National Association
for Behavioral Healthcare

Access. Care. Recovery.

2019 NABH ANNUAL SURVEY

Reporting 2017 Data

The data in this report were collected, analyzed, and reported by Dobson DaVanzo & Associates, 450 Maple Avenue East, Suite 303, Vienna, VA 22180.

Our thanks to the members of the National Association for Behavioral Healthcare (NABH) for their time and effort in responding to our questionnaires.

To order additional copies of the NABH 2019 Annual Survey, send your request and payment to NABH, 900 17th Street, NW, Suite 420, Washington, DC 20006-2507. The cost of the NABH Annual Survey is $400.00. Orders must be prepaid. DC residents add 5.75% sales tax. American Express, MasterCard, and Visa accepted. (For MasterCard and Visa, please provide the three-digit CW code on the back of the card; for American Express, provide the four-digit CVV code.)

The National Association for Behavioral Healthcare advocates for behavioral healthcare and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective treatment and prevention programs for children, adolescents, adults, and older adults with mental and substance use disorders. The organization was founded in 1933. In 2018 it became the National Association for Behavioral Healthcare.

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A MESSAGE FROM THE PRESIDENT AND CEO

This year's Annual Survey reflects that National Association for Behavioral Healthcare (NABH) members continue to be heavily involved in the changing behavioral healthcare marketplace. According to recent estimates, nearly one in five U.S. adults live with a mental illness.[1] These individuals not only face mental health issues, they are also more likely to have physical health and substance use disorders (SUD) and ultimately shorter lifespans. This year's NABH Annual Survey demonstrates a continued commitment to meet the need for our members' services as an essential part of the U.S. healthcare delivery system.

An analysis of survey results across the past four years reflects three competing statistical narratives:

- Inconsistency,
- Consistency, and
- Emergent trends

Across the changing mix of survey respondents, the relationship between average inpatient hospital admissions, average inpatient hospital length of stay per facility, and average inpatient total days of care remained mostly steady throughout 2016-2019. At the same time, average residential admissions and average residential length of stay per facility fluctuated over time, even as average number of residential days of care held steady. For partial hospitalizations, average number of admissions fluctuated over time, average number of visits per admission remained relatively stable, while average number of visits fluctuated over time. These changes, that are inconsistent among the facility types, not only reflect the differences in the capacities of the various settings, but also the response of the behavioral healthcare community to the changing nature of the type of patients they are treating and the varying demands for different treatment settings, from one community to the next.

The overall trends show consistencies in the payer mix for psychiatric services. For example, payers for inpatient hospital admissions and partial hospitalization admissions remained consistent at roughly 50% public and 50% commercial over four years. There is an emerging trend in the shift of payers in residential treatment centers as, private payers are taking on a much larger share of coverage while public payers are covering a smaller share of the cost. These types of observations could prove foundational to current and future NABH members as they work to provide the best possible care to their patients.

Thank you to all those who completed this year's survey, which allowed us to capture the services our members provide. Our thanks also to the team from Dobson DaVanzo & Associates in Vienna, Va., for assisting us with survey design and fielding the survey through an online format for the seventh straight year. We welcome your feedback as we continuously work to improve the relevance of the survey findings to our membership and to the field.

Thank you again for your time in this data-gathering effort. We invite you to visit www.NABH.org for additional information.

Mark Covall
President and CEO

[1] Substance Abuse and Mental Health Services Administration. Results from the 2017 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab8-33A

2019 ANNUAL SURVEY OVERVIEW

This report provides a snapshot of behavioral healthcare delivery based on a 2019 survey (using 2017 data) of responding NABH-member organizations. The NABH membership includes hospitals, psychiatric and addiction treatment units and divisions within general healthcare systems, residential treatment centers, youth services organizations, and outpatient services throughout the United States.

This year's report contains four separate sections.

An introductory first section provides context on the broad scope and impact of mental and substance use disorders nationwide by highlighting key prevalence data obtained from publicly available data sources.

The second section provides a snapshot of NABH members' 2017 data, reported in the form of national averages based on data from all facilities responding in 2019. This section provides an overview of the types of services members provide, payment sources, facility size, and key utilization indicators such as days of care, admissions, and length of stay. Because the mix of respondents varies from year to year, this section's results must be compared with those of previous years' reports with caution.

The third section presents trend data. These trends are based on responses from hospitals and residential treatment facilities over the past four years of the Annual Survey. This section provides a perspective on market changes in care provision over time for NABH members responding to the Annual Survey.

The fourth and final section provides technical information on sample size and how the survey was conducted.

Putting the Annual Survey Into Context

To put the NABH Annual Survey into context, it is helpful to understand the broad scope and impact of mental and substance use disorders in the United States (U.S.). The information presented here was drawn from publicly available sources such as the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Nationwide Prevalence and Impact of Mental Health and Substance Use Disorders

Lives are at stake.

Suicide, alcohol and illicit drug use have led to a rising number of deaths nationwide. This public health crisis has expanded in scope to affect individuals of all ages, genders, ethnicities, and geographic areas. Behavioral healthcare issues affect society at large and have devastating consequences for individuals and families. NABH members play an important role in providing treatment intervention in order to promote recovery and prevent unnecessary death.

Suicide is currently at a 30-year high and remains one of the top 10 leading causes of death in the U.S. In 2017, there were an estimated 1.4 million suicide attempts resulting in 47,173 deaths.[2] Of those, across age groups, the highest suicide rate in 2017 was found among adults between 45 and 54 years of age (20.2 per 100,000 in this age group), and the second highest among those 85 or older (20.1 per 100,000 in this age group).[3] Across ethnicities, age-adjusted suicide rates were the highest among Whites (15.9 per 100,000 Whites) and the second highest amongst American Indians and Alaska Natives (13.42 per 100,000 per American Indians and Alaska Natives).[4] Men, at 22.4 per 100,000 men, were 3.54 times more likely to die from suicide than women.[5]

Excessive alcohol use is rising in the U.S as well. Approximately 26.9% of adults were binge drinkers within the last month and 6.2% of adults have an alcohol use disorder, including 9.8 million men and 5.3 million women.[6] Alcohol-attributable deaths average 88,129 per year as a result of excessive alcohol use.[7]

The U.S. is experiencing an epidemic of drug overdose deaths.[8] The most recent statistics reveal that about 47,600 drug overdose deaths in the U.S. involved an opioid. The number of overdose deaths is now 6 times higher than in 1999, and on average, 130 Americans die each day from an opioid overdose (e.g. prescription opioid pain relievers and heroin).[9]

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[2] American Foundation for Suicide Prevention. Suicide Statistics. Accessed Jun 2019. https://afsp.org/about-suicide/suicide-statistics/

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] National Institute of Health on Alcohol Abuse and Alcoholism. Alcohol Facts and Statistics. Updated August 2018. Accessed July 2019.

[7] CDC. Alcohol-Related Disease Impact (ARDI) application, 2013. Available at www.cdc.gov/ARDI. Accessed Jul 2019.

[8] CDC. Understanding the Epidemic. Updated Dec 2018. Accessed Jun 2019. https://www.cdc.gov/drugoverdose/epidemic/index.html

[9] Ibid.

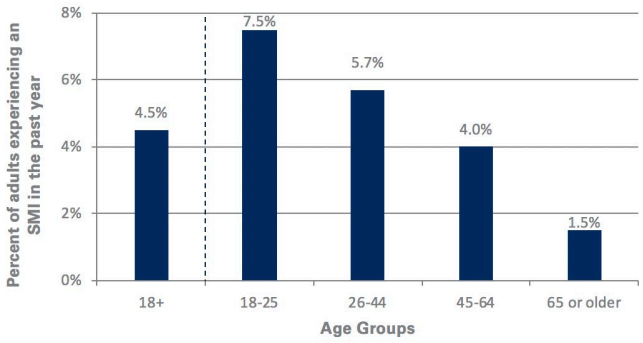
Prevalence of Mental Health and Substance Use Disorders.

Adults

Approximately 18.9% of adults experienced a mental illness in 2017.[10] Of those, an estimated 11.2 million American adults live with a serious mental illness (SMI), representing about 4.5% of the over age 18 U.S. population.[11]

SMIs are mental, behavioral, or emotional disorders that result in functional impairments which substantially interfere with or limit one's major life activities. SMIs are more prevalent in adults residing in non-metropolitan areas (5.2%) than in metropolitan areas (4.4%).[12] They affect all ages and both genders. Among adults, those aged 18-25 and 26-44 had the highest prevalence of SMIs in 2017 (**Exhibit 1.1**), with 7.5% and 5.7%, respectively, experiencing an SMI in the past year.[13]

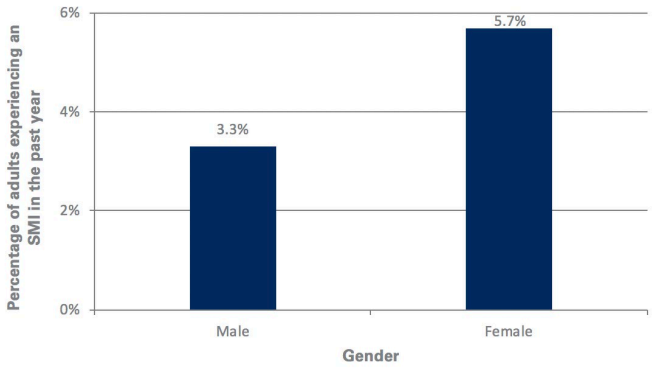
Exhibit 1.1 Serious mental illness (SMI) in the past year among adults 18 and older, by age (2017).



Source: SAMHSA. Behavioral Health Barometer: United States, 2017 Published in 2019.

As shown in **Exhibit 1.2**, females were more likely to have reported experiencing an SMI than males in 2017 (5.7% of females and 3.3% of males).[14] SMIs also disproportionately affect those with lower incomes, those who are unemployed, and those in the penal system.[15]

Exhibit 1.2 Serious mental illness (SMI) in the past year among adults 18 and older, by gender (2017).



Source: SAMHSA. Behavioral Health Barometer: United States, 2017. Published in 2019.

Youth

Mental health disorders are highly prevalent and persistent in adolescents in the United States, and most adult mental health disorders first present in childhood and adolescence. Approximately one-half of all chronic mental illnesses begin by age 14 and three-quarters begin by age 24.[16]

In 2017, 13.3% of youth aged 12 to 17 suffered a major depressive episode (MDE) within the past year, up from 12.8% of youth who reported an MDE in 2016.[17] Of the 3.2 million youth reporting an MDE within the past year, 41.5%

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[10] Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[11] Ibid.

[12] Ibid 10.

[13] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: United States, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–19–Baro-17-US. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

[14] Ibid 13.

[15] Center for Behavioral Health Statistics and Quality. (2018). 2017 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.

[16] Kessler et al. "Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement." Arch Gen Psychiatry. April 2012;69(4):372-380. See http://archpsyc.jamanetwork.com/article.aspx?articleid=1151058.

[17] Ibid 10.

received treatment for depression in 2017, an increase from 40.9% in 2016.[18] Female youths were more likely to have an MDE than males (20.0% and 6.8%, respectively) and were more likely to have received treatment than male youths (44.8% to 32.5%, respectively).[19]

Suicide rates are of concern in the youth population as they present an added risk of school drop-out and crime. In 2017, adolescents and young adults aged 15 to 24 experienced a suicide rate of 14.46 per 100,000.[20] Approximately 70% of youth in the juvenile justice system have some mental health condition and an estimated 20% have an SMI.[21]

Co-occurring mental health and substance use disorders

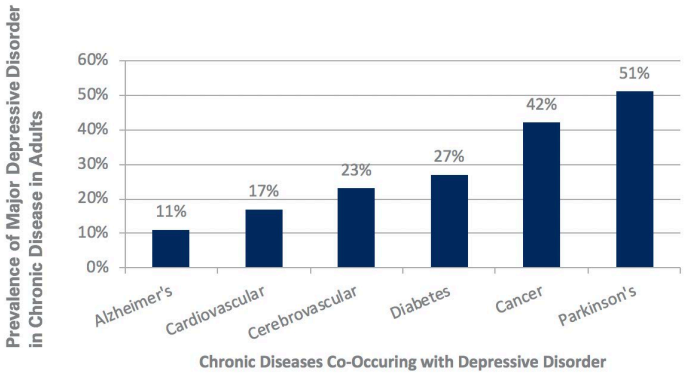
Substance use disorder (SUD) is highly correlated with mental illness. Of the 18.7 million adults reporting an SUD in 2017, 8.5 million (45.6%) also experienced any mental illness (AMI).[22] Conversely, of the 46.6 million adults who had AMI, 8.5 million (18.3%) had an SUD in the past year.[23]

Correlations between SMIs and SUDs in 2017 show that 44.1% of adults with SMIs reported illicit drug use in the past year.[24] Adults with a mental illness were also more likely to be binge drinkers and be heavy alcohol users compared to the overall population.[25]

Co-Occurrence of Mental and Physical Illness and the Effect on Healthcare Utilization

Adults experiencing mental illnesses have higher rates of certain chronic physical illnesses and higher emergency department (ED) use.[26] Adults aged 18 and older who experienced AMIs, SMIs, or MDEs in the past year had increased rates of high blood pressure, asthma, diabetes, heart disease, and stroke.[27] 21.9% of adults experiencing AMIs in the past year had high blood pressure (vs.18.3% of those not experiencing any mental illness).[28] Similarly, 15.7% of adults who had any mental illness in the past year also had asthma (vs.10.6% of those without mental illness).[29] Depression is also a co-occurring morbidity in 11% of Alzheimer's disease patients, 17% of cardiovascular disease patients, 23% of cerebrovascular patients, 27% of diabetes patients, 42% of cancer patients, and 51% of patients with Parkinson's (**Exhibit 1.3**).[30]

Exhibit 1.3 Co-Occurrence of Depression in Chronic Disease.



Source: National Center for Chronic Disease Prevention and Health Promotion. Published 2012.

[18] Ibid.

[19] Ibid.

[20] Ibid 2.

[21] National Alliance on Mental Illness, Mental Health By the Numbers. Arlington, VA: National Alliance on Mental Illness, 2015. Accessed Jun 2019. https://www.nami.org/learn-more/mental-health-by-the-numbers.

[22] Ibid 10.

[23] Ibid.

[24] Ibid 15.

[25] Ibid.

[26] Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality. "The NSDUH Report: Physical Health Conditions among Adults with Mental Illnesses." Available at https://www.medpagetoday.com/upload/2012/4/13/SR103AdultsAMI2012.pdf. April 5, 2012.

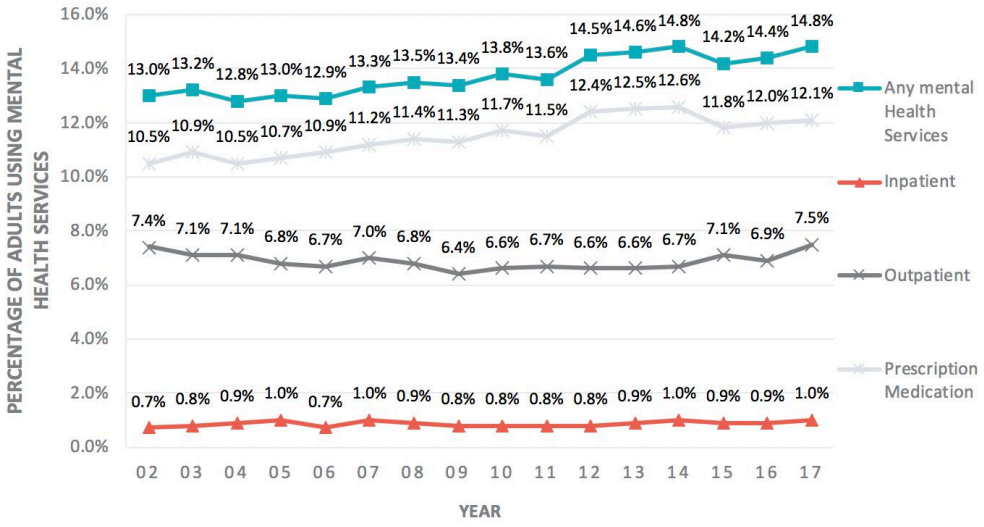
[27] Ibid.

[28] Ibid.

[29] Ibid.

[30] National Center for Chronic Disease Prevention and Health Promotion. "Mental Health and Chronic Disease." National Healthy Worksite. October 2012. Retrieved from: http://www.cdc.gov/nationalhealthyworksite/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf

Exhibit 1.4. Mental Health Service Utilization Among All Adults in U.S., 2002-2017



Source: SAMHSA. 2017 National Survey on Drug Use and Health. Published 2018.

Significant differences were reported in emergency department (ED) use and hospitalization rates between adults reporting mental illnesses in the past year and those without a mental illness. For example, 47.6% of adults with SMI in the past year used EDs (vs. 30.5% of those without SMIs). Adults with SMIs were more likely to have been hospitalized than those without SMIs (20.4% and 11.6%, respectively).[31]

According to a 2016 estimate by the Agency for Healthcare Research and Quality (AHRQ), approximately one in eight ED visits by adults in the U.S. is due to a mental health and/or SUD event.[32] The co-existence of mental and physical illnesses that often goes untreated contributes to much shorter lifespans among those with mental illnesses. In fact, adults with SMIs die on average 25 years earlier than the average adult in the U.S. population without an SMI.[33]

There was an increased demand for mental health services from 2016 to 2017

According to SAMHSA's 2017 National Survey on Drug Use and Health the number of adults who reported using any mental health services (regardless of the presence of a mental illness or an SUD) increased from 35 million in 2016 to 36.4 million in 2017, representing a corresponding increase in the proportion of adult utilization from 14.4% in 2016 to 14.8% in 2017 (**Exhibit 1.4**).[34] This estimate is similar to the ones observed between 2012 and 2016 but greater than in all years between 2002 and 2011.[35] Additionally, service utilization for all adults requiring a prescription medication, regardless of their mental health status, had a general upward trend going from 10.5% in 2002 to 12.1% in 2017.[36] Utilization remained steady among adults hospitalized in an inpatient setting, regardless of their mental health status, increasing slightly at both the

[31] Ibid 26.

[32] Weiss, A. et al. (2016). Trends in Emergency department Visits Involving Mental and Substance Use Disorders, 2006-2013. Rockville, MD: Agency for Healthcare Research and Quality. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf.

[33] Parks, J., et al. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: National Association of State Mental Health Program Directors Medical Directors Council.

[34] Ibid 10.

[35] Ibid.

[36] Ibid 10.

Exhibit 1.5. Mental Health Service Utilization Among Adults with Mental Illnesses in U.S., 2002-2017

Source: SAMHSA. 2017 National Survey on Drug Use and Health. Published 2019.

beginning and end of the time period from 2002 to 2017. Outpatient service utilization showed a slight decrease over the first half of the observed time period, from 2002 to 2009, steadily increased between 2010 and 2016, and showed a statistically significant increase from 6.9% in 2016 to 7.5% in 2017.[37]

Exhibit 1.5 shows that the percentage of adults with AMIs who accessed mental health services slightly declined from 43.1% in 2016 to 42.6% in 2017.[38] Adults with AMI demonstrated a slight but non-significant decrease in utilization of prescription medication (37.1% in 2016 to 35.7% in 2017), while inpatient service access remained the same at 3.3%.[39] There was a slight increase in utilization of outpatient treatment in this population (24.5% in 2016 to 25.7% in 2017%).[40]

According to SAMHSA, in 2017, among the 11.1 million adults aged 18 or older with AMI who had a perceived unmet need for mental health services and did not receive those services, a majority could not afford the cost of care (44.6%), 34.1% thought that the problem could be handled without treatment, 29.2% did not know where to go for services, and 21.4% did not think they had the time to seek care.[41] See **Exhibit 1.6**.

Mental health and substance use disorder treatment expenditures are on the rise

Total mental health (MH) and SUD spending in the U.S. rose from $131 billion in 2006 to $212 billion in 2015.[42] These estimates from SAMHSA serve as a basis for tracking major policy initiatives and trends in the field of behavioral health after the Great Recession (2007-2009), such as the Mental Health Parity and Addiction Equity Act of 2008, the Affordable Care Act of 2010, increases in the rates of suicide, and the ongoing opioid epidemic.[43] For example, the rise in SUD spending was particularly more noticeable than MH spending from 2010-2015, increasing from $23 billion to $56 billion, and coincided with the rise of the opioid epidemic.[44]

[37] Ibid.

[38] Ibid.

[39] Ibid.

[40] Ibid.

[41] Ibid 10.

[42] Substance Abuse and Mental Health Services Administration. Behavioral Health Spending & Use Accounts 2006–2015. HHS Pub. No. (SMA) 19-5095. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2019.

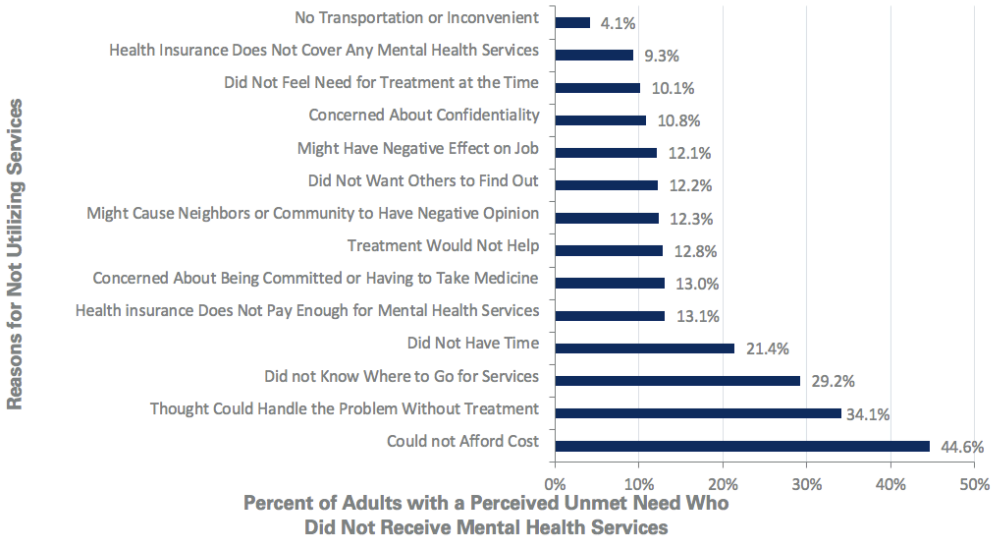
[43] Ibid.

[44] Ibid.

In 2015, slightly less than half of MH and SUD spending came from private sources (43%), while the rest (57%) came from public sources (See **Exhibit 1.7**).[45] Within private sources, a majority of the funding came from private insurance, and about one quarter was out-of-pocket. In the public sector, Medicaid was the source of just under half of all expenditures.[46]

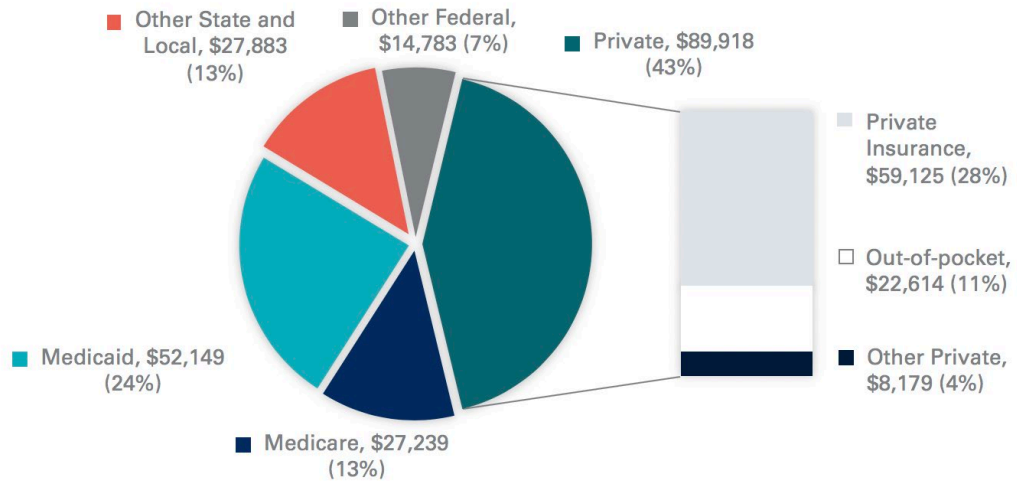
The statistics in this section suggest that the magnitude of behavioral healthcare issues remains significant. Realizing this context highlights the importance of behavioral healthcare and the NABH annual survey in informing members about their role in care provision in an evolving marketplace.

Exhibit 1.6. Adults with a Perceived Unmet Need for Mental Health Services Who Did Not Receive Mental Health Services, 2017



Source: SAMHSA. 2017 National Survey on Drug Use and Health. Published 2019.

Exhibit 1.7 MH and SUD Spending by Payer Source, 2015



Source: SAMHSA. Behavioral Health Spending and Use Accounts 2006-2015. Published 2019.

[45] Ibid.

[46] Ibid 42.

A SNAPSHOT OF NABH MEMBERSHIP EXPERIENCE

This 2019 report is based on responses to NABH's Annual Survey questionnaire that reflects FY2017 activities. Data were provided by 351 psychiatric and addiction treatment facilities owned and operated by NABH system members. This compares to 249 respondents in last year's report.

The NABH Annual Survey is voluntary. There is a different mix of respondent organizations each year, varying by size and operational characteristics. It is important to emphasize that the data collected in 2019 represent national averages that reflect survey respondents' diversity in teaching and non-teaching organizations, large and small organizations, and long-term and short-term facilities.

NABH-member organizations provide a wide variety of services for children, adolescents, adults, and older adults who face mental illnesses and SUDs. The NABH membership includes diverse organizations throughout the United States including inpatient hospitals, residential treatment programs, partial hospitalization programs, and outpatient centers serving individuals of all ages. These programs are offered in metropolitan, suburban, and rural locations, where NABH-member organizations provide a range of services - from acute inpatient care to outpatient counseling. The membership includes both not-for-profit and for-profit organizations.

This section reports data either as national averages of NABH-member facilities or by set-up and staffed bed categories to provide a snapshot of respondents' service provision experience in 2017. Providers may use the data presented by set-up and staffed bed categories to compare their own experience to those of facilities of a similar size.

It is important to keep in mind that an individual program may vary from these statistics based on its own specific characteristics: i.e., whether it is rural or urban, prevailing costs in the geographic area for staffing and facilities, and other factors (such as the age or individual health conditions of a specific patient population, and degree and type of health insurance coverage).

All Responding Members

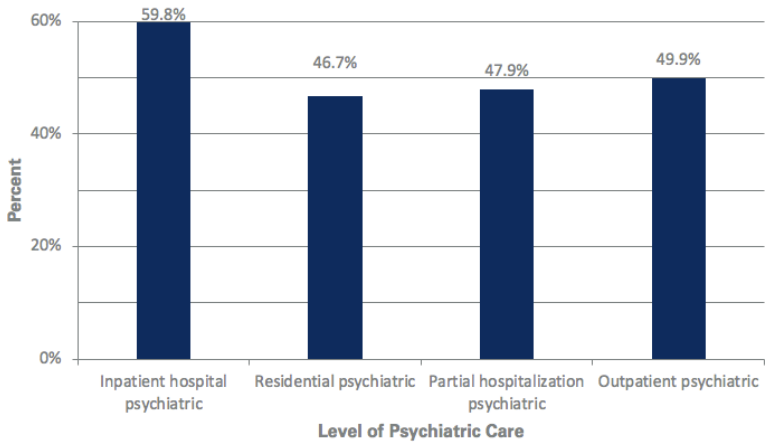
Levels of care and services provided

The following exhibits show the percent of survey respondents offering specific levels of care or serving a specific population. Since respondents most often provide services to multiple populations within their systems of care, they may be shown in multiple categories.

Exhibit 2.1 NABH-member organizations and their facilities provide psychiatric care in a continuum of settings including inpatient hospital, residential, partial hospitalization, and outpatient. More than half of respondents provided inpatient hospital psychiatric care (59.8%), and just under half of respondents provided residential psychiatric care (46.7%), partial hospitalization psychiatric care (47.9%), and/or outpatient psychiatric care (49.9%). See **Exhibit 2.3** for survey reported frequencies by level of care.

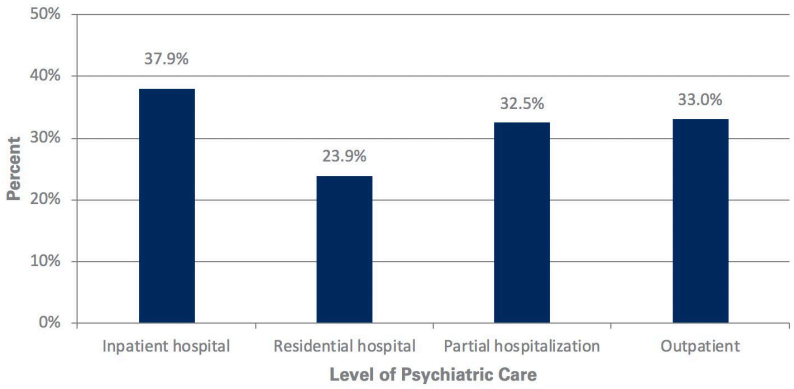
Exhibit 2.2 NABH-member organizations also provide addiction treatment in a continuum of settings including inpatient hospital, residential, partial hospitalization, and outpatient. Less than one quarter of hospital respondents (23.9%) reported providing residential psychiatric addiction treatment services while more than one-third (37.9%) reported providing inpatient hospital psychiatric addiction treatment. See **Exhibit 2.3** for survey frequencies by level of care.

Exhibit 2.1 Percent of Respondents Offering Each Level of Psychiatric Care, 2017



Source: NABH survey of members conducted in 2019. 351 respondents reported for 2017, including 210 providing inpatient hospital psychiatric services, 164 providing residential psychiatric services, 168 providing partial hospitalization psychiatric services, and 175 providing outpatient psychiatric services

Exhibit 2.2 Percent of Respondents Offering Each Level of Addiction Treatment, 2017



Source: NABH survey of members conducted in 2019. 351 respondents reported for 2017, including 133 providing inpatient hospital addiction services, 84 providing residential addiction services, 114 providing partial hospitalization services, and 116 providing outpatient addiction services.

Exhibit 2.3 Level of Care Provided at NABH-Member Organizations (All Respondents), 2017

Level of Care	(n)	(%)
Inpatient hospital psychiatric care	210	59.8%
Residential psychiatric care	164	46.7%
Partial hospitalization psychiatric care	168	47.9%
Outpatient psychiatric care	175	49.9%
Inpatient hospital psychiatric addiction treatment	133	37.9%
Residential psychiatric addiction treatment	84	23.9%
Partial hospitalization psychiatric addiction treatment	114	32.5%
Outpatient psychiatric addiction treatment	116	33.0%

Source: NABH survey of members conducted in 2019. Note: (%) is calculated by dividing n (the number of respondents in each designated category) by the total number of survey respondents (351 members).

Exhibit 2.4 In 2017, 36.8% of reporting NABH-members provided psychiatric services to children at inpatient hospitals, 27.6% in residential programs, 24.8% in partial hospitalization programs, and 27.4% in outpatient settings. Psychiatric services for adolescents were provided at 49.0% of the reporting inpatient hospital facilities, 39.0% of residential hospital facilities, and at about one-third of partial hospitalization and outpatient facilities (32.2% and 34.2%, respectively). While about half of the NABH-member facilities provided inpatient (55.8%), partial hospitalization (45.3%), and outpatient psychiatric care (47.6%) to adults, only under one-third of the residential facilities provided this service to them in 2017 (29.3%). Older adults received psychiatric services at half of the reporting inpatient facilities (51.0%), over one-third of the partial hospitalization (37.6%) and outpatient facilities (40.2%), and at just under one quarter of residential facilities (23.6%).

Exhibit 2.4 Psychiatric Services Provided at NABH-Member Organizations (All Respondents) by Age Groups, 2017

Population	Inpatient Hospital		Residential		Partial Hospitalization		Outpatient	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Children	129	36.8%	97	27.6%	87	24.8%	96	27.4%
Adolescents	172	49.0%	137	39.0%	113	32.2%	120	34.2%
Adults	196	55.8%	103	29.3%	159	45.3%	167	47.6%
Older adults	179	51.0%	83	23.6%	132	37.6%	141	40.2%

Source: NABH survey of members conducted in 2019. Note: (%) is calculated by dividing n (the number of respondents in each designated category) by the total number of survey respondents (351 members). Service categories are not mutually exclusive and will not sum to 100%.

Exhibit 2.5 In 2017, 16.8% of reporting NABH-members provided youth addiction treatment services in inpatient facilities, 13.1% in residential facilities, 10.3% in partial hospitalization facilities, and 12.5% in outpatient facilities. Adult addiction treatment was provided more frequently, especially in inpatient (36.2% of respondents), partial hospitalization (30.5% of respondents), and outpatient (31.6% of respondents) settings. However, adult addiction treatment was provided in residential treatment settings at a much lower proportion (13.4% of respondents) than other care settings.

Exhibit 2.5 Addiction Treatment Services Provided at NABH-Member Organizations (All Respondents) by Age Groups, 2017

Population	Inpatient Hospital		Residential		Partial Hospitalization		Outpatient	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Youth addiction treatment	59	16.8%	46	13.1%	36	10.3%	44	12.5%
Adult addiction treatment	127	36.2%	47	13.4%	107	30.5%	111	31.6%

Source: NABH survey of members conducted in 2019. Note: (%) is calculated by dividing n (the number of respondents in each designated category) by the total number of survey respondents (351 members). Service categories are not mutually exclusive and will not sum to 100%.

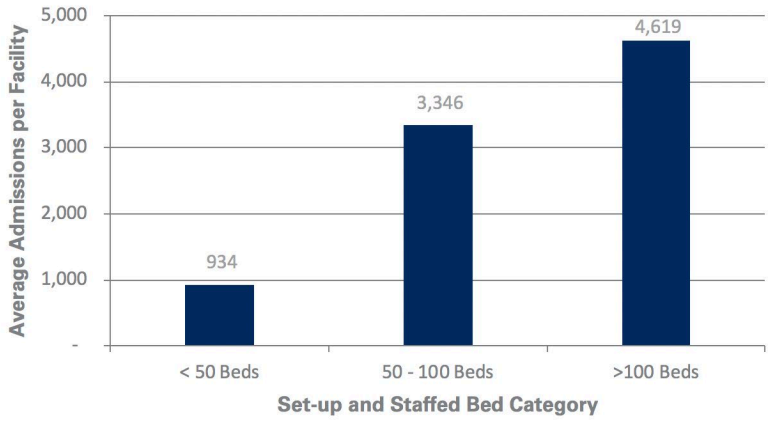
Inpatient Hospitalization

For the purposes of this report, inpatient hospitals include inpatient psychiatric hospitals and general hospital behavioral health units.

Inpatient Admissions, Length of Stay, and Days of Care

Exhibit 2.6 On average, inpatient hospitals with fewer than 50 beds reported 934 inpatient admissions, those with 50-100 beds reported 3,346 inpatient admissions, and those with more than 100 beds reported 4,619 admissions in 2017.

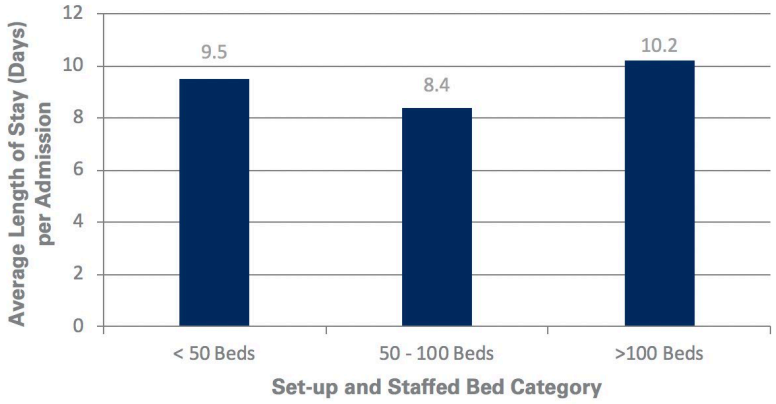
Exhibit 2.6 Average Inpatient Hospital Admissions per Facility by Facility Set-Up and Staffed Bed Category, 2017



Source: NABH survey of members conducted in 2019. 105 facilities (including 13 with fewer than 50 beds, 36 with 50 to 100 beds, and 56 with more than 100 beds) reported inpatient hospital admission data for 2017.

Exhibit 2.7 Facilities with fewer than 50 beds reported an average length of stay of 9.5 days, facilities with 50-100 beds reported an average length of stay of 8.4 days, and facilities with greater than 100 beds reported an average length of stay of 10.2 days in 2017.

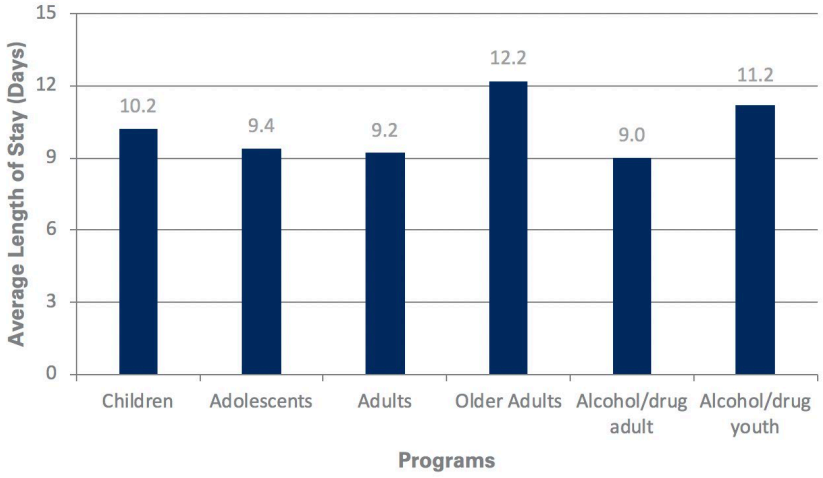
Exhibit 2.7 Average Inpatient Hospital Length of Stay per Admission by Facility Set-Up and Staffed Bed Category, 2017



Source: NABH survey of members conducted in 2019. Note: Average length of stay was calculated for the number of facilities that reported both total days of care and the number of admissions, and is calculated for only those facilities as average inpatient total days of care per facility divided by average inpatient hospital admissions per facility.

Exhibit 2.8 Lengths of stay at inpatient hospitals vary by program. On average, length of stay was the longest at 12.2 days for psychiatric programs aimed toward older adults, followed by 10.2 days for the programs aimed towards children, 9.4 days for adolescents, and 9.2 days for adults (excluding stays that met or exceeded 30 days). The average length of stay in adult drug/alcohol programs was the shortest at 9.0 days, and youths spent an average of 11.2 days in drug/alcohol programs. (Note: For year-to-year changes, see section three “Trends”.)

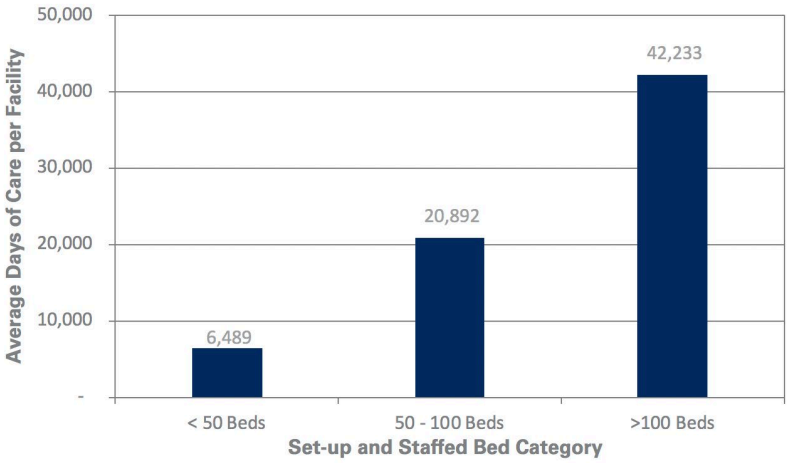
Exhibit 2.8 Average Length of Stay per Admission at Inpatient Hospitals by Program, 2017



Source: NABH survey of members conducted in 2019. 51 hospitals reported for child programs, 81 reported for adolescent programs, 98 reported for adult programs, 69 reported for older adult programs, 57 reported for alcohol and drug use programs for adults, and 5 hospitals reported information for alcohol and drug use programs for youths for 2017.

Exhibit 2.9 On average, inpatient hospitals with fewer than 50 beds provided 6,489 days of care, those with 50-100 beds provided 20,892 days of care, and those with more than 100 beds provided 42,233 days of care in 2017.[47]

Exhibit 2.9 Average Inpatient Hospital Days of Care per Facility by Facility Set-Up and Staffed Bed Category, 2017



Source: NABH survey of members conducted 2019. 152 facilities (including 21 with fewer than 50 beds, 56 with 50 to 100 beds, and 75 with more than 100 beds) reported days of care data for 2017.

Exhibit 2.10 Across all bed sizes at inpatient hospitals, 2017 observed 3,778 average admissions per facility, 8.6 days of average length of stay per facility, and 30,491 average total days of care per facility.

Exhibit 2.10 Average Inpatient Hospital Admissions, Length of Stay, and Days of Care by Facility Set-Up and Staffed Bed Category, 2017

Set-up & staffed bed categories	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
Average inpatient hospital admissions per facility	934	3,346	4,619	3,778
Average inpatient hospital length of stay per admission (mean)	9.5	8.4	10.2	8.6
Average inpatient hospital total days of care per facility	6,489	20,892	42,233	30,491

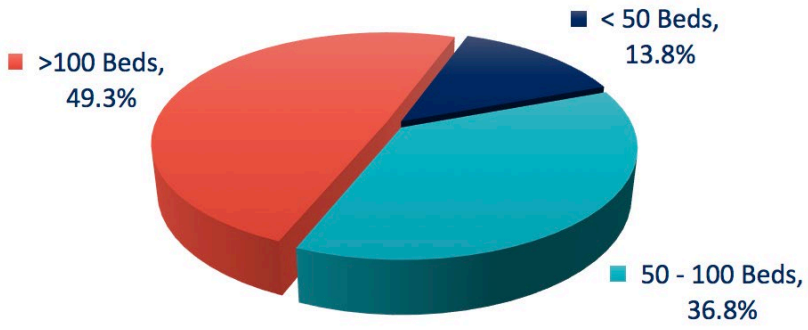
Source: NABH survey of members conducted in 2017. Note: Average length of stay was calculated for the number of facilities that reported both total days of care and the number of admissions, and is calculated for only those facilities as average inpatient total days of care per facility divided by average inpatient hospital admissions per facility.

[47] Readers should note that the values in Exhibits 2.6 and 2.9 reflect the responses of NABH members who answered the corresponding part of the question asked.

Inpatient Facility Size and Occupancy

Exhibit 2.11 Reported facility size of inpatient psychiatric hospitals varied, with 13.8% of inpatient hospitals having fewer than 50 set-up and staffed beds, 36.8% having 50-100 staffed beds, and 49.3% having more than 100 beds.

Exhibit 2.11 Inpatient Psychiatric Facility Size Reported by Set-Up and Staffed Bed Category, 2017



Source: NABH survey of members conducted in 2019. 152 facilities reported bed sizes for 2017.

Exhibit 2.12 The average occupancy rate in inpatient psychiatric hospitals with fewer than 50 beds was 78.5%, which was slightly higher than occupancy rates at inpatient hospitals with 50-100 beds (74.9%), and those with greater than 100 beds (76.2%). On average, occupancy was 76.0% across all facilities in 2017. Note that facilities with fewer than 50 beds were above the average occupancy rate, while those with between 50 and 100 beds were below the average occupancy rate.

Exhibit 2.12 Inpatient Psychiatric Occupancy Rate by Facility Set-Up and Staffed Bed Category, 2017

Set-up & staffed bed categories	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
25th percentile occupancy rate	73.6%	66.7%	66.0%	66.7%
Average occupancy rate	78.5%	74.9%	76.2%	76.0%
75th percentile occupancy rate	93.8%	84.9%	87.9%	87.5%

Source: NABH survey of members conducted in 2019. 12 facilities with fewer than 50 beds, 35 facilities with 50 to 100 beds, and 54 facilities with more than 100 beds reported for 2017.

Inpatient Expenses

Exhibit 2.13 provides a snapshot of national inpatient facility average expenses by bed size in 2017. Inpatient facilities with fewer than 50 beds reported the lowest average total hospital expenses at approximately $10 million. Those with 50-100 beds reported average total hospital expenses of approximately $26 million, and facilities with more than 100 beds reported average total hospital expenses of approximately $40.2 million.

Exhibit 2.13 Inpatient Psychiatric Average Total Expenses by Facility Set-Up and Staffed Bed Category, 2017

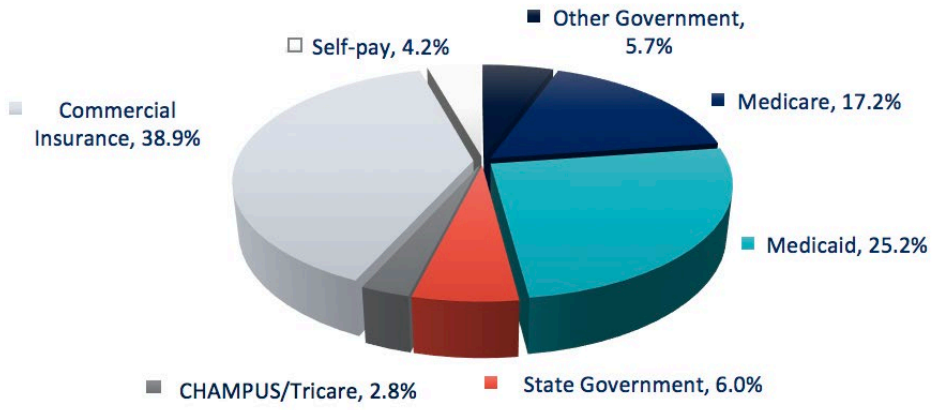
Set-up & staffed bed categories	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
Percent of inpatient facilities	11.7%	34.0%	54.4%	100.00%
Average hospital expenses per facility	$9,969,646	$26,081,088	$40,187,361	$31,873,457
Average inpatient hospital total days of care per facility	5,950	20,582	42,233	30,649

Source: NABH survey of members conducted in 2019. 12 facilities with fewer than 50 beds, 35 with 50 to 100 beds, and 56 facilities with more than 100 beds reported for 2017.

Payers for Services

Exhibit 2.14 and 2.15 show that payers for inpatient hospital services are a heterogeneous mix of public and private. Medicare (17.2%), Medicaid (25.2%), state government (6.0%), CHAMPUS/TRICARE (2.8%), and other government-funded patients (5.7%) accounted for 56.9% of all psychiatric inpatient hospital admissions in 2017, while commercially insured (38.9%) and self-pay (4.2%) patients accounted for 43.2% of total inpatient hospital admissions in 2017.

Exhibit 2.14 Psychiatric Inpatient Hospital Payers for Services, 2017



Source: NABH survey of members conducted in 2019. 117 facilities reported Medicare payments; 112 reported Medicaid; 59 reported State government; 93 reported CHAMPUS/TRICARE; 43 reported other government; 125 reported commercial insurance; and 110 reported self-pay.

Exhibit 2.15 Psychiatric Inpatient Hospital Payers for Services, 2017

Payer	(%)
Public	
Medicare	17.2%
Medicaid	25.2%
State/county/local government	6.0%
CHAMPUS/TRICARE	2.8%
Other government	5.7%
Total Public	**56.9%**
Private	
Commercial insurance	38.9%
Self-pay	4.2%
Total Private	**43.2%**
TOTAL	**100.0%**

Source: NABH survey of members conducted in 2019. Note: "Commercial insurers" includes payers such as Blue Cross/Blue Shield, employer contracts, and HMO/PPO or at-risk contracts. "Other" includes other governmental entities.

Residential Treatment

Residential treatment is defined for this report as overnight care in conjunction with an intensive treatment program in a setting other than a hospital. Residential treatment provides an essential service for many individuals, especially those who are experiencing acute crisis situations that require intensive resources. Residential treatment is provided by programs that are both hospital-based residential programs and freestanding.

Residential Admissions, Length of Stay, and Days of Care

Exhibit 2.16 In 2017, residential treatment centers (RTC) of all types – hospital-based and freestanding – that operated with fewer than 50 beds had 231 admissions on average, with an average length of stay of 26 days per admission and delivered an average of 5,964 days of care per facility. RTCs between 50 and 100 beds had 303 admissions on average, with an average length of stay of 67 days per admission and delivered 20,272 days of care. RTCs with greater than 100 beds had 722 admissions on average, with an average length of stay of 62 days per admission and delivered an average 44,722 days of care. Note that the average length of stay in facilities with more than 100 beds was shorter than those with 50 to 100 beds, and the average length of stay for all RTCs in 2017 was 58 days.

Exhibit 2.16 Average Residential Psychiatric Treatment Center Admissions, Length of Stay and Days of Care by Facility Set-Up and Staffed Bed Category, 2017[48]

Set-up & staffed bed categories/residential	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
Average residential admissions per facility	231	303	722	480
Average length of stay per admission	26	67	62	58
Average residential days of care per facility	5,964	20,272	44,722	28,047

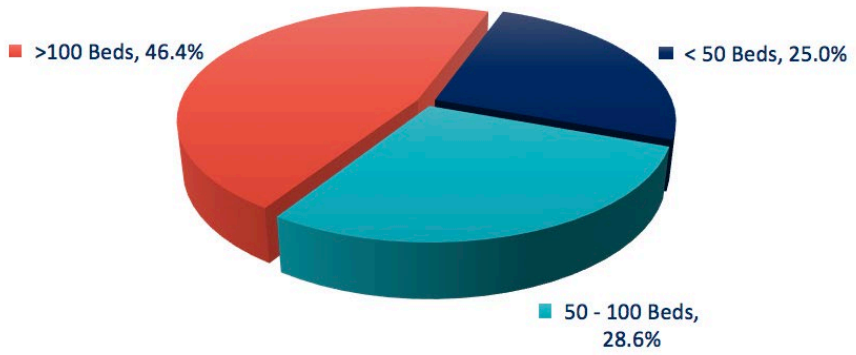
Source: NABH survey of members conducted in 2017. 55 facilities (including 7 with fewer than 50 beds, 8 with 50 to 100 beds, and 13 with more than 100 beds) reported average number of residential days of care in 2017. Note: Average length of stay was calculated for the number of facilities that reported both total days of care and the number of admissions, and is calculated for only those facilities as average total days of residential care per facility divided by average residential care admissions per facility.

[48] Average residential admissions multiplied by average length of stay does not exactly produce average number of residential days of care per year due to rounding.

Residential Facility Size and Occupancy

Exhibit 2.17 Reported facility size of freestanding and hospital-based residential psychiatric treatment facilities was more concentrated almost similarly in smaller and medium-sized facilities. RTCs with fewer than 50 beds comprised 25% of all RTCs reporting, and those with 50 to 100 beds comprised 28.6% of all RTCs reporting. Those with greater than 100 beds comprised 46.4% of all RTCs reporting bed size.

Exhibit 2.17 Residential Psychiatric Facility Size Reported by Set-Up and Staffed Bed Category



Source: NABH survey of members conducted in 2019. 28 residential treatment facilities reported for 2017.

Exhibit 2.18 Average occupancy in hospital-based and freestanding residential programs in all hospitals was 77.2% in 2017. In residential treatment centers with fewer than 50 beds, average occupancy was 75.7%. In those with 50 to 100 beds, average occupancy was 76.8%, and in those with more than 100 beds, average occupancy was 78.5%.

Exhibit 2.18 Residential Occupancy Rate by Facility Set-up & Staffed Bed Category, 2017

Set-up & staffed bed categories	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
Average residential occupancy (percentage)	75.7%	76.8%	78.5%	77.2%

Source: NABH survey of members conducted in 2019. Residential occupancy was reported by 31 facilities (including 9 with less than 50 beds, 10 with 50 to 100 beds, and 12 with more than 100 beds) for 2017.

Residential Expenses

Average total expenses in all residential programs (both freestanding and hospital-based combined) were approximately $13.2 million for an average of 26,379 days of care in 2017. Residential programs with fewer than 50 beds had an average total expense of $10.1 million and averaged 7,785 days of care, those with beds between 50 and 100 averaged at $9.3 million and provided an average 18,967 days of care, and those with greater than 100 beds had the highest average total expenses at $18,436,971 million and the highest average days of care at 45,884 days.

Residential Payers for Services

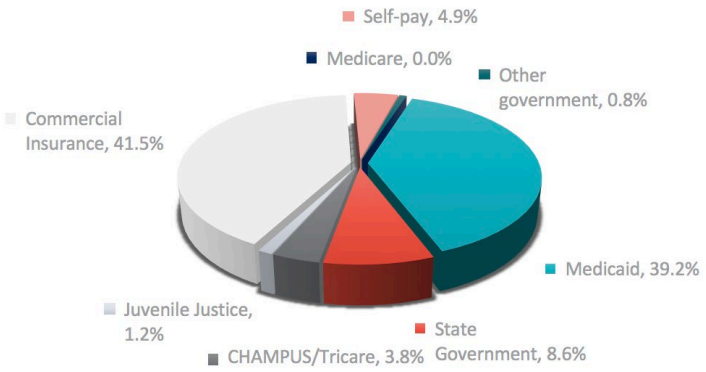
Exhibits 2.20 and 2.21 show that payers for residential admissions are both public and private. The majority of treatment funding, based on admissions, for both freestanding RTCs and hospital-based RTCs came from government sources in 2017 (53.6%). Government sources included Medicaid (39.2%), state government (8.6%), CHAMPUS/ TRICARE (3.8%), juvenile justice (1.2%), and other government sources (0.8%). Approximately 46.4% of payments came from private sources, including commercial insurers (41.5%) and self-payments (4.9%). Please note that there are no Medicare payments for residential care.

Exhibit 2.19 Residential Treatment Program Average Expenses, 2017 (in both freestanding RTCs and hospital-based RTCs)

Set-up & staffed bed categories	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
Average residential total expenses	$10,148,413	$9,289,503	$ 18,436,971	$13,206,163
Average number of residential days of care per year	7,785	18,967	45,884	26,379

Source: NABH survey of members conducted in 2019. 30 facilities (including 9 with fewer than 50 beds, 9 with 50 to 100 beds, and 12 with more than 100 beds) reported average total expenses for 2017.

Exhibit 2.20 Residential Payers for Services, 2017. (in both freestanding RTCs and hospital based RTCs)



Source: NABH survey of members conducted in 2019. 0 facilities reported Medicare payments; 32 reported Medicaid; 28 reported State government; 20 reported CHAMPUS/TRICARE; 7 reported juvenile justice; 8 reported other government; 43 reported commercial insurance; and 30 reported self-pay.

Exhibit 2.21 Residential Payers for Services, 2017. (in both freestanding RTCs and hospital based RTCs)

Payer	(%)
Public	
Medicare	0.0%
Medicaid	39.2%
State/county/local government	8.6%
CHAMPUS/TRICARE	3.8%
Juvenile justice	1.2%
Other government	0.8%
Total Public	**53.6%**
Private	
Commercial insurance	41.5%
Self-pay	4.9%
Total Private	**46.4%**
TOTAL	**100.0%**

Source: NABH survey of members conducted in 2019. Note: "Commercial insurers" includes payers such as Blue Cross/Blue Shield, employer contracts, and HMO/PPO or at-risk contracts. "Other" includes other governmental entities.

Partial Hospitalization

Partial hospitalization is defined for this report as a planned program of mental health treatment services generally provided to groups of patients in sessions lasting three or more hours. For some, partial hospitalization provides a transition from inpatient treatment and for others, it may help them avoid hospitalization. Partial hospitalization programs are organized in different ways – some offer programs during daytime hours, others at night. Typically, a partial hospitalization program provides a four to six-hour program for four or five days per week.

Partial Hospitalization Admissions, Visits Per Admission, and Visits

Exhibit 2.22 In 2017, partial hospitalization programs that operated with fewer than 50 beds had an average of 498 admissions per year, an average 10 visits per admission, with an average of 4,999 visits per year. Programs with beds between 50-100 had 849 admissions per year and 11.9 visits per admission on average, with an average 10,061 of visits per year. Partial hospitalization programs with more than 100 beds had an average of 642 admissions per year and 10 visits per admission, with an average of 6,427 visits per year. For all bed sizes, the average number of partial hospitalization admissions were 698 and visits per admission averaged at 10.7. There were 7,482 average number of visits per year.

Exhibit 2.22 Partial Hospitalization Admissions, Visits per Admission and Visits, 2017. (in psychiatric hospitals and general hospital behavioral health services)[49] [50]

Set-up & staffed categories	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
Average partial hospitalization admissions per year	498	849	642	698
Average number of partial hospitalization visits per admission (mean)	10.0	11.9	10.0	10.7
Average number of total partial hospitalizations visits per year	4,999	10,061	6,427	7,482

Source: NABH survey of members conducted in 2019. 60 hospitals (4 with fewer than 50 beds, 19 with 50 to 100 beds, and 37 with more than 100 beds) reported partial hospitalization admissions for 2017. Note: Partial hospitalization visits are not necessarily on consecutive days. Average visits per admission were calculated for the number of facilities that reported both total visits per year and the number of admissions, and is calculated for only those facilities as total average partial hospitalization visits per admission divided by total average partial hospital admissions per year.

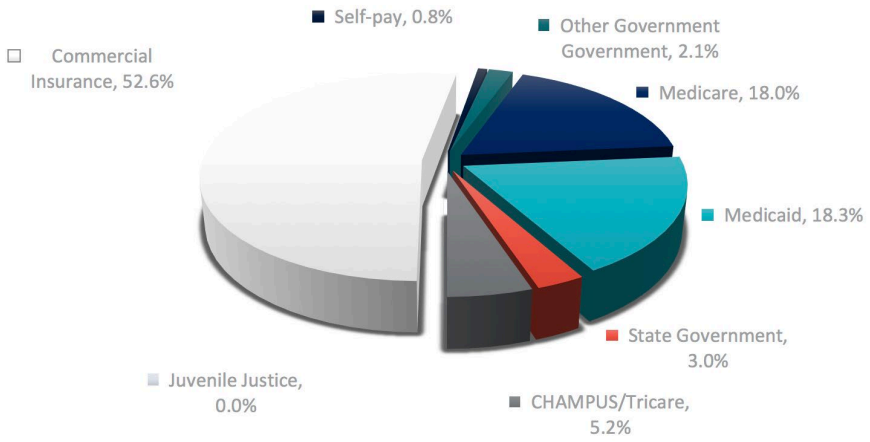
[49] The survey received only four respondents each for the fewer than 50 beds category, these data are not reported and not included in the overall averages to protect anonymity of respondents.

[50] Average partial hospitalization admissions multiplied by the average number of partial hospitalization visits per year does not exactly produce average number of total partial hospitalization visits per year due to rounding.

Partial Hospitalization Payers for Services

Exhibits 2.23 and 2.24 show that payers for partial hospitalization are both public and private. Approximately 46.6% of admissions came from patients who were insured through governmental sources in 2017, including Medicare (18.0%), Medicaid (18.3%), state government (3.0%), CHAMPUS/TRICARE (5.2%), and other government sources (2.1%). Approximately 53.4% of partial hospitalization admissions came from privately insured patients, including commercial insurance (52.6%) and self-payments (0.8%).

Exhibit 2.23 Partial Hospitalization Payers for Services, 2017



Source: NABH survey of members conducted in 2019. 57 facilities reported Medicare payments, 37 reported Medicaid, 11 reported State government, 46 reported CHAMPUS/TRICARE, 0 reported juvenile justice, 18 reported other government, 66 reported commercial insurance, and 45 reported self-pay.

Exhibit 2.24 Partial Hospitalization Payers for Services, 2017. (in psychiatric hospitals and general hospital behavioral health services)

Payer	(%)
Public	
Medicare	18.0%
Medicaid	18.3%
State/county/local government	3.0%
CHAMPUS/TRICARE	5.2%
Juvenile Justice	0.0%
Other government	2.1%
Total Public	**46.6%**
Private	
Commercial insurance	52.6%
Self-pay	0.8%
Total Private	**53.4%**
TOTAL	**100.0%**

Source: NABH survey of members conducted in 2019. Note: "Commercial insurers" includes payers such as Blue Cross/Blue Shield, employer contracts, and HMO/PPO or at-risk contracts. "Other" includes other government entities.

Outpatient Care

Outpatient services are behavioral healthcare services provided to ambulatory patients on an individual, group, or family basis, generally for fewer than three hours in a single visit. Regular outpatient services are typically provided once or twice per week, whereas intensive outpatient services comprise a prescribed course of treatment in which the patient receives outpatient care no less than three times per week. Intensive outpatient services may include more than one service per day.

Outpatient Admissions and Visits

In 2017, there was an average of 586 admissions (745 regular admissions and 426 intensive admissions) for an overall average of 6,315 outpatient visits (7,669 regular visits and 4,961 intensive visits) within reporting NABH-member specialty hospitals and psychiatric units of all bed sizes. This number is based on data for psychiatric hospitals and general hospital behavioral healthcare units.

Exhibit 2.25 Outpatient Admissions and Visits (Regular and Intensive) by Facilities' Set-Up and Staffed Bed Capacity, 2017

Set-up & staffed categories	< 50 beds	50 - 100 beds	> 100 beds	All bed sizes
Average outpatient admissions (intensive)	198	276	609	426
Average outpatient admissions (regular)	964	81	917	745
Total average outpatient admissions (regular + intensive)	581	178	763	586
Average outpatient visits (intensive)	2,074	4,070	7,011	4,961
Average outpatient visits (regular)	11,597	2,625	8,009	7,669
Overall average outpatient visits per year (regular + intensive)	6,836	3,347	7,510	6,315

Source: NABH survey of members conducted in 2019. For facilities with less than 50 beds: 18 facilities reported for intensive and regular admissions, and 20 facilities reported for intensive and regular visits. For facilities with 50-100 beds: 15 reported for both admissions, and 18 reported for both visits. For facilities with greater than 100 beds: 35 reported for both admissions, and 36 reported for both visits. All data are reported for 2017.

TREND ANALYSIS

Aggregate trends shown in the NABH Annual Survey over time

As the survey is completely voluntary, different facilities respond from one year to the next. This remains relevant for the 2019 survey data as well. As different mixes of providers reply to the survey every year, the variations in the mix of provider types has an impact on the data reported. In some instances, site specific differences predominate, and no apparent consistency or trends in reporting are observed across time. In other instances, however, statistics are comparable across years, suggesting consistency in care provision across NABH members. Finally, in a few instances, emerging trends appear.

Additionally, changes in care volume capacities at different facility types may also have an impact on the variations observed across facility set-ups. We believe, however, that these trends provide an opportunity to gain useful information.

Exhibit 3.1 shows that in the four Annual Surveys published from 2016-2019, reporting on data from 2014-2017, responding facilities have reported that inpatient admissions per facility, average length of stay, and average total days of care follow similar patterns.

Average inpatient admissions per facility decreased from 3,987 in 2016 to 3,301 in 2018, but then increased to 3,778 in 2019 – close to the 2016 figure. Thus, the number of admissions to inpatient hospitals has remained relatively consistent across the period despite the changes in the make-up of survey respondents each year.

Similarly, the average length of stay for reporting inpatient hospitals has increased from 7.6 days in 2016 to 8.4 days in 2017, and then 8.8 days in 2018. This length of stay slightly decreased to 8.6 in 2019. The trend in average length of stay for inpatient hospitals is relatively flat with a slight rise, suggesting that the mix of respondents has no major impact on the reported data for average length of stay in inpatient hospitals, allowing us to observe a modest increase in length of stay over time.

For inpatient hospitals, average total days of care for reporting inpatient facilities has fluctuated only slightly from 2016-2019 – showing a slight increase from 29,974 days in 2016 to 30,491 days in 2019. However, as this value holds steady at around 30,000 days and shows no clear trend, this data is suggestive of the fact that changes in the inpatient hospital respondent cohort from one year to the next do not have an effect on average inpatient total days of care for these facilities. It is likely that relatively fixed target capacities in inpatient hospitals allow for average inpatient admissions, length of stay and total days of care to remain mostly steady throughout the years, despite a varying mix of NABH-member respondents.

By way of contrast, the make-up of participating providers appears to have a strong impact in the reporting of residential treatment center admissions. As seen in **Exhibit 3.1**, average residential admissions increased from 261 days in 2016 to 1,016 days in 2017, and then decreased to 860 days in 2018, decreasing further to 480 days in 2019. These large variations in residential admissions likely indicate that the differences in responding facilities have a large effect on reported RTC admissions in any given year, or that the market demand is highly unstable.

Likewise, the average length of stay reported for residential programs shows a decline from 108 days in 2016 to 30 days in 2017, 35 days in 2018, and then a slight increase to 58 days in 2019. These disparities in the average length of stay from year to year clearly demonstrate once again,

that for residential treatment, the mix of participating respondents is important, indicating very different use of residential treatment in terms of the balance of the average length of stay as compared to the number of admissions.

Th data shows that average residential treatment days of care per year increased from 28,168 days in 2016 to 30,123 days in 2017, and then decreased slightly to 30,071 days, before falling to 28,047 days in 2019. These data reflect relatively small differences in residential treatment days of care across reporting facilities over time despite rather large differences in admissions and lengths of stay. This would indicate comparable capacity (total days) with a different mix of admissions and average length of stay across residential treatment facilities over time. This report shows that as the average number of residential admissions and average residential length of stay per facility fluctuate over time, the average number of residential days holds steady. This pattern is likely observed due to a fixed target capacity of residential treatment centers.

Exhibit 3.1 Average Admissions, Length of Stay and Days of Care, by Facilities' Set-up & Staffed Bed Categories for Inpatient Hospital and Residential Treatment Centers, 2016-2019

Set-up & staffed bed categories— inpatient/residential Mean across all bed sizes	2016*	2017*	2018*	2019*
Average inpatient hospital admissions per facility	3,987	3,438	3,301	3,778
Average inpatient hospital length of stay per facility (mean)	7.6	8.4	8.8	8.6
Average inpatient hospital total days of care per facility	29,974	28,921	29,031	30,491
Average residential admissions per facility	261	1,016	860	480
Average residential length of stay per facility (mean)	108	30	35	58
Average number of residential days of care per year	28,168	30,123	30,071	28,047
Response Rate of NABH Members[51]	41.9%	52.4%	39.3%	39.0%
n=Number of survey respondents per year	259	330	249	351
N=Total number of NABH Members per year	617	630	608	933

**Note: The years correspond to the year of publication of the NABH Annual Reports. They respectively report data from 2014-2017.*

[51] Readers should note that the NABH membership grew from around 617 hospitals and treatment centers in 2016 to include more than 900 hospitals and treatment centers in 2019 which shows that even though the response rate has remained about the same, the number of responding facilities has increased.

Exhibit 3.2 shows that average partial hospital admissions increased from 740 in 2016 to 936 in 2017, remained flat at 953 in 2018, and then decreased to 698 in 2019. At the same time, the average number of partial hospitalization visits per admission fluctuates between 9.8 and 13.4. Respondents' number of total partial hospitalization visits per year increased from 7,545 in 2016 to 12,558 in 2017. This is an example of survey participation possibly driving the findings. In 2018, the number of visits decreases to 9,350 and then decreases further to 7,482 in 2019. This exhibit points to a key finding that partial hospitalization reporting is driven by the type of respondent facilities in the survey, especially for total partial hospitalization visits per year. Fluctuations observed in average partial hospitalization admissions, visits per admission, and visits per year indicate that the capacity of partial hospitalization settings may be amenable to change in survey participants from one year to the next.

Exhibit 3.2 Average Number of Partial Hospitalization Admissions per Year, Visits per Admission, and Visits per Year, by Facilities' Set-up & Staffed Bed Categories for Partial Hospitalization Programs, 2016-2019

Set-up & staffed categories—Partial Hospitalization Mean across all bed sizes	2016*	2017*	2018*	2019*
Average partial hospitalization admissions per year	740	936	953	698
Average number of partial hospitalization visits per admission (mean)	10.2	13.4	9.8	10.7
Average Number of total partial hospitalization visits per year	7,545	12,558	9,350	7,482

**Note: The years correspond to the year of publication of the NABH Annual Reports. They respectively report data from 2014-2017.*

Exhibit 3.3 shows that there is a sharp fluctuation in the total of intensive and regular outpatient admissions from 2016-2018, followed by a sharp decline in 2019. In terms of total admissions (intensive + regular), we see 582 in 2016, increasing to 1,539 in 2017. Total admissions decrease slightly to 1,365 in 2018 before further decreasing to 586 in 2019. This volatility is likely driven by the mix of survey respondents.

This exhibit also shows an increase in the number of overall average outpatient visits (intensive and regular), growing from 4,575 in 2016 to 12,363 in 2017. This increases again in 2018 to 15,818 and then decreases to 6,315 in 2019. The mix of outpatient responses is highly variable over time indicating a varied mix of respondents. These outpatient statistics would suggest that the reliance on outpatient admissions as part of the overall service mix is highly dependent on the particular providers reporting. This would suggest that the NABH membership is highly varied in its provision of outpatient services as a care modality.

Exhibit 3.3 Average Outpatient Admissions and Visits per Year (Intensive and Regular) by Facilities' Set-up and Staffed Bed Capacity for Outpatient Care, 2016-2019

Set-up & staffed bed categories— Outpatient Mean across all bed sizes	2016*	2017*	2018*	2019*
Average outpatient Admissions per year (Intensive)	347	818	942	426
Average outpatient admissions per year (Regular)	874	2,261	1,788	745
Total average outpatient admissions per year (Intensive + Regular)	582	1,539	1,365	586
Average outpatient visits per year (Intensive)	7,020	10,580	9,987	4,961
Average outpatient visits per year (Regular)	5,795	14,146	21,650	7,669
Overall average outpatient visits per year (Intensive + Regular)	4,575	12,363	15,818	6,315

**Note: The years correspond to the year of publication of the NABH Annual Reports. They respectively report data from 2014-2017.*

Exhibit 3.4 shows that the payer mix for inpatient care remained constant at between 55 and 60 percent being public throughout the observed four years of the survey. Given the change in the mix of responding providers, this indicates a high level of stability in public funding for inpatient care. The exception being that, for residential facilities, the payer mix is 94 percent public in 2016 and decreases to 81.7 percent in 2017. Public payers further decrease to 56.3 percent in 2018 and 53.6 percent in 2019. This decline in the public funding of RTCs is the strongest trend observed in the 2019 survey. Partial hospitalization shows the same steady public contribution we observe for inpatient care. The proportion of public payers range between 43.8 and 48.6 percent over the period. Of note, when compared to the 2015 data for the national distribution of MH and SUD expenditures by payer type reported by SAMHSA (as seen in **Exhibit 1.7**), where the proportion of public and private payers' expenditures are roughly 50/50, the proportion of public and private payers' total inpatient, residential, and partial hospitalization funding for care reported in 2019 for 2017 is approximately 50/50 for each of the payer types as well. In this context, survey respondents seem to reflect the national trend.

Exhibit 3.4 Inpatient Hospital, Residential Treatment and Partial Hospitalization Program Payers for Services, 2016-2019

Payers for Services	2016		2017		2018		2019	
	Public	Private	Public	Private	Public	Private	Public	Private
Inpatient	55.4%	44.6%	58.3%	41.6%	56.9%	43.1%	56.9%	43.2%
Residential	94.0%	6.0%	81.7%	18.4%	56.3%	43.7%	53.6%	46.4%
Partial Hospitalization	43.8%	56.2%	48.6%	51.5%	46.6%	53.4%	46.6%	53.4%

Information collected from the Annual Survey over the past four years suggests that behavioral health treatment varies across the mix of reporting facilities one year to the next. The NABH membership is diverse and includes facilities ranging from hospitals to freestanding residential treatment centers and variations in between. Yet, despite these differences in reporting, facilities report consistent findings each year for many core statistics such as average total admissions, average total days of care, average length of stay, and so on. Moreover, the distribution of payer mix observed in the NABH-member population in 2017 as reported in 2019 is largely the same as observed in the SAMHSA's 2015 national MH and SUD spending as shown in **Exhibit 1.7**. As we continue to analyze the Annual Survey, it is important to consider where these high-level consistencies and inconsistencies occur, and what they mean for the facilities reporting (and not reporting) and, more generally, the NABH membership overall.

Within the observed time period of 2016 to 2019, the behavioral healthcare field has experienced an increasing impact of the opioid epidemic. Larger societal changes may help to explain why respondents are reporting a different mix of outpatient care one year to the next.

In conclusion, while the data reported in each year's Annual Survey is often influenced by the respondent NABH-member organizations for that year, this year's report shows that our data generally reflects trends that are consistent throughout the years. Additionally, the reported data on payer mix for services across reporting NABH-member organizations is similar to the national 2015 data observed in overall MH and SUD spending. Finally, NABH-member organizations as a whole continue to provide a consistent mix of treatment modalities and life-saving care to individuals with mental health and substance use disorders.

ABOUT THE SURVEY

Survey Name

As per the change in 2018, the NABH Annual Survey is named to reflect the date of its publication. This report is the "2019 NABH Annual Survey." It provides results from a member survey conducted in 2018, in which respondents reported 2017 data.

Survey Respondents

The response rate, coupled with the representative geographic and ownership distribution of the respondents, helps to present an accurate view of trends in the field.

Exhibit 4.1 While the number of responses from specialty inpatient hospitals and freestanding residential treatment centers for psychiatric care increased from 2016 to 2017, the number of general hospitals and freestanding residential treatment centers offering substance abuse care remained about the same, and the number of freestanding residential treatment centers offering psychiatric care increased. The majority of respondents to this survey are hospital-based behavioral healthcare systems (n=127) that operate programs with specialty inpatient hospitals.

Exhibit 4.1 Distribution of Survey Respondents, 2016 and 2017.

Type of Organization	2016 (n)	2016 (%)	2017 (n)	2017 (%)
Specialty Inpatient Hospital	109	45.6%	127	44.7%
General hospital behavioral healthcare service / unit	45	18.8%	46	16.2%
Freestanding residential treatment center – Substance Abuse	40	16.7%	39	13.7%
Freestanding residential treatment center – Psychiatric	31	13.0%	65	22.9%
Other	14	5.9%	7	2.5%
Total	***239**	**100.0%**	***284**	**100%**

*Source: NABH survey of members conducted in 2017/2018. *10 respondents did not provide information on facility type in 2016 and 67 respondents did not provide this information in 2017.*

Exhibit 4.2 Behavioral health systems belonging to NABH operate facilities in all parts of the U.S. A geographically representative sample of the hospitals and residential treatment centers within the NABH membership responded to this Annual Survey. This year, 933 respondents received the NABH survey (including freestanding hospitals, psychiatric units/ divisions in general hospitals, and residential treatment centers). healthcare systems (n=127) that operate programs with specialty inpatient hospitals.

Exhibit 4.2 Respondents (vs. NABH Membership) by Census Region, 2017.

Census Region	NABH Membership 2017		Survey Respondents 2017 Survey	
	(n)	(%)	(n)	(%)
New England	50	5.36%	16	4.56%
Middle Atlantic	97	10.40%	35	9.97%
South Atlantic	230	24.65%	81	23.08%
East North Central	87	9.32%	42	11.97%
East South Central	96	10.29%	40	11.40%
West North Central	48	5.14%	18	5.13%
West South Central	129	13.83%	47	13.39%
Mountain	90	9.65%	41	11.68%
Pacific	104	11.15%	29	8.26%
U.S. Associated Areas	2	0.21%	2	0.57%
Total	**933**	**100.0%**	**351**	**100.0%**

Source: 2017 NABH Membership List, NABH survey of members conducted in 2017. Note: This membership total only includes the psychiatric hospitals, psychiatric units in general hospitals, and residential treatment centers that received the 2017 Annual Survey. The NABH membership includes more than 700 total entities, including all the above plus schools, partial hospitalization programs, outpatient centers, and more.

Exhibit 4.3 Of the 933 members who had access to the survey, 351 NABH-member facilities (37.6%) responded with information that also included their location. When analyzed for geographic distribution, survey response rate was the highest for states in the East North Central region (67.74%) and lowest for the states in the New England region (34.04%).

Exhibit 4.3 Response Rate by Census Region, 2019.

Census Region	Sent Survey	Responded to Survey	Response Rate
	(n)	(n)	(%)
New England	50	16	34.04%
Middle Atlantic	97	35	52.24%
South Atlantic	230	81	46.02%
East North Central	87	42	67.74%
East South Central	96	40	63.49%
West North Central	48	18	48.65%
West South Central	129	47	51.09%
Mountain	90	41	66.13%
Pacific	104	29	34.94%
U.S. Associated Areas	2	2	100.00%
Total	**933**	**351**	**37.6%**

Source: 2017 NABH Membership List, NABH survey of members conducted in 2017.

Cautions in Using Data

Throughout this document unless otherwise indicated, (n) refers to the item response; the number of responses to each individual question (not the total number of respondents to the survey). For example, in **Exhibit 2.3** on "Level of Care Provided":

	(n)	(%)
Inpatient Hospital Psychiatric care	**98**	**39.4%**

the (n) means that 210 facilities out of the 351 that responded offer this level of care, which is 59.8% of respondents - not that 59.8% of 210 facilities provide this care.

In tables where responses total 100%, the percentages indicate the percentage of the 351 respondents that each line item represents.

A "system" is defined as all behavioral healthcare operations under the same ownership (or management) in a defined regional, state, or national area. A system member may be, for example, a corporation or a psychiatric hospital that operates, owns, or manages multiple levels or sites of care. System members may also be organizations offering specialized levels of care (such as psychiatric units in general hospitals, partial hospitalization, or residential treatment) that coordinate with the broader health-delivery system.

About NABH

The National Association for Behavioral Healthcare (NABH) advocates for behavioral healthcare and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective treatment and prevention programs for children, adolescents, adults, and older adults with mental and substance use disorders. The organization was founded as the National Association of Private Psychiatric Hospitals in 1933 and changed its name to the National Association of Psychiatric Health Systems in 1993. In 2018, the association rebranded to the National Association for Behavioral Healthcare.

For more information on this survey or the association, please contact NABH at 900 17th Street, NW, Suite 420, Washington, DC 20006-2507; Phone: 202/393-6700; Fax: 202/783-6041; Email: NABH@NABH.org; Web: www.NABH.org.

GLOSSARY

Glossary of Terms

Organizations responding to the National Association for Behavioral Healthcare's Annual Survey are instructed to use the following definitions when completing the data-collection instrument.

Admissions (inpatient): Persons admitted or readmitted to inpatient services, as well as persons who have returned from long-term leave or transferred from non-inpatient (e.g., outpatient or partial hospitalization care) components of organizations.

Adolescent: Age 13 through 17 years.

Adult: Age 18 through 64 years.

Average length of stay: Average length of stay was calculated for the number of facilities that reported both total days of care and the number of admissions, and is calculated for only those facilities as average total days of care per facility divided by average admissions per facility.

Census Divisions:
New England = CT, ME, MA, NH, RI, VT;
Middle Atlantic = NJ, NY, PA;
South Atlantic = DE, DC, FL, GA, MD, NC, SC, VA, WV;
East North Central = IL, IN, MI, OH, WI;
East South Central = AL, KY, MS, TN;
West North Central = IA, KS, MN, MO, NE, ND, SD;
West South Central = AR, LA, OK, TX;
Mountain = AZ, CO, ID, MT, NV, NM, UT, WY;
Pacific = AK, CA, HI, OR, WA;
U.S. Associated Areas = American Samoa, Guam, Marshall Islands, Puerto Rico, Virgin Islands

Child: Less than 13 years of age.

Expenses: All operating and non-operating expenses, excluding capital expenditures.

Inpatient care: Provision of 24-hour care in a hospital setting.

Intensive outpatient services: A prescribed course of treatment in which the patient receives outpatient care no less than three times a week (which may include more than one service/day).

Intensive residential services: Intensively staffed housing arrangements for clients/patients. May include medical, psychosocial, vocational, recreational, or other support services.

Licensed bed capacity: Official maximum number of inpatient psychiatric hospital beds authorized by state licensure.

Mean: The average of a set of values.

Medicaid (Title XIX): The federal-state medical assistance program designed to pay for healthcare services used by eligible people. It is operated and partially funded by the states under general federal rules and with federal financial assistance.

Medicare (Title XVIII): The federal health insurance program that provides protection to persons 65 years of age and over and to persons eligible for Social Security Disability payments for more than two years.

Occupancy rate: Average daily census for the year divided by number of set-up and staffed beds.

Older adult: Age 65 and older.

Outpatient services (regular): A standard office visit no more than two times a week.

Partial hospitalization: A planned program of mental health treatment services provided to groups of patients with three or more sessions per day.

Program: An organized set of therapeutic activities, which, under professional guidance, has as a goal the treatment of a psychiatric and/or substance abuse disorder or the reduction of the impairment resulting from a psychiatric and/or substance abuse disorder. Five frequently encountered programs (child, adolescent, adult, older adult/geriatrics, and alcohol and/or drug use programs) have been identified.

Residential treatment care: Overnight care in conjunction with an intensive treatment program in a setting other than a hospital.

Staffed bed capacity: Actual number of inpatient psychiatric beds set-up, staffed, and available for service.

Young adult: Ages 18-21.

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