Capacity Management for Substance Abuse Treatment Systems

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SECTION I.

INTRODUCTION

The Center for Substance Abuse Treatment (CSAT) works closely with States and grantees to increase access to substance use disorder treatment and to serve more people more quickly. Formerly known as the Office for Treatment Improvement (OTI), CSAT has introduced Federal, State, and grantee partnerships that have refined a number of strategies in treatment systems to capitalize on clients' motivation to enter treatment when clients present themselves. Engaging clients quickly means that treatment systems must serve clients before they grow tired of waiting, lose their motivation, or "fall between the cracks."

Effectively engaging clients requires a comprehensive, systemic effort with the following features:

- Portals into treatment systems that have rational processes for assessing clients' needs and matching clients with the appropriate levels of care within reasonable geographic proximity

- Mechanisms for tracking and managing the flow of clients coming into treatment and for managing, maintaining contact with, and retaining clients who cannot be admitted when the appropriate treatment programs are at capacity

Capacity management efforts typically target priority populations that represent a greater degree of risk to themselves, their communities, or others if their use is not interrupted. Pregnant women who use substances may be harming their fetuses; individuals who inject drugs are at greater risk of contracting and transmitting infectious diseases. Both populations merit priority in admissions to treatment programs.

The experiences at the Federal, State, and grantee levels have yielded many valuable lessons regarding the complexity of capacity management systems as well as the opportunities and challenges that remain. This paper explores lessons learned and additional issues and approaches that treatment systems might consider when addressing capacity management practices. To ensure that the paper is guided by real-world perspectives, CSAT convened a Capacity Management Consensus Panel to identify and disseminate salient issues and practices that confront managers and practitioners throughout the country. The panel comprised individuals involved in capacity management activities at Federal, State, municipal, and regional levels. Panelists included management, programmatic, and data professionals from treatment systems located in urban, rural/frontier, and suburban settings. States represented on the panel included:

- Arizona
- Illinois
- Maryland
- New Mexico
- Texas
- Virginia
- Washington State

The consensus panel was convened in Rockville, Maryland, on June 19–20, 2008.

A. History of Federal Capacity Management Initiatives

Shortly after it was created in 1989, OTI launched a series of Federal initiatives aimed at increasing access to treatment. The brief history below illustrates the evolution of these initiatives and provides context for today's efforts:

- Section 509(E) of the Public Health Service (PHS) Act created the 1989 Drug Abuse Treatment Waiting List Reduction Grant Program to offer 1-year grants to help States and localities reduce waiting lists by expanding drug treatment programs.

- Instead of focusing on the number of people on waiting lists as the Waiting List Reduction Grant Program did, the Waiting Period Reduction Amendments of 1990 (P.L. 101-374) produced 1-year grants that addressed the length of time individuals remain on waiting lists.

- In 1991, PHS concurred with a Department of Health and Human Services (HHS) Office of the Inspector General recommendation to create a uniform waiting list definition and a systematic way for all States to maintain waiting lists.

- Through a consensus process in 1992, OTI developed and published the Uniform Waiting List definition to respond to HHS questions about the accuracy of waiting lists.

- Title 45 of the Code of Federal Regulations Part 96 (45 CFR Part 96), Substance Abuse Prevention and Treatment (SAPT) Block Grants; Interim Final Rule was published in March 1993 and introduced several new requirements aimed at limiting the wait time for and increasing retention of pregnant women and people who inject drugs who cannot be admitted to treatment right away.

B. The Uniform Waiting List Definition

The 1992 consensus panel defined the Uniform Waiting List as follows:

> "A waiting list is a document identifying individuals seeking services for substance abuse treatment when appropriate treatment slots are not available. It is a written log or roster initiated and maintained by a substance abuse treatment program whenever service capacity has been reached. The document identifies the individuals who are actively seeking treatment and meet screening and eligibility criteria for services."

The consensus panel that developed this definition pointed to the following as the aims of waiting list systems:

1) Ensure documented screening and intake procedures based on concepts of aligning and triaging high-priority and needy cases.

2) Document treatment demand and unmet need that can justify expanding capacity.

3) Identify gaps in services if characteristics of individuals are identified.

4) Facilitate appropriate referrals, particularly through a central registry or central intake process.

C. SAPT Block Grant Requirements

By passing the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act (P.L. 102-321, 102d Congress) of 1992, Congress significantly changed the Federal oversight and support of community-based substance use disorder treatment:

- Substance abuse and mental health-related research activities were separated from service-related activities, and the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, ADAMHA's research arms, were moved to the National Institutes of Health.

- The service-related offices remained and became a part of the Substance Abuse and Mental Health Services Administration (SAMHSA), and OTI became CSAT.

- The Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant was split into a block grant for mental health and a block grant for substance abuse, with the latter becoming the SAPT Block Grant.

The ADMS Block Grant had only two specific capacity management requirements. Specifically, ADMS-funded programs that treated people who inject drugs had to notify the State when they reached 90 percent of their capacities and they had to admit people who inject drugs within 7 days of their seeking treatment.

By the time the ADAMHA Reorganization Act was passed in 1992, both houses of Congress and Federal staffers had given significant thought to provisions that the new regulations should include to address concerns of that day. For instance, the House of Representatives proposed an amendment that required treatment to be offered “on demand” to pregnant women and people who inject drugs. The Senate conferees agreed that on-demand treatment is a laudable goal, but they concluded that there were probably not enough resources to offer treatment on demand. Instead, the conferees introduced other measures intended to expedite access to appropriate treatment to priority populations. In addition, the new measures required SAPT Block Grant-funded States and programs to:

- Admit pregnant women and people who inject drugs within prescribed timeframes.
- Offer “interim services” to these populations if admission is not possible within the prescribed timeframes.
- Maintain mechanisms to effectively track, maintain contact with, and report on any of these individuals awaiting admission to treatment.

The target populations and required activities outlined in the ADAMHA Reorganization Act are indicators of congressional interest in block grant-funded entities taking extraordinary measures to slow the spread of infectious diseases among people who inject drugs, their partners, their communities, and their children.

The table on the next page outlines specific capacity management requirements that are included in the SAPT Block Grant regulations.

SAPT Block Grant Capacity Management Requirements		
Focus	**Specific Requirement**	**Entity Responsible for Complying**
Admission Preference	Publicize the availability of services for pregnant women, including that pregnant women must receive admission preference, and require all SAPT Block Grant-funded programs to give such preference.	State agencies
	Give pregnant women preference in admissions to treatment.	All block grant-funded programs
	Give preference to treatment in the following order: 1) Pregnant women who inject drugs 2) Other pregnant clients 3) Others who inject drugs 4) Others	All block grant-funded programs
Wait List/Capacity Management	Maintain a continually updated system for identifying treatment capacity for pregnant women who cannot be admitted and a mechanism for matching such women to treatment programs with sufficient capacity.	State agencies
	Require block grant-funded programs to refer pregnant women to the State when such women cannot be admitted because of insufficient capacity.	State agencies
	Refer pregnant women to the State when such women cannot be admitted because of insufficient capacity.	All block grant-funded programs
	Refer pregnant women to programs with the capacity to admit them or ensure that interim services are made available within 48 hours after the women seek treatment.	State agencies
	Establish a capacity management system that: • Enables and requires each program that provides treatment for people who inject drugs to (1) readily report to the State when the program reaches 90 percent of its	State agencies

	capacity and (2) submit such reports within 7 days of reaching 90 percent of capacity. • Maintains a continually updated record of the reports. • Makes excess capacity information available to block grant-funded programs that treat intravenous substance abuse.	
	Submit a report notifying the State of 90-percent capacity within 7 days.	Block grant-funded IVDA programs
	Maintain a waiting list management system that systematically reports treatment demand and requires block grant-funded programs that treat people who inject drugs to: • Establish a waiting list with a unique client identifier for each waiting list client. • Consult the State's capacity management system to ensure that waiting list clients are transferred to programs within a reasonable geographic area at the earliest possible time. • Allow clients to be removed from waiting lists only when they cannot be located or they refuse treatment.	State agencies and block grant-funded IVDA programs
Admission Timeframes and Interim Services	For pregnant women who cannot be admitted because of insufficient capacity, ensure that interim services, including prenatal care, are made available within 48 hours after seeking treatment.	All block grant-funded programs
	Admit each individual who requests and is in need of treatment for injection drug abuse not later than 14 days, ***or*** satisfy each of the following requirements: • Admit these individuals within 120 days. • Have a mechanism for maintaining contact with these individuals awaiting admission. • Make interim services available within 48 hours.	Block grant-funded IVDA programs

	Provide the following as interim services: • Counseling and education about HIV disease and tuberculosis, the risks of needle sharing, the risks of disease transmission to sex partners and infants, and steps to ensure that HIV transmission does not occur • Referrals for HIV and TB services, if necessary • Referrals for prenatal care and counseling on the effects of alcohol and drug use on the fetus • Options for States and localities to offer federally authorized methadone services provided the interim methadone services supplement but do not supplant comprehensive methadone programs.	State agencies
Monitoring	Have effective strategies for monitoring programs' compliance with the above requirements.	State agencies

D. Current Context

Recent interest and activity in the substance use disorder field have not paralleled the capacity management activities that evolved between 1989 and 1993, despite the many significant changes since the mid-1990s. The lessons learned over the years in managing access to service provide the most significant opportunities for continued development that remain before the field. The tools and technologies available today have allowed for a new understanding of capacity management. Infusing technologies that were in their infancy in the 1990s will increase the ability of treatment systems to capture, track, report, and transfer data about clients awaiting treatment. It is important to reexamine the continued applicability of longstanding capacity management requirements that were enacted when State and local treatment systems had different operational requirements and faced different issues than those faced today.

Forthright exploration of opportunities and challenges will provide needed guidance to State and local agencies and treatment providers that have to make regulatory, funding, administrative, and programmatic decisions affecting expeditious access to care. The remaining sections of this paper address the following consensus panel discussion points:

- Section II. An overview of capacity management systems that includes a discussion of the challenge of defining capacity and the purpose and components of capacity management systems
- Section III. Waiting list management issues and practices
- Section IV. A discussion on priority populations
- Section V. The aim and elements of interim services
- Section VI. The role of automated systems
- Section VII. The variables that affect capacity and capacity management, such as funding mechanisms, geography, population density, among others
- Section VIII. Recommendations from panelists

SECTION II.

OVERVIEW OF CAPACITY MANAGEMENT SYSTEMS

A. Defining Capacity

Determining a program's capacity to serve clients is a core issue that the consensus panel addressed. Essentially, capacity is determined by its definition. For instance, in intensive programs, such as residential programs, capacity is usually simple to define: the capacity available to treat individuals is typically determined by the number of beds available in the program. Defining capacity at other levels of care, particularly outpatient treatment, is not as straightforward and certainly not guided by a dominant variable that clearly defines capacity. Determining capacity in outpatient programs must consider such components as the following:

- **Service mix**—The services that an outpatient program offer might include a mix of individual counseling, couples counseling, group counseling, educational groups, and other services. The capacity across these services is vastly different. For instance, individual counseling and couples counseling have more limited capacities than group counseling, and the nature of education groups makes them more amenable to larger numbers of clients than counseling groups.

- **Service intensity**—The frequency and length of services are major drivers of outpatient capacity. Counseling programs that offer less frequent and shorter sessions can serve more clients than programs that provide more frequent and longer counseling sessions. So, with equal staffing levels across the program types, it is reasonable to expect, for instance, that an opioid treatment program that treats many clients who need a minimum number of contacts can serve more clients than an intensive outpatient program that see clients 3 hours per day 5 days per week.

- **Staffing requirements**—Substance use disorder treatment often occurs in group settings, and a program's capacity to offer this service can be affected by specific State, health plan, or programmatic requirements that dictate counselor-to-client ratios and/or the number of counselors required to facilitate groups. Programs that have lower counselor-to-client ratios have a more limited capacity than groups with higher ratios, and co-facilitated groups have a more limited capacity than groups run by one person.

- **Client type**—The specific service needs of some clients also affect a program's capacity. For instance, clients with co-occurring substance use and mental disorders may require services that call for a lower counselor-to-client ratio and/or a broader service mix that precludes large group settings than other settings do.

Defining Outpatient Capacity

In the Fairfax-Falls Church Community Services Board Alcohol and Drug Services system, outpatient capacity is determined by service mix, intensity, and client type:

- Standard outpatient services typically consist of 1 full-time counselor leading 5 groups. Each group has up to 12 clients and meets one to three times per week for 4 to 6 months. The caseload is about 1 counselor to 40–50 clients. Clients in these groups may be receiving individual counseling and enrolled in education and/or relapse prevention groups once a week for a limited time, and they may also be in process groups.

- Day treatment services include two options: (1) 2 counselors offering a 12-person group 3 hours per day 5 days per week (i.e., a 1 to 6 ratio) or (2) 1 counselor offering a 12-person group 3 hours per day 3 days per week (i.e., a 1 to 12 ratio).

- For co-occurring services, the caseload is 1 clinician to approximately 15 clients. These clients also receive more individual counseling than other clients do, and they might be enrolled in other standard outpatient services.

- **Payment mechanism**—Payment mechanisms also influence capacity determination. Some reimbursement approaches are based on bundled services (i.e., a standard mix of services in a single package) within specific settings, whereas other funding approaches reimburse for "a la carte" services (i.e., each service is purchased separately) in whichever setting the client is treated. The latter approach depends less on a predictable service level and mix and makes capacity calculations more challenging.

The Impact of Unbundled Funding Approaches

Illinois uses a "global contract" to reimburse providers on a fee-for-service basis. Under this contract, services are "unbundled," which means that the services are delivered and reimbursed on an "a la carte" basis to match each client's needs. For instance, a client might be offered group counseling as one billable service and case management as a separate billable service. Projecting capacity is not entirely precise with unbundled funding because the mix of services that clients receive within a particular level of care is less uniform than systems in which services are bundled.

- A wide range of variables are taken into account to determine outpatient treatment capacity, and the consensus panel members had equally varied approaches to determining capacity in their own jurisdictions. Generally, the approaches that panelists discussed can be grouped into the following two categories:

- **Workload standards**—These standards primarily revolve around group counseling with built-in assumptions regarding the percentage of the rest of a counselor's time that should be used to provide individual counseling and case management, maintain records and communication, and receive supervision and training. Workload is based on the number of clients that a clinician can serve or the maximum number of units of service that the clinician can provide. Workload standards are heavily influenced by the program's service mix, service intensity, and staffing requirements discussed above.

- **Access measures**—One of the interesting approaches that the panelists discussed is measuring capacity primarily based on how quickly a program or a system can get clients into the appropriate levels of care within established standards. The rationale here is that the standard should focus on access rather than the number of people who can be served.

Access as the Measure of Capacity

At the time of the consensus panel meeting, Washington State was exploring the option of using performance-based contracting to convey access measures that are based on the average time it takes for programs to admit a client. The State plans to outline different measures for different levels of care.

The Northern Arizona Regional Behavioral Health Authority defines capacity primarily by standards that determine how quickly clients must be admitted into services. The Arizona Department of Health Services Division of Behavioral Health Services Policies for Providers applies standards as set by the Arizona Medicaid agency (the Arizona Health Care Cost Containment System) which outlines very specific time lines for access standards.

B. Purpose of Capacity Management Systems

The consensus panel identified the following primary aims of capacity management systems:

- **Facilitate access to care as quickly as possible**—Treatment systems that can reliably track clients' first contacts and first appointments, maintain contact with clients awaiting treatment, and direct clients to providers with available capacity stand a greater chance of helping clients access care quickly.

- **Reduce risk**—As previously indicated, a major aim of the Federal and State capacity management efforts has been to reduce the harm that continued substance use poses to substance-using populations, their loved ones, and their communities.

- **Document need**—Well-developed capacity management systems are excellent vehicles for capturing reliable data about treatment demand versus capacity. Not only can such systems capture data about the unmet demand for services, but such systems can also be devised to pinpoint level (e.g., intensive outpatient) and location of need if they feature solid assessment and patient placement processes and data.

C. Components of Capacity Management Systems

Through the evolution of systems and requirements, the following have emerged as common capacity management components:

- Waiting list management systems
- Priority populations
- Interim services
- Automated systems

Each component is discussed in detail below.

Another Potential Use of Capacity Management Systems

Identify process improvements— Illinois has been participating in a CSAT-funded project that focuses on process improvements to increase "front-end" process efficiencies and reduce the burden and time involved in clinical assessments.

SECTION III.

WAITING LIST MANAGEMENT

A. Waiting List Definition

Although the 1992 Uniform Waiting List definition (see Section I) remains sound in principle, it has not been updated to reflect the current business practices and the direction of waiting list management. For instance, the definition was developed when automated waiting lists were not commonly available. Furthermore, the definition does not acknowledge that waiting lists, particularly Web-based lists, may be managed by more entities than just programs, such as statewide lists managed by State agencies and regional or municipal lists developed by managed care organizations or county governments.

B. Required Waiting List Elements and Procedures

By nature, waiting lists recognize the reality that limited resources make it nearly impossible to offer on-demand treatment. Despite that limitation, well-managed waiting lists bring order to the lives of those who cannot enter treatment right away. The Uniform Waiting List definition and the SAPT Block Grant requirements call for minimum elements and processes to manage waiting list systems effectively. The SAPT Block Grant requires programs serving pregnant women and people who inject drugs to include a unique client identifier in waiting lists. The Uniform Waiting List definition requires more comprehensive data elements (outlined in the following table) that fulfill the requirements of the block grant's waiting list and enable waiting list managers to determine wait time, priority populations, and the rationale and flow of clients on and off the list.

Required Elements in the Uniform Waiting Definition

Application date and sequence number

Dates and Type of contact

Date and reason for removal from waiting list

Staff person compiling the information

Screening mechanism and location of program

Client name, mailing address, telephone number, and other contract information

Screening criteria checklist

Disposition, including how and when the person was informed of the disposition, the recommended resource and how the recommendation was made, and followup contact with the referral agency

Priority categories for admission and the individual's status giving priority categories

In addition, the Uniform Waiting List definition and the SAPT Block Grant requirements call for comprehensive systems and processes to manage access to care. The processes outline the conditions for tracking and maintaining contact with clients, as well as removing clients from waiting list; referring clients to appropriate treatment; and updating treatment capacity information.

One SAPT Block Grant component requires funded programs that serve people who inject drugs to:

- Notify the State upon reaching 90 percent of program capacity.
- Submit such notices within 7 days.

Although the original intent is evident (i.e., to provide the State with some idea of available capacity for people who inject drugs), the lag time between placement on the list and beginning treatment begs the question of how current and useful this information is to the State if it does not receive it within 7 days. Nevertheless, the required elements and processes outlined in the uniform definition and block grant regulations remain viable today and can be incorporated into an automated process.

C. Measuring Access: When Does the Clock Start Ticking?

Because a major aim of capacity management systems is to ensure that individuals who need treatment for substance use disorders are admitted into treatment quickly, a rational method for measuring access is an element of capacity management systems. In fact, the SAPT Block Grant includes the following access requirements:

- Within 48 hours, block grant-funded programs must offer interim services to pregnant women who cannot be admitted because of insufficient capacity.

- Within 14 days, programs that serve people who inject drugs must admit each individual who requests and is in need of treatment for injection drug use. If the programs cannot admit these individuals within 14 days, they must offer interim services within 48 hours and admit these individuals into treatment within 120 days.

In both cases, the question on which access is based is, "When does the clock start ticking?" In other words, must interim services be offered to pregnant women within 48 hours from their first contact, first face-to-face appearance, or some other starting point? Because the block grant requirements and the Uniform Waiting List definition do not specifically state when the clock should start ticking, the consensus panel wrestled with the following options:

- **The client's initial contact with the program**—The time between a client making initial contact and the initial assessment as well as the time between initial contact and admission would be reasonable measures of access. Few consensus panelists saw this measure as the best approach because the initial contact is often via the telephone and is not an opportune time to determine the most appropriate level of care to which a client should be admitted. Also, the brief nature of the encounter may not provide sufficient detail to determine whether a client belongs to one of the priority populations.

- **Once an assessment/intake has been completed**—The assessment process provides an opportunity for programs to gather information needed to determine the most appropriate level of care for a client and to determine whether a client belongs to a priority population. When the level of care is determined during the assessment process, it is clear that the clock can start ticking right away. However, some treatment systems do not make level-of-care decisions at the time of assessment.

- **Once the level of care has been determined**—In some systems, assessments and decisions about the most appropriate levels of care are not done simultaneously. For instance, counselors might have to follow the assessment process by presenting the case to a clinical supervisor or staff members who determine the most appropriate level of care. The rationale for waiting until the level of care is determined to start measuring access in this type of system is that it provides a truer indicator of the program type to which a client should be admitted. The obvious disadvantage is the potential for a time delay between the assessment and the level-of-care recommendation.

Obviously, the different starting points result in vastly different measures. During discussions, the consensus panel leaned toward starting the clock when an assessment is completed. Regardless of which measure a system ultimately uses, there is even more consensus in the field that treatment systems should take great care in moving clients through the front-end process in a manner that yields expeditious and appropriate decisions about clients' levels of need. As previously

mentioned, Illinois has deliberately included an examination of its front-end process improvements as a part of its capacity management efforts. Washington State also measures (1) the time between initial contact and the assessment and (2) the time between the assessment and admission.

D. Unique Client Identifiers

Finally, block grants require capacity management systems to include unique client identifiers to track waiting list clients. Essentially, these identifiers are often alpha-numeric identifiers (e.g., client record number) that are assigned to clients entering a system and enable programs and the State to identify and report on clients. Ideally, the unique client identifier should be issued on a statewide basis and be unique to a specific client. Consequently, unique client identifiers are vital to the integrity of waiting list systems because they safeguard against having State waiting lists artificially inflated by clients who find their way onto waiting lists of multiple providers.

The following issues are noted with unique client identifiers:

- **Inability to assign identifiers before admission into treatment**—In some States, assigning unique client identifiers depends on when the State or other sub-State entity is set up to determine when treatment begins. For some treatment systems, a client record may not be opened and a client identifier may not be assigned until clients are admitted to treatment. In these instances, a program or a State may not be able to use unique client identifiers to track waiting list clients.

- **Lack of statewide identifiers**—State systems that do not have statewide unique client identifiers are limited in their ability to identify clients simultaneously enrolled on multiple waiting lists.

SECTION IV.

PRIORITY POPULATIONS

A. Who Are They, and What's Currently Needed?

When Congress deliberated the ADAMHA Reorganization Act, fetal exposure to alcohol and drugs and the spread of infectious disease through injection drug use were specifically targeted. As a result of these serious public health risks, the SAPT Block Grant requirements outlined measures that block grant-funded treatment systems must take to reduce the time that pregnant women and people who inject drugs wait for treatment and steps treatment systems need to take while these priority populations await treatment. Giving these populations preference in the order in which they are admitted to treatment and taking extra steps to keep them engaged were done to limit not only the deleterious effects they experience but also the deleterious effects on their families, communities, and society at large.

The consensus panel agreed that there is a need to focus on pregnant women; however, the panel saw a need to revisit the discussion on priority populations. Although injection drug use remains a major contributor to the proliferation of infectious diseases, the panel acknowledged that many other locality-specific problems and populations require attention and that problems and populations change over time. For instance, when Congress passed the ADAMHA Reorganization Act, many pockets of the country had neither witnessed nor anticipated the methamphetamine problems that have quickly devastated so many communities. Because the societal costs that result from specific substance use disorders and specific populations vary from State to State and over time, the consensus panel suggested that States be afforded the flexibility to identify priority populations that are specific to their jurisdictions.

B. How Are They Managed?

To serve and manage priority populations well, capacity management systems must have effective means for the following:

- **Identify them—**Treatment systems must have reliable assessment/intake processes that identify priority populations. For instance, the processes must include questions or other means for determining whether clients are pregnant or inject drugs.

- **Prioritize them—**If priority populations cannot be admitted into treatment right away, treatment systems must have the means for placing them on waiting lists in an order that is consistent with Federal mandates and clinical determinants. For block grant-funded programs, clients must be placed on waiting lists that gives preference to treatment in the following order:

  1) Pregnant women who inject drugs
  2) Other pregnant women
  3) Others who inject drugs
  4) Others

- **Track them—**Particularly for priority population members who cannot be admitted to treatment right away, treatment systems must be able to maintain contact with them. Such tracking should include mechanisms that enable the program to do the following effectively:

  - Determine when space becomes available at the appropriate treatment program
  - Remove clients from waiting lists when they are admitted for treatment or refuse treatment
  - Maintain the appropriate priority order and reprioritize lists as clients come onto or move off the lists

As previously discussed, unique client identifiers are essential to enabling treatment systems to track waiting list clients. Managing priority populations is becoming increasingly automated. For instance, automated waiting list systems are being designed with built-in algorithms that enable priority population identification and reprioritization of waiting lists as clients move onto and off the lists.

C. Competing Priorities

The impetus for this paper was fueled in part by the fact that treatment demand continues to outweigh treatment capacity. Even with the most efficient capacity management systems, there are times when priority populations and others must wait for admission to treatment. Managing capacity and access can be further complicated when multiple systems vie to have their clients receive priority status. Panelists indicated that a multitude of external entities pressure treatment systems to prioritize specific populations. For instance, many State criminal justice systems often insist on having criminal offenders with substance use disorders receive priority admission status and/or having those individuals placed in treatment programs that may not be clinically appropriate for them. Other entities with high-priority populations include child welfare systems and other federally funded programs (e.g., grants from the Department of Housing and Urban Development). These pressures make it difficult to prioritize clients in a manner that is consistent with the SAPT Block Grant requirements and that ensures clinically appropriate placement decisions.

Some panelists pointed to efforts that they have found effective in mitigating potential conflict over priority populations and placement decisions. For instance, the Fairfax-Falls Church Community Services Board has participated in longstanding efforts that include working agreements with the courts and the probation and parole systems that clearly indicate that, although the criminal justice system refers individuals to the treatment system, those referrals are for assessments only and the treatment system is responsible for placement decisions based on assessment outcome. The Fairfax-Falls Church experience is illustrative of the following qualities that some treatment systems have found to be particularly effective:

- Work collaboratively with the other entities to arrive at a clear understanding of needs (e.g., the criminal justice system's appropriate use of treatment as a component of sentencing or condition of release from incarceration) and the roles of each party in meeting those needs

- Establish an upfront understanding and clearly articulated rules for communicating about shared clients

Predictable and agreeable roles and communication mechanisms that ensure a collaborative relationship and the understanding that each party's priorities are being met mitigate pressures to make decisions inconsistent with block grant priorities and good clinical practice.

SECTION V.

INTERIM SERVICES

A. Aim of Interim Services

A primary reason for Congress's mandate that interim services be provided to pregnant women and people who inject drugs was to mitigate the risks of fetal exposure to alcohol and drugs and to help contain the spread of infectious disease. Therefore, interim services were included as SAPT Block Grant requirements largely because of these public health concerns. In addition to their public health benefits, interim services offer the opportunity to motivate, engage, and retain clients awaiting admission to comprehensive treatment services as outlined below:

- **Maintain motivation**—Effective interim services allow treatment systems to use services such as motivational interviewing to build on the motivation that brought clients to assessments without those clients having to wait until treatment capacity becomes available.

- **Enhance engagement and retention**—For some clients, their motivation to enter treatment is fleeting without continued contact from treatment professionals. By offering interim services, treatment systems expand the opportunity to actively engage these clients and maintain contact with clients before admission into treatment. Whether because of the aforementioned fleeting motivation or other changes in a client's life, interim services enable treatment systems to minimize the propensity for waiting list clients to fall between the cracks before being admitted to treatment.

B. What Interim Services Entail

The SAPT Block Grant requires funded programs serving pregnant women and people who inject drugs to provide the following services to these populations when they cannot be admitted because of insufficient capacity:

- Counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sex partners and infants, and steps to prevent HIV transmission

- Referrals for HIV and TB services, if necessary

- Referrals for prenatal care and counseling on the effects of alcohol and drug use on the fetus

The block grant also provides States and localities the option to offer federally authorized methadone services provided the interim methadone services supplement but do not supplant comprehensive methadone programs. Programs will likely find new ways to expand interim service options as innovations are discovered and technology advances.

Interim Service Examples

Aside from the above-required elements, States and programs have considerable latitude in what they offer as interim services and how often they offer them. For instance, interim services in the jurisdictions of the consensus panel members include the following:

- Services offered in person, over the phone, and by e-mail

- Peer mentorship and provider-driven services

- Open-ended groups, outreach/drop-in centers, case management services, and risk assessment activities

C. Interim Service Issues

Because interim services do not represent a specific set of services like individual or group counseling, the consensus panel sees the following data/definitional and reimbursement concerns as needing greater consideration at the Federal and State levels:

- **Interim service definitions and data**—The Federal Treatment Episode Data Sets do not include a specific definition or data element for interim services, so States and programs do not have a clear-cut method for recording, getting credit for, or reporting interim services as a cluster of services. However, in Virginia, interim services can be counted under the new "Consumer Monitoring" category.

- **Interim service reimbursement**—Unless specific services that are offered as interim services are reimbursable, interim services are not reimbursed as a class.

SECTION VI.

THE ROLE OF AUTOMATED SYSTEMS

A. What Automated Capacity Management Systems Do

Capacity management systems in publicly funded treatment systems have evolved considerably over time. At the time that the Uniform Waiting List definition was developed and the current SAPT Block Grant requirements were introduced, capacity management at the provider level was primarily a paper-and-pencil activity. These early approaches rarely provided State agencies real-time data about waiting lists or programs with available capacity. Typically, these data were already out of date by the time the programs or intermediary entities (e.g., municipal or regional agencies) faxed, called in, or uploaded the data to the State's client information system, as infrequently as every 7 to 30 days. The intent of capacity management is to facilitate access to care as quickly as possible, but States are somewhat handicapped in their abilities because they rarely received timely data to intervene.

Whether the capacity management system is paper and pencil, automated, or some combination of the two, the system can work well if it is monitored and used effectively to provide reliable data when they are needed. Web-based systems that offer real-time data and functions represent the "gold standard." As a result of lower-cost technologies, wider availability of already-tested systems and ideas, and integration of information management professionals in State and local agencies, automated capacity management systems are increasingly accessible and manageable.

Comprehensive, automated capacity management systems are increasingly Web-based systems that include many of the following features:

- **Nearly real-time data**—These systems are capable of capturing and reporting data changes that providers enter, and States can access the data when they are entered.

- **Comprehensive capacity data**—These systems should report on funded and licensed service treatment capacity and the current capacity in these programs.

- **Statewide information**—To enable programs, intermediary agencies, and/or States to direct clients to available treatment, individuals helping clients with such movement should have access to capacity and availability data throughout the State.

- **Comprehensive waiting list data**—These systems include the following information about each client on the waiting list:

  1) Client name, contact information, and unique client identifier
  2) Dates of application for admission and sequence number
  3) Priority category for admission (e.g., pregnant woman and/or person who injects drugs)
  4) Dates and type of contact
  5) Date and reason for removal from the waiting list
  6) Staff person obtaining the information
  7) Screening and assessment information, including the disposition/decision

- **Measures of access to care**—The systems should include the ability to measure the length of time it takes each client to be admitted.
- **Mechanisms to adjust/reprioritize waiting lists**—As clients move on and off the list, the system should automatically adjust the list, including reprioritizing the placement of priority clients.

Increasingly, States are moving toward comprehensive electronic health records; this might be an opportune time for these States to consider folding automated capacity management systems into the electronic health record systems.

B. How Capacity Management Data Are Used

Automated capacity management systems that provide nearly real-time data offer considerable promise to States, intermediary entities, and programs. Investments in these automated approaches add significantly to the ability to manage individual clients and the system as a whole. Below are the salient benefits and uses of automated capacity management data:

- Ensure that priority populations can access the most appropriate levels of care within reasonable geographic proximity when space becomes available.
- Enable States and others to accurately measure individual client access and to measure access among clients.
- Facilitate caseload forecasting within and across programs.
- Provide the means for objectively determining the gap between capacity and demand and support requests for funding increases, planning for future service development, or decisions to move funds from one service or provider to another.
- Use as performance measures in performance-based contracts.

If designed with multiple funding sources in mind, automated systems enable treatment entities to manage the priority populations of the various funding streams more efficiently.

No system is any better than how it is used and managed. If providers do not enter accurate, complete, and timely data and those managing capacity do not use the data to direct and report on waiting list clients and capacity management activities, automated systems are no more useful than paper-and-pencil systems.

Automated Waiting List Management

Each day, State-funded providers in Texas enter data in the State's client information system, the Behavioral Health Integrated Provider System (BHIPS). BHIPS has the following capacity management features:

- A waiting list management component that includes a unique client identifier, sorts priority populations (pregnant women and people who inject drugs), and places priority populations on the waiting list in the order required by the SAPT Block Grant
- The ability to track each program's capacity and the average wait time on provider, regional, and statewide bases

The State has assigned one person to monitor waiting list clients' movement on and off the list and to facilitate transfers of clients who can be served more quickly by another program within a reasonable geographic proximity. Furthermore, each program is required to maintain the following waiting list services:

- A mechanism for maintaining contact with individuals on the waiting list
- Interim services
- A mechanism for placing clients into treatment when space becomes available

The State communicates its requirements through administrative rules and contracts.

SECTION VII.

VARIABLES THAT IMPACT CAPACITY AND CAPACITY MANAGEMENT

Many factors influence and are influenced by capacity management issues and practices. Although many of these variables have already been discussed earlier in this paper, some are repeated below along with variables not previously mentioned. However, this list is not an all-inclusive list of influencing factors.

A. Defining Capacity

The most notable variable that affects capacity and capacity management is the definition of capacity, particularly in outpatient programs. Uniform definitions of capacity within a treatment system are essential to that system's having the basis for determining the optimal number of clients that it can serve.

B. Capturing Capacity Management Data

Earlier discussions in this paper focused on few factors that complicate how capacity management data are captured. These points are reiterated below:

- There is no uniform definition of when to start measuring access to care. Although the goal is to get clients into treatment as quickly as possible, there are no specific guidelines and there is no universal practice regarding whether measuring access (i.e., the time before treatment starts) begins when the client initially contacts a program for an assessment or after the assessment or placement decision is made. For a number of reasons, the consensus panel leaned toward having the clock start when a client completes the assessment process.

- In some treatment systems, individuals are not counted as clients until they are actually admitted into treatment. Data for these clients may be lost.

- No single data element or set of data represents interim services, so States are challenged with reliably capturing data to reflect this constellation of services. This issue is certainly compounded by the fact that States have great latitude in the range of interim services they offer; thus, there is no description, measure, or data that represent all the variations of interim services within and across States.

C. Funding Mechanisms

In addition to the inconsistency in capturing and getting credit for capacity management-related data, few funding mechanisms are in place to fund some of the specific activities that make up capacity management activities. Thus, programs have limited incentive for developing and implementing innovative practices intended to recruit, engage, and retain clients before those clients are admitted into fully funded services.

Funding mechanisms vary significantly in the extent to which they fund service capacity (units of service, number of clients in a level of care, etc.) versus treatment episodes (i.e., a funded service that allows funds to follow the client regardless of the levels of care or mix of services the client receives). Mechanisms that fund capacity offer more clear-cut measures of capacity, whereas funding that follows the client and includes "a la carte" services offer more flexibility regarding the mix of services that are funded.

D. Population Density

Sparsely populated areas pose a unique challenge to treatment systems because they may not have a sufficient number of clients within a reasonable geographic area to justify a full slate of comprehensive services. States that have specific geographic barriers (mountain ranges, major bodies of water, etc.) have a similar challenge. Programs in these areas have to resort to different approaches to serve clients spread out over a vast region. For instance, counselors in these programs often lack enough clients in an area to form counseling groups, so they might offer more individual counseling and less group counseling and/or rotate among satellite offices throughout the week. Thus, the higher level of individual services and travel time combine to limit the capacity of these programs.

E. Cultural Influences

In some instances, cultural/ethnic affiliation is a variable that can dissuade clients from going outside their communities to access care. Their local programs are subject to experiencing an inflated demand for services even if comparable services are available in nearby communities.

F. State Systems Organization

The organizational composition, location, leadership, and span of authority have the potential for affecting a State substance abuse agency's ability to manage capacity. Not only does the organizational placement of State agencies vary across the country, but the organizational placement of these agencies has changed considerably over the past several years. Many agencies have undergone reorganization that has resulted in diminished roles or movement to new departmental homes in State government. For some, the reorganization has resulted in altered influence and functions that could affect the agencies' authority to set the direction for statewide capacity management systems. For instance, information management activities might be outside the domain of the agencies, or many of these agencies are now components of larger units (e.g., behavioral health agencies) that have consolidated functions such as information management. Consequently, some substance use disorder-specific interests may have been lost to accommodate the interests of all the reconfigured agencies.

State systems have also witnessed a tremendous amount of change in State directors in recent years. This flux in leadership at the State agency level has likely affected the progress States have made in updating their capacity management practices because the new directors may need time to get acclimated to their roles; once they become acclimated, they might have a different vision and new priorities for managing the treatment system.

The sub-State organization also influences capacity management activities because some responsibilities are shared with other entities. Most States are organized according to one of the following three structures:

- **Administrative service organizations (ASOs)**—Some States like Iowa and New Mexico rely on statewide ASOs as intermediary organizations with which the State contracts to manage care, access, and/or provider networks throughout the State. Most often, the States contract with ASOs to carry out many functions on behalf of the State, including capacity management activities.

- **Regional/municipal intermediaries**—In many States, such as Arizona and North Carolina, States contract with regional entities to administer services over single or multijurisdictional geographic regions, while some States, such as California, use intermediaries that administer services for a single jurisdiction each. These intermediaries either deliver the services or contract with nonprofit or local government agencies to deliver services.

- **Directly contracted systems**—Other States, such as Connecticut, contract directly with providers to deliver services.

Thus, the scope of responsibility and management of many capacity management functions, including waiting list management and monitoring compliance with capacity management requirements, might be distributed among multiple layers of the State.

G. Competing Pressures from Other Systems

Many treatment programs receive funds and clients from multiple sources, including the criminal justice system, social service agencies, public health departments, mental health agencies, and private insurance companies. The reality of operating treatment programs today means that these programs must often maintain a diversified funding base. Varied and sometimes conflicting requirements, including who constitutes a priority population and how capacity is managed and reported, are chief components of the conundrum that accompanies the different funding streams. Each funding and referral source may have a set of requirements that calls for unique capacity management systems/components. Accommodating these varied requirements has the potential for consequences such as displacing clients from other sources, increasing staff time, increasing reporting requirements, and generally representing a disincentive for providers to diversify their funding streams (e.g., reluctance to apply for new grant opportunities).

H. Political or Public Concerns

There is little doubt that spikes in certain drug problems get the attention of both political leaders and the public. As a result of concerns about the spread of infectious diseases, most notably HIV disease, Congress took action to target populations at particular risk for contracting and spreading HIV and other infectious disease. This concern had a direct impact on people who inject drugs becoming a priority population and on HIV services being featured among the interim services. As new issues and populations surface, it is conceivable that political and public concerns could further influence priority populations and services.

I. Population-Specific Concerns

Some populations require more intensive services than others based on diagnostic, developmental, or other characteristics. For instance, clients with co-occurring disorders, women with dependent children, and youth, particularly those in more intensive levels of care, often require a low counselor-to-client ratio and a diverse mix of services. Thus, programs for these populations, compared with programs for other populations, might be more resource intensive and have less capacity to serve their target audiences.

J. Workforce Issues

More than any time before, the substance use disorder field has been challenged by the need to maintain an experienced workforce in treatment settings. As discussed earlier, capacity in programs is linked very closely to the workload of the clinicians in a program. Therefore, the perpetual staff shortages in the field have a real effect on capacity. For instance, an outpatient program that has five full-time counselors and is already at capacity can be staggered by the loss of one or more of these counselors.

SECTION VIII.

CONCLUSIONS AND RECOMMENDATIONS

The many years of organized capacity management activities, coupled with the insights and experiences of CSAT's Capacity Management Consensus Panel, have revealed a number of lessons learned and additional challenges and opportunities that lie ahead. Based on the lessons that have emanated from the field, the following appear to be some of the most notable next steps in the advancement of capacity management systems:

- Reach a national consensus, or at least a consensus within each State, regarding the definition of capacity.
- Reach a consensus regarding appropriate access measures, such as the time between the completion of assessment and the time that a client is admitted into treatment.
- Allow more flexibility regarding the use of locality-specific priority populations and interim services.
- Determine the best methods for getting statistical and financial credit for capacity management activities such as interim services.
- Establish more formal working relationships with agencies that appear to have competing demands to enlist those agencies as partners, rather than competitors, regarding variables such as who is treated and how, the rules and practices governing priority populations, and disclosure of client information.

Panelists agreed that it did not matter if capacity is managed at the local, regional, or State level. Instead, the following three elements seemed critical for determining the effectiveness of capacity management systems:

- **Clear expectations**—Panelists found that the greatest success in capacity management systems comes when what is needed and why it is needed (i.e., what is the benefit to the service providers and recipients) are clearly communicated to those who collect, enter, and manage the data. It is also important for the State and its sub-State partners to establish a culture in which meeting these expectations are the norm. Consistent communication, follow through, and performance-based contracts are examples of approaches that can help reinforce the expectations.
- **Real-time capacity information**—Accurate, real-time data provide treatment systems the greatest ability to help clients access the most appropriate care as quickly as possible. Achieving these aims is possible when managers of capacity can access real-time information about who is awaiting treatment, who should get priority in admissions, and where available capacity treatment exists.
- **Dedicated management**—Just because you build it, does not always mean they will come. Good systems become great when they are actively and proficiently managed. Thus, solid capacity management systems benefit from the support of upper management and sufficient personnel to persistently communicate with providers, monitor capacity management data and activities, and intervene when clients need to be moved on or off waiting lists.