization (i.e., licensure, certification, or accreditation); authorization status (i.e., required, required of state funded entities, voluntary, other); deemed status provisions; and inspections for initial or renewal/routine program authorization
  - Staff-to-client ratios

- *Process Measures*
  - Quality assurance/accountability measures including requirements for criteria-based/measurable objectives, peer review/case review, collection of treatment statistics, and client satisfaction surveys
  - Quality assurance-related inspections including random, unannounced inspection requirements and corrective action/follow-up inspection requirements

### **Performance Measures**

- *Recognition of Treatment Need*
  - Assessment
  - Patient placement and diagnostic criteria to include requirements for use of the ASAM, DSM, and/or ASI tools
- *Treatment Provision*
  - Counseling services including provisions governing individual, group, and family counseling
  - Testing services for substance abuse, HIV/AIDS, tuberculosis, sexually transmitted diseases, and Hepatitis B or C
  - Education services for substance abuse, HIV/AIDS, tuberculosis, sexually transmitted diseases, and Hepatitis B or C
- *Maintenance of Treatment Effects*
  - Relapse prevention
  - Continuing care/aftercare
  - Support groups (e.g., 12-step)

Upon collecting the relevant policies, data were coded by a legislative analyst and verified by a senior analyst. Each provision was coded as a simple dichotomous, “yes/no” variable with additional fields capturing the extent to which the provisions applied to standard and/or intensive outpatient programs and the extent to which the provisions were mandatory or optional. A decisions rule document was created based on resolution of coding questions that arose during this initial coding to ensure the consistency of the data.

A combination of exact and generally accepted terms were used to guide the coding activities. For example, provisions governing whether the state recognized JCAHO accreditation were based on “exact” terminology; whereas, assessment was coded based on general terminology such that if the policies contained the words “assessment” or “initial screening” or “screening” or “biopsychosocial assessment”, the state received credit for requiring or offering “assessment” at intake.

Once the initial coding was verified by the senior analyst, several steps were taken to ensure coding consistency. First, an analyst verified that coding between states was consistent in the topic areas where we tended to rely on general rather than exact terminology: education and testing requirements, quality assurance provisions, and support groups. Second, senior analysts completed a third review of the entire data set to ensure consistency and accuracy of the coding performed initially. As a final cross-check, the entire data set was cross-checked against the relevant statutory and administrative law citations to ensure accurate data capture and coding.

### *State Verification*

Once all coding and consistency checks were completed, a subset of the data were sent via electronic mail to state contacts in the agency responsible for authorizing such programs. So as to reduce the respondent burden, the state contacts were asked to verify the program authorization, inspection, and quality assurance (on a summary variable basis) provisions. The state contacts were not asked to verify the information captured regarding the staff-to-client ratio or the performance measure variables since these provisions are based on more generally accepted terminology. Responses were received from 45 states (88.24% response rate) and revealed that our initial coding was correct in over 90 percent of the cases.

## *Data Analysis*

The state verified data were imported into SPSS v. 12.0.1 for analyses. Basic descriptive statistics (e.g., frequencies) were computed to assess the prevalence of the provisions within the conceptual framework presented. To determine where on the continuum states are leaning (i.e., more towards the quality measures comprised of the structural/process variables as compared to the performance measures or *visa versa*) we created two composite scores that reflect the percentage of the individual components of each measure that a given state has enacted.

The quality measure composite score was constructed by summing the frequency of the individual structural and process measures (with a maximum “score” of 11 points) and then dividing the individual state’s score by 11 (maximum quality measure score) and multiplying it by 100 to obtain a percentage of the quality measures required in the state. For ease of interpretation, we only included the dichotomous program authorization (yes/no) and deemed status-any (yes/no) variables in this computation as opposed to distinguishing between program authorization type (e.g., licensure, certification, or accreditation) or counting separately each type of national accreditation body (e.g., JCAHO, CARF, or COA) for which deemed status may be granted.

The performance measure composite score was created by summing the individual components of the recognition of treatment need, treatment provision, and maintenance of treatment effects categories. The maximum performance measure score was 12 points. The performance measure score for each state was then divided by 12 (maximum performance measure score) and multiplied by 100 to obtain a percentage of the performance measures required in the state. For ease of computation, we collapsed the testing and education variables

into two dummy variables that indicate whether the state law requires “any” type of substance abuse or infectious disease-related testing or education services.

The quality and performance measure composite scores were then aggregated across the states to assess the extent to which the states, overall, have leaned more towards one set of policy indicators as compared to the others. A series of paired sample t-tests were conducted to assess the mean percentage difference in the inclusion of the quality versus performance measures, the mean percentage difference in the inclusion of the structural versus process measures, and the mean percentage difference in the inclusion of the recognition of treatment need, treatment provision, and maintenance of treatment effect provisions.

## **RESULTS**

### **Applying the Framework: State Laws Governing Outpatient Treatment Programs**

As of February 1, 2004, every state had enacted at least one provision captured in our framework; it is the components of those provisions that vary tremendously (see Table 1). Generally, the quality measures (i.e., the structural and process measures) applied to all outpatient substance abuse treatment programs, regardless of whether they offered standard or intensive outpatient programs. The state requirements governing the performance measures varied, however, based on whether they applied to standard or intensive outpatient programs. Below we present the quality measures applying to all programs and then present the performance measures—first for standard outpatient programs and then for intensive outpatient programs.

**Insert Table 1 about here**

## *Quality Measures*

### Structural Measures of Quality

Four structural measures were examined: program authorization requirements, deemed status, program authorization-related inspections, and staff-to-client ratios. Every state has adopted some type of program authorization provision (i.e., licensure, certification, or accreditation). The distribution of licensure versus certification or accreditation was relatively even with 26 states (51%) licensing outpatient substance abuse treatment programs and the remaining 25 states (49%) either certifying or accrediting programs. The states vary, however, in regard to whether program authorization is required or voluntary. Hawaii's law requires that programs be accredited but, as of the time of this study, the state had yet to promulgate rules specifying the components of the accreditation and, as such, the state was considered to not have any regulatory requirements beyond requiring accreditation. In two states (Alaska and South Dakota), authorization is entirely voluntary and it is voluntary for non-state funded programs in five states. With the exception of Alaska, Hawaii, and South Dakota, all of the states (48 states, 94%) require state funded programs to be authorized and nearly three-quarters of the states (36 states, 71%) require all programs (state- and non-state funded) to be authorized prior to delivering treatment services.

In terms of the other structural measures explored in this study, program authorization-related inspections were much more prevalent in the state laws than were deemed status or staff-to-client ratio provisions. Nearly one-half of the states (49%) recognize national accreditation of outpatient substance abuse treatment programs in lieu of state certification; however, far fewer states specifically recognize accreditation by a named accrediting body such as JCAHO (33%),

CARF (29%), or COA (18%). In 13 states (26%), national accreditation is recognized but the states did not specify a specific accrediting body. The majority of the states (82%) require inspections as part of either the initial program authorization application process or for renewal or routine purposes. At the same time, less than one-third of the states (31%) specify minimal staff-to-client ratios for outpatient substance abuse treatment programs although the ratios themselves varied tremendously from a low of 1 staff person for every 8 clients in Massachusetts to a high of 49 patients per staff person in New Jersey.

### Process Measures of Quality

Overall, state attention to the process measures of interest for this study was somewhat more commonplace than their attention to the structural measures; however, an examination of the individual process measure components revealed tremendous variation in state requirements. Some type of quality assurance/accountability provision is required in 45 states (88%), while some type of quality assurance-related inspection is required in 44 states (86%). In terms of the quality assurance/accountability measures, the majority of states require treatment programs to develop measurable objectives and collect treatment statistics, but less than half of the states require peer/case review of client records or client satisfaction surveys. Although quality assurance-related inspections are required in the majority of states, state policies are more likely to include provisions for corrective or follow-up action inspections than they are to include provisions for conducting random, unannounced inspections.

### *Performance Measures Governing Standard Outpatient Programs*

Recognition of Treatment Need. Not surprisingly, every state that required state-funded programs to be authorized (48 states, 94%) also required that the programs conduct an initial

patient assessment to determine the extent of treatment need. Slightly less than one-half of the states (47%) addressed patient placement or diagnostic criteria, with the majority of these states requiring outpatient treatment programs to use ASAM patient placement or DSM diagnostic criteria; only 10 percent of the states require authorized programs to use the ASI.

Treatment Provision. State attention to the treatment components of the framework also varied with over two-thirds of the states requiring that standard outpatient treatment programs include some type of counseling (87%) or substance abuse or infectious disease-related educational service (67%). Less than one-half of the states (41%) require treatment programs to include substance abuse or infectious disease-related testing. Group and individual counseling provisions were particularly commonplace in the state laws governing standard outpatient programs while family counseling was required in just under one-half of the states. HIV and substance abuse-related education services were the most prevalent types of education required of standard outpatient treatment programs (43% and 37%, respectively). Education for STDs, TB, or Hepatitis B or C was only required in less than one-fifth of the states.

Maintenance of Treatment Effects. State attention to factors influencing relapse post-treatment were less prevalent than was state attention to other components of the framework. While more than one-half (57%) of the states require standard outpatient programs to including continuing/aftercare components, less than one-quarter of the states require authorized programs to include relapse prevention (20%) or support groups (22%).

#### *Performance Measures Governing Intensive Outpatient Programs*

Twenty-six states specifically addressed intensive outpatient substance abuse treatment programs in their laws. When a state identified requirements *specifically* applying to intensive

programs, they were always mandated (as compared to sometimes being optional for standard outpatient programs). As Table 2 indicates, two performance measure categories were captured in this study for intensive programs—treatment provision components and maintenance of treatment effects. With a few exceptions, state requirements relative to the “recognition of treatment need” category (i.e., inclusion of an assessment or use of ASAM or DSM criteria or the use of the ASI tool) did not clearly distinguish between standard and intensive outpatient programs and, therefore, were only coded as noted above relative to standard outpatient programs.

### **Insert Table 2 about here**

As the table indicates, when states specified provisions for intensive programs, they tended to emphasize requirements for counseling services more than testing or education services or the maintenance of treatment effect variables. In most instances, states that specified treatment provisions that applied to intensive outpatient programs clearly indicated that the requirements applied to both standard and intensive outpatient programs. There were a few exceptions to this finding whereby some states only specified requirements for intensive outpatient programs: group, individual, and family counseling (North Dakota and Oregon); family counseling (Texas, Virginia, and Wyoming); substance abuse testing (South Dakota); continuing care (Wyoming); and support groups (Montana, North Dakota, and Wyoming).

### **Quality or Performance Measures: What Do State Policies Emphasize?**

As Table 3 indicates, state policies were significantly more likely to include the quality measures than the performance measure components of the framework. (We were unable to create a comparable summary of state laws specifically governing intensive outpatient programs

since the state policies addressing intensive programs did cover the realm of provisions of interest for this study.)

### **Insert Table 3 about here**

On average, the state policies include 63 percent (7 of the 11) of the quality measure provisions. Of the 11 possible quality measure components, two states' policies (Hawaii and New Mexico) only address the program authorization provision (i.e., licensure, certification, or accreditation); while one state's policy (Oklahoma) addresses each of the 11 provisions of interest. The states were only marginally more likely to include the structural measures of program capacity as compared to the process measures of program accountability (see Table 3).

A different result was found with regard to the performance measures. On average, the state policies incorporate less than one-half of the 12 possible performance measure provisions. No state policy includes all of the performance measure provisions. As of the reference date for this study, Hawaii had not promulgated rules to incorporate any of the performance measure provisions. Two states (Oklahoma and Rhode Island) have incorporated 10 of the 12 performance measure provisions into their policies. Overall, the states were significantly more likely to include the treatment provision components of the framework than they were to include either the recognition of treatment need or the maintenance of treatment effects provisions (see Table 3).

## **DISCUSSION**

This study illustrates the true variation in state laws governing outpatient substance abuse treatment programs and is consistent with the variance seen in other aspects of state drug policy

(Chriqui, Pacula, McBride, Reichmann, VanderWaal & Terry-McElrath 2002; Pacula, Chriqui, Reichmann, & Terry-McElrath 2002). While the states have actively incorporated into their laws a number of the quality measures recommended in the literature (Donabedian 1966; 1980; 1982; 1985; IOM 1999, 2001); as of early 2004, the states had yet to incorporate into their laws many of the performance measure-related provisions espoused by the WCG and others (McCorry et al. 2000; Hon 2004). Parlaying this relative to our regulatory continuum, the state laws tend to fall more along the treatment program “impact” side of the continuum rather than the client outcome “impact” side of the continuum. In other words, the policies that are in place currently would likely have the most direct link to treatment program capacity and accountability as compared to those likely to more directly relate to performance measurement or client outcomes (Derose & Petitti 2003; McCorry et al. 2000; Hon 2004). This overarching finding may not be surprising, however, given the relative “newness” of the performance measure development activity. In addition, the performance measures, as conceived by WCG are intended to focus on health plan performance (McCorry et al. 2000; Hon 2004) as opposed to state policy components. Thus, it is plausible that these issues are being addressed elsewhere in the treatment “regulatory” system, just not through public policy regulation. However, if performance measure provisions were to be incorporated into state laws, they could serve as criterion by which states might set a minimum quality threshold that is consistently applied to treatment programs authorized in the given state and may therefore improve patient outcomes in that state. Recent data from the general health care sector have demonstrated the success of performance measurement in improvements in the processes of care (Williams, Schmaltz, Morton, Koss & Loeb 2005).

State attention to the quality measures as evidenced by the structural and process components was fairly consistent. The structural and the process variables are somewhat inter-

related in that without the initial authorization activities (i.e., the structural measures), the processes of care would not occur. Likewise, the structural measures are meaningless unless they are implemented as intended and treatment programs are held accountable (Donabedian 1966; 1980; 1982; 1985; IOM 1999, 2001). With regard to the structural measures, the relatively even distribution of states that license versus certify or accredit outpatient substance abuse treatment programs is particularly noteworthy given that the literature indicates that licensure tends to provide a minimal standard of care whereas certification and/or accreditation tends to indicate more optimal standards of care are met at the time of authorization (Rooney & Van Ostenberg 1999; GAO 1991). Whether license states included more or less of the provisions of interest in this study is a subject for future study. At this juncture, it is important to highlight this distinction so that we can begin to explore what impact, if any, state policies are having on treatment program practices and, ultimately, client outcomes.

Several other interesting findings relative to the structural measures of interest included the fact that not every state requires *all* outpatient substance abuse treatment programs to be authorized. Authorization is voluntary in two states, required of all state funded programs in 48 states, and required of all programs (i.e., state and non-state funded programs) in 36 states. The connection between authorization requirements and state funding has been documented elsewhere (Friedmann et al. 1999b) so it is not surprising that with the exception of the two voluntary states (Alaska and South Dakota) and Hawaii (that has yet to promulgate regulations), all states are at least requiring state funded programs to be authorized. Mandates on non-state funded programs are somewhat of a different story from a regulatory perspective but such mandates might help to facilitate more consistency in what is being required of treatment programs, regardless of their funding source.

At the same time, while one-half of the states recognize national accreditation in lieu of state authorization, 13 of these states do not mention a specific accrediting body such as JCAHO, CARF, or COA. On the one hand, this may affect the extent to which treatment programs actually apply for national accreditation given the resources required to undertake such a process and not having specific guidance on which accreditation is most “appropriate” (JCAHO 2004; Friedmann et al. 1999a). On the other hand, it may provide the states and the programs with more flexibility as new accrediting bodies emerge over time.

Given the documented history relative to the use of inspections in health care regulation (Gostin et al. 2003; Anderson 2003; Grad 1990), it was somewhat surprising to discover that not every state requires at least an initial program authorization inspection. We speculate that part of the issue at hand may entirely be one of state resources. For example, one official who responded to our state verification effort felt it critical to let us know that while the state does require inspections, the budget only provides for one inspector for the entire state. Such a situation is akin to an “unfunded mandate” whereby inspections are required but resources are not allocated to enable their conduct. At the same time, states may recognize that limited resources will not support inspection mandates and, as a result, they may not be including such mandates into their policies. The practical implication from a quality perspective, however, is that many treatment programs may not be inspected prior to their actual state authorization or at time of renewal. Such situations pose the threat of deficient and/or non-compliant treatment programs that could considerably affect the quality of care delivered to outpatient substance abuse treatment clients.

In terms of the process measures of accountability, while it was somewhat encouraging to determine that most states have included at least some type of quality assurance-related provision into their mandates for authorized outpatient treatment programs, the state policies have placed

lesser emphasis on the more quantifiable accountability approaches such as conducting peer reviews or collecting treatment statistics which would facilitate the programs' ability to monitor their functioning, effectiveness, and accountability (IOM 2001; Shojania et al. 2004). As a result, the state policies may simply be setting a framework, but failing to provide explicit benchmarks for accountability by the programs themselves. However, it is possible that state policies do not include requirements for some of the accountability measures since programs collect and report such data to feed into the state's SAPT Block Grant Application (SAMHSA 2004). Also, although quality assurance related inspections are required in the majority of the states; it appears that the states, as a whole, are taking an "either/or" approach to such mandates by requiring either random, unannounced inspections or corrective action/follow-up inspections when a deficiency has been found. Both types of inspections are important to ensuring that programs be held accountable (Dooley 2002; GAO 2004; SEIU 2003). One possible explanation for the fact that states do not require both types of inspections may simply be limited state resources (as noted earlier)—it is easier to conduct inspections for those programs for which deficiencies have been found; it requires more resources to develop and implement a random inspection program.

When we closely examine the states' emphasis on the performance measure variables, certain components stand out as being more commonplace than others. Given the utility for the ASAM, DSM, and ASI tools to improve the accuracy of assessment and/or diagnosis (APA 1994; McLellan et al. 1980; Mee-Lee et al. 2003), it was somewhat surprising that less than one-quarter of the state policies require outpatient programs to use the ASAM patient placement criteria or to use the DSM-IV at time of diagnosis and only 10 percent of the state policies require use of the ASI. This may be due in part to the fact that treatment programs already report incorporating these tools into their everyday treatment program

practices (McLellan et al. 1980; Mee-Lee et al. 2001) so states do not feel it is necessary to specify this in law or regulation.

The states were more consistent, however, in terms of the core components of treatment service delivery and continuing/aftercare provisions. For example, individual and group counseling, educational provisions, and continuing care/aftercare services were required in the majority of the states. Individual and group counseling as well as education programs focusing on infectious disease transmission (e.g., HIV-related education) are central components of most treatment programs in the U.S. (NIDA 1999; Batki & Ferrando 1996; Broome et al. 1999). The limited number of states to require substance abuse and infectious disease-related testing services may be more due to potential structural barriers in the system (i.e., lack of trained staff, resource requirements, medical and safety hazards, etc.) than the fact that the states do not want treatment programs to engage in these practices. The importance of aftercare programs in conjunction with treatment services in clients' long-term abstinence has been documented in the literature (Brown et al. 2002; Siegal et al. 2002). The fact that the majority of states require outpatient programs to provide aftercare components is an important standard. One area that was not prevalent, that the literature suggests is important, is relapse prevention through such efforts as support groups (McKay et al. 2005). The data from this study revealed that overall state policies are not incorporating such services into their treatment program requirements. If, as the literature suggests (McLellan et al. 2005), addiction is a chronic reoccurring disease, then a focus on maintaining treatment effects could be an important part of state policy development.

Finally, although our study resources did not permit us to capture state provisions requiring that treatment programs provide transitional and ancillary services and linkages to the medical and social support systems, we hypothesize that such requirements may relate to the

significant problems of access to quality services faced by minorities in the U.S. (American College of Physicians 2003).

### *Study Limitations and Areas for Future Research*

Because they comprise the most common drug treatment services in the U.S., we addressed standard and intensive outpatient treatment programs. While we believe that this initial description of state policies that govern quality and performance measure elements in outpatient substance abuse treatment programs is an important first step in understanding the existence and variance in state policies, we recognize that there are important limitations to our study.

First, this was a cross-sectional, point-prevalence study examining state policies in effect as of February 1, 2004. Policies adopted or effective following this reference date were not included. So, for example, Oregon's evidence-based law (2003 Oregon Laws Ch. 14 (SB 81)) that requires state agencies to spend at least 25 percent of state monies for evidence-based programs beginning July 1, 2005, was not captured herein.

Relatedly and as noted above, while we attempted to capture most of the policy provisions identified in the regulatory continuum framework, our study resources did not permit capture of several critical components related to treatment provision including linkages to medical and social services, collateral services, and medications/pharmacotherapies. We believe that these are critical components of an effective treatment program and plan to capture them in future studies. We also recognize that other modalities (i.e., residential, day treatment, hospital-based treatment, and outpatient Opioid/Methadone treatment programs) could have been and should, eventually, be explored. Also, we were unable to examine the state policies governing the provision of outpatient treatment services to Medicaid enrollees. Exploration of the policies

addressing these additional modalities, groups of clients (e.g., Medicaid enrollees), or treatment components are areas for future study.

It also should be noted that for purposes of this study, if a state did not specify whether the provisions applied to standard outpatient and/or intensive outpatient programs, we coded conservatively and identified it only as applying to standard outpatient programs. Therefore, it is quite possible that we have substantially undercounted the number of states with requirements specifically governing intensive outpatient programs.

Finally, the information presented in this report includes only the information that could be gleaned from the states' statutes and regulations (and, in a few cases, state standards). This study did not capture information about state-to-provider contract arrangements, instructional letters to the provider from the state, or state-specified practice expectations. It also did not assess how the state policies are being implemented or enforced in practice. The latter point is important because while a state may have a given law on the books, in practice it may be implemented very differently. In contrast, some states may not specify their substance abuse treatment requirements in a formal law or regulation but, rather, may include such information in state-level contracts with treatment service agencies. In addition, some of the state laws/regulations may allow for a facility-level interpretation when it comes to implementing the legal provisions. As a result, additional variation may be seen from facility to facility within a given state.

## **CONCLUSION**

Even with these limitations, this study has provided an integrated conceptual framework to analyze the continuum of state treatment regulations and an initial application of the

framework to the state outpatient substance abuse treatment regulatory landscape. Such an application has provided a useful first step in describing the distribution of states that are categorized in the various components of the quality conceptual framework and identifying potentially important gaps in state policies that would, if they were adopted, at least indirectly relate to improved client outcomes. However, it will be necessary to continue to refine and adapt the framework and to determine whether it applies to other treatment modalities. Additionally, work is still needed to answer the highly significant question as to whether state policy really has any effect on individual outcomes. As we indicated in the continuum, it is quite plausible that state policy mainly impacts the treatment programs while indirectly relating to individual client outcomes. A critical next step involves linking the state treatment policy data with actual treatment program practices so we can begin to explore this hypothesis.

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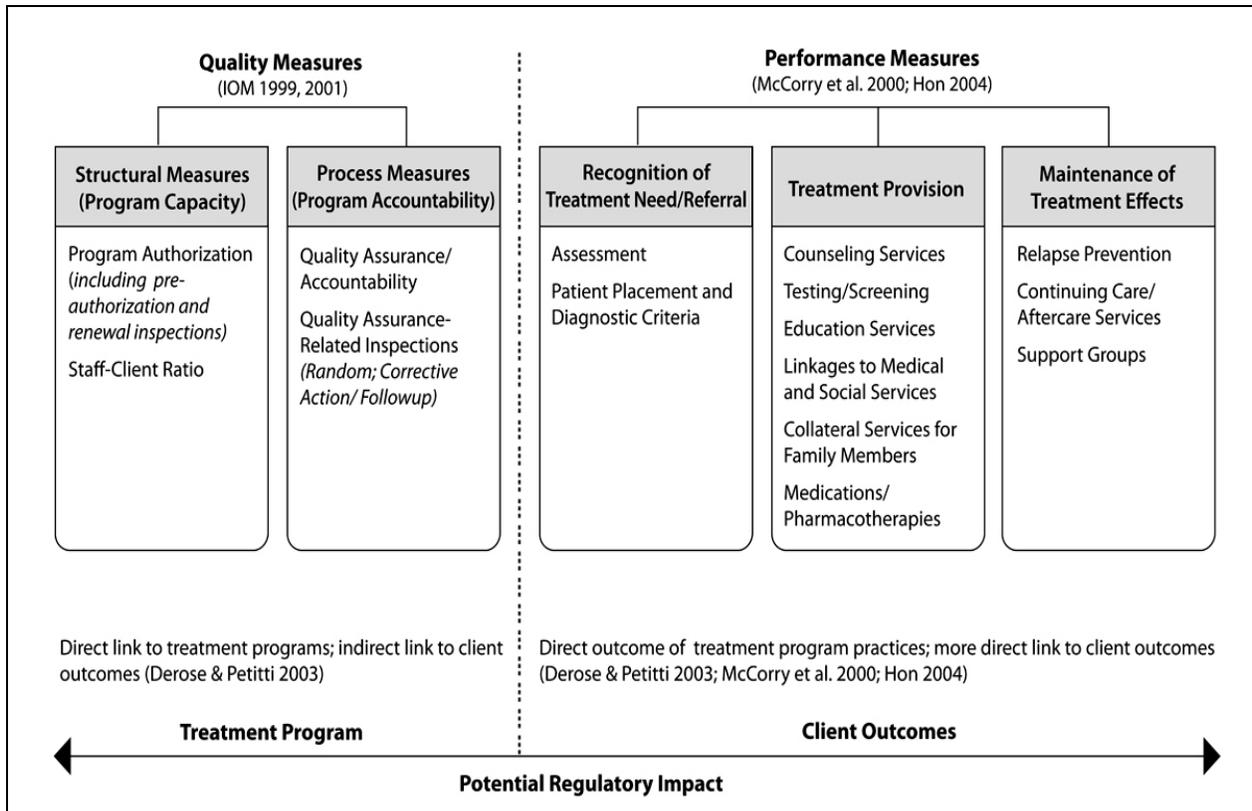
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**Figure 1. Framework for Assessing the Continuum of State Substance Abuse Treatment Regulation**



**Table 1. Summary of State \* Policies Governing Standard Outpatient Substance Abuse Treatment Programs by the Regulatory Framework Components (as of February 1, 2004)**

REGULATORY FRAMEWORK COMPONENT	Number of States (N=51)	Percent of All States (N=51)
<b>QUALITY MEASURES</b>		
<b>Structural Measures</b>		
Program Authorization (Type)		
License	26	51%
Certify <sup>†</sup>	22	43%
Accredit <sup>‡</sup>	3	6%
Deemed Status (Any) <sup>§</sup>	25	49%
JCAHO	17	33%
CARF	15	29%
COA	9	18%
National Accreditation Recognized but Agency Name Not Specified	13	26%
Program Authorization-Related Inspections (Any)	42	82%
Pre-authorization inspection	39	77%
Renewal/routine inspection	36	71%
Staff ratios specified	16	31%
<b>Process Measures</b>		
Quality Assurance/Accountability Provisions (Any)	45	88%
Criteria-based/measurable objectives	35	69%
Peer review/case review	24	47%
Collection of treatment statistics	28	55%
Client satisfaction survey	17	33%
Quality Assurance-Related Inspections (Any)	44	86%
Random, unannounced inspection	29	57%
Corrective action/follow-up inspection	40	78%
<b>PERFORMANCE MEASURES</b>		
<b>Recognition of Treatment Need</b>		
Assessment	48	94%
Patient Placement and Diagnostic Criteria (Any)	24	47%
ASAM Required	13	26%
DSM Required	14	28%
ASI Required	5	10%
<b>Treatment Provision</b>		
Counseling Services (Any)	42	82%
Group	37	73%
Individual	39	76%
Family	23	45%
Testing Services (Any)	21	41%
Substance Abuse	11	22%
HIV	16	31%
STD	9	18%
TB	13	26%
Hepatitis B or C	4	8%
Education Services (Any)**	34	67%
Substance Abuse	19	37%
HIV	22	43%
STD	6	12%
TB	9	18%
Hepatitis B or C	5	10%

<b>REGULATORY FRAMEWORK COMPONENT</b>	<b>Number of States (N=51)</b>	<b>Percent of All States (N=51)</b>
<b>Maintenance of Treatment Effects</b>		
Relapse Prevention	10	20%
Continuing Care/Aftercare	29	57%
Support Groups	11	22%

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**Table Notes:**

\* “State” is defined to include the 50 states and the District of Columbia.

† “Certify” includes two states (Kansas and Nebraska) that use a combination of licensure and certification.

‡ “Accredit” includes one state (North Carolina) that uses a combination of certification and accreditation.

§ “Deemed Status” is not mutually exclusive and is coded “yes” if a state has recognized accreditation in lieu of state standards for any of the following accrediting bodies: JCAHO, CARF, COA, national accrediting body (name not specified).

\*\* “Education Services (Any)” is coded “yes” if a state requires any educational services for standard outpatient programs. In five states, educational services are required but they do not include education for substance abuse, HIV/AIDS, STDs, TB, or Hepatitis B or C.

**Table 2. Summary of State \* Policies Governing Intensive † Outpatient Substance Abuse Treatment Programs by Selected Components of the Regulatory Framework Continuum (as of February 1, 2004)**

<b>REGULATORY FRAMEWORK COMPONENT‡</b>	<b>Number of States</b>	<b>Percent of States with IOP Provisions (N=26)</b>	<b>Percent of All States (N=51)</b>
<b>SELECTED PERFORMANCE MEASURES</b>			
<b>Treatment Provision</b>			
Counseling Services (Any)	21	81%	41%
Individual	18	69%	35%
Group	19	73%	37%
Family	18	69%	35%
Testing Services (Any)	7	27%	14%
Substance Abuse	4	15%	8%
HIV	5	19%	10%
STD	4	15%	8%
TB	3	12%	6%
Hepatitis B or C	2	8%	4%
Education Services (Any)	12	46%	24%
Substance Abuse	8	31%	16%
HIV	6	23%	12%
STD	2	8%	4%
TB	3	12%	6%
Hepatitis B or C	3	12%	6%
<b>Maintenance of Treatment Effects</b>			
Relapse Prevention	5	19%	10%
Continuing care/Aftercare	7	27%	14%
Support Groups	6	23%	12%

\* “State” is defined as the 50 states and the District of Columbia.

† States were only given “credit” for having policies governing “intensive outpatient programs” if the policy explicitly mentioned intensive programs. Policies that did not specify the type of program to which they applied were coded as applying to standard outpatient programs only.

‡ Only those components of the framework in which state policies routinely distinguished between standard and intensive outpatient programs are included in this table.

**Table 3. Mean Percentage Differences in Inclusion of Regulatory Framework Categories (N=51)**

<b>Category</b>	<b>Mean Percentage of Provisions M (SD)</b>	<b>t</b>
Quality Measures	60.60 (19.72)	5.001***
Performance Measures	45.58 (19.96)	
Structural Measures	65.49 (20.8)	1.987*
Process Measures	56.54 (28.7)	
Treatment Provision	58.43 (29.35)	4.458***
Recognition of Treatment Need	39.22 (20.77)	
Treatment Provision	58.43 (29.35)	5.482**
Maintenance of Treatment Effects	32.68 (30.91)	
Recognition of Treatment Need	39.22 (20.77)	1.386
Maintenance of Treatment Effects	32.68 (30.91)	

Note:  $df=50$

+ $p<.10$  \* $p<.05$  \*\* $p<.01$  \*\*\* $p<.001$

## Appendix. State Policy Coding Categories

Category	Description
<b>QUALITY MEASURES</b>	
<b>Structural Measures</b>	
Program authorization type	What type of state authorization the program receives prior to operation.
License	Treatment programs are licensed by the state licensing authority prior to operating.
Certification	Treatment programs are certified by the state certification authority prior to operating.
Accreditation	Treatment programs are accredited by the state accreditation authority prior to operating.
Deemed Status	Whether the state recognizes accreditation from a national accrediting organization in lieu of state authorization.
JCAHO	State recognizes accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
CARF	State recognizes accreditation from the Commission on the Accreditation of Rehabilitative Facilities (CARF).
COA	State recognizes accreditation from the Council on Accreditation (COA).
National accreditation recognized but agency name not specified	Specific national accrediting body not mentioned but does recognize accreditation from national organizations generally.
Program authorization-related inspection requirements	Whether the law specifies whether inspections or on-site surveys are conducted of the program as part of state authorization.
Pre-authorization inspection	Requirement that programs be inspected by the state authority prior to receiving licensure/certification/accreditation
Renewal of authorization inspection	Requirement that programs be inspected by the state authority prior to having their license/certificate/accreditation renewed OR requirement that programs receive routine or regular inspections without specification as to whether this occurs before authorization is renewed.
Staff ratios specified	Whether the policies specify a certain required staff to client ratio for outpatient/intensive outpatient programs in order to be authorized.
<b>Process Measures</b>	
Quality Control Provisions	Whether the program requires certain quality control measures as part of the state authorization process.
QA program required	Whether the law/regulation requires that outpatient treatment programs/facilities have a QA program. (This is some sort of review of activities other than mission statement (if any of the other requirements of the QA program are required.)
Criteria-based/measurable objectives required	Whether the policies requires that outpatient treatment programs/facilities have criteria-based/measurable objectives (to ensure that they are meeting their goals) as part of their quality assurance review.
Peer review/ case review required	Whether the policies requires that outpatient treatment programs are required to have staff or other professionals periodically review client cases for the correctness of the diagnosis, treatment appropriateness, or treatment satisfaction.
Requires collection of treatment statistics	Whether the law/regulation requires that outpatient treatment programs are required to send treatment statistics to the state for further review, or if the facility/program collects treatment statistics as part of its QA process.
Client satisfaction survey Required	Whether the law/regulation requires that outpatient treatment programs/facilities are required to survey/interview clients or client families as their level of satisfaction with treatment as part of their QA program.
Accountability-related inspections	Whether the law requires random, unannounced or corrective action inspections.
Random, unannounced inspection	State authority is authorized to conduct random, unannounced inspections at outpatient treatment facilities/programs (typically as part of a compliance check process).

<b>Category</b>	<b>Description</b>
Corrective action/follow-up required	Specifies whether the law/regulation requires that outpatient treatment programs/facilities are required to follow-up or take corrective action in coordination with inspections.

## **PERFORMANCE MEASURES**

### **Recognition of Treatment Need**

Assessment	The program must complete assessments of clients prior to treatment in order to receive state authorization. Assessment was coded “yes” based on the following definition: "Those procedures by which a program evaluates an individual's strengths, weaknesses, problems and needs, and determines priorities so that a treatment plan can be developed." pg 359 ASAM PPC-2R, 2001.
Patient placement criteria	Policies require use of ASAM, DSM, or ASI in order to place clients in the appropriate treatment.
ASAM required	Program is required to use the Patient Placement Criteria of the American Society for Addiction Medicine to appropriately place clients.
DSM required	Program is required to use the Diagnostic and Statistical Manual of Mental Disorders (DSM) in order to appropriately diagnose clients.
ASI required	Program is required to use the Addiction Severity Index (ASI) in their patient assessment.

### **Treatment Provision**

Counseling Services	State requires programs to include individual, group, and/or family counseling services as part of the treatment program.
Individual	Individual Counseling required (Note: if the word “counseling” was used, but the law did not specify which kind of counseling was required, then coded as individual, group, and family).
Group	Group Counseling required (Note: if the word “counseling” was used, but the law did not specify which kind of counseling was required, then coded as individual, group, and family).
Family	Family Counseling required (Note: if the word “counseling” was used, but the law did not specify which kind of counseling was required, then coded as individual, group, and family).
Testing Services	State requires treatment programs to offer the following testing/screening services:
HIV/AIDS testing	HIV/AIDS testing required.
STD testing	STD testing required.
TB testing	TB testing required.
Hepatitis B or C testing	Hepatitis B or C testing required (the laws did not differentiate between B or C).
Education Services	State requires programs to include education services either directly or by referral, to clients for the following subject areas:
Substance Abuse education	Substance abuse, chemical dependency, addiction-related education required.
HIV/AIDS education	HIV/AIDS-related education/counseling required.
STD education	STD-related education required.
TB education	TB-related education required.
Hepatitis B or C education	Hepatitis B or C education required (the laws did not differentiate between B or C).

### **Maintenance of Treatment Effects**

Relapse Prevention	State requires that treatment programs include a relapse prevention component.
Continuing care/aftercare	Continuing Care/Aftercare required for standard outpatient/intensive outpatient modality. If the Continuing Care/Aftercare program is a separate program not within the outpatient modality and not required for clients from the outpatient/intensive outpatients to participate in, then coded “NO”.
Support Groups	State requires treatment programs to provide support groups, either directly or by referral to clients.

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