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Addiction treatment centers' progress in preparing for health care reform

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Abstract

The Patient Protection and Affordable Care Act (PPACA) is expected to significantly alter addiction treatment service delivery. Researchers designed the Health Reform Readiness Index (HRRI) for addiction treatment organizations to assess their readiness for the PPACA. Four-hundred twenty-seven organizations completed the HRRI throughout a three-year period, using a four-point scale to rank their readiness on 13 conditions. HRRI results completed during two different time periods (between 10/1/2010–6/30/2011 and 9/1/2011–9/30/2012) were analyzed and compared. Most respondents self-assessed as being in the early stages of preparation for 9 of the 13 conditions. Survey results showed that organizations with annual budgets <\$5 million (n = 295) were less likely to be prepared for the PPACA than organizations with annual budgets >\$5 million (n = 132). The HRRI results suggest that the addiction field, and in particular smaller organizations, is not preparing adequately for health care reform; organizations that are making preparations are making only modest gains.

Keywords

Health care reform; organizational change; health care delivery; health reform readiness

1. Introduction

On January 1, 2014, most major provisions of the Patient Protection and Affordable Care Act (PPACA) will be phased in, resulting in a significant change to how health care in the United States is delivered and health insurance coverage provided (Patient Protection and Affordable Care Act [PPACA], 2010; PPACA, Sec. 1101; Connors & Gostin, 2010; Garfield, Lave, & Donohue, 2010). Health reform through PPACA seeks to increase health care insurance coverage and reduce health care costs by improving: prevention and wellness (PPACA, Title IV, Sec. 4001–4402); integrated care (PPACA, Sec. 3502); health

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Competing interests

The authors declare that they have no competing interests.

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information technology implementation (PPACA, Sec. 1561); evidence-based treatment (PPACA, Sec. 4105); workforce development (PPACA, Title V, Sec. 5001–5701); and quality management (PPACA, Sec. 2717) in the health care delivery system. The PPACA includes coverage for behavioral health services, and is expected to insure 5.5 million people with mental health or addiction disorders who were previously without coverage (Manderscheid, 2010).

Two provisions of PPACA are projected to have a significant impact on the addiction treatment system: the integration of primary and specialty health care and the use of traditional health insurance plans to provide health coverage within newly formed health exchanges (Croft & Parish, 2012). The existing separation of mental health, addiction, and physical health care systems make it difficult for individuals with co-occurring disorders to receive the care they need (Kessler, Stafford, & Messier, 2009; Pincus et al., 2007). The medical home concept that accompanied the PPACA legislation supports the need to treat the “whole person” by integrating physical health, addiction treatment, mental health, and support services such as housing and vocational services (Mechanic, 2012). Policy makers predict that all of these changes will reduce the number of publicly funded organizations that operate outside the traditional health system, with separate mechanisms for financing and delivering services. (Buck, 2011; Garfield et al., 2010.)

Medical home models, along with PPACA sanctioned health plans, are expected to require addiction treatment providers to make several adjustments in their approaches to clinical care. Treatment counselors will need to: adhere to credentialing standards that require advanced degrees many of them do not have (Roy & Miller, 2012); use evidence-based practices such as medication-assisted treatment (Mechanic, 2012; el-Guebaly, 2012); and apply data measures to monitor patient progress and outcomes (Chassin, Loeb, Schmaltz, & Wachter, 2010).

In addition to changes to clinical care, the PPACA will call upon health organizations to have certain infrastructure capabilities, such as an electronic health record that affords data portability between health entities (Popovits, 2010). They must also have fee-for-service billing mechanisms to participate in Medicaid programs or health plans associated with the health exchanges (Barry & Huskamp, 2011). Unfortunately, many treatment organizations lack not only the infrastructure for health information technology or billing systems; they also may lack awareness of the pressing need to put these systems in place to fully participate in the new environment of health care reform. Concern over this lack of awareness prompted the development of the Health Reform Readiness Index (HRRI), a tool that publicly funded community-based addiction treatment organizations can use to gauge their readiness for health reform.

1.1 Health Reform Readiness Index

The HRRI was developed as part of the Accelerating Reform Initiative (ARI), a demonstration project conducted in 2010 by NIATx. NIATx, based at the University of Wisconsin–Madison, is a national resource center dedicated to improving the quality of addiction treatment (Robert Wood Johnson Foundation, 2013). The HRRI development process had four phases. In Phase 1, researchers drafted a survey instrument based on their knowledge of the PPACA and the ARI organizations’ reports of what they needed to do to prepare for this legislation. In Phase 2, the ARI organizations were asked to pilot test the survey by applying the instrument to their organizations. After the pilot test, the organizations gave feedback on the survey questions’ clarity and how they measured intended PPACA constructs. In Phase 3, researchers revised the survey based on the focus group feedback. During Phase 4 of survey development, which occurred five months after initial survey completion, the ARI participants once again applied the survey and provided

feedback to assure the survey's ability to measure intended constructs. The feedback provided supported the construct validity of the survey and this version of the survey was used for the Health Reform Readiness Index (HRRI) assessment described in this study. The development of the HRRI tool and its initial application are described in greater detail in Molfenter, Capoccia, Boyle, and Sherbeck (2012).

The HRRI includes two categories of reform readiness conditions: "Building Blocks," and "Your Organization." The Building Block conditions include 1) Patient/Family Role, 2) Evidence-Based Treatment, 3) Accountability for Patient Care, and 4) Integrated Continuum of Care. "Your Organization" conditions consist of 5) Board of Directors, 6) Workforce, 7) Patient Record, 8) Holistic (or Integrated) Care, 9) Outcomes Measurement, 10) Quality Management, 11) Patient Health Technology, 12) Administrative Information Technology (IT), and 13) Finances. Each condition has an indicator of health reform readiness. (Table 1)

The HRRI survey was designed as: 1) A self-assessment survey to be completed on the NIATx website (NIATx HRRI, 2010); 2) An opportunity for addiction agencies to create awareness of what's needed to thrive in the changing landscape of addiction treatment and health care; and 3) A method to gather information on the collective status of health reform readiness among addiction treatment agencies in the United States. This research will report the overall readiness of addiction treatment centers to meet the expected needs of the PPACA. It will also describe the changes in readiness that occurred between two time periods when data was collected: Time Period 1 (T1), October 1, 2010 through June 30, 2011, and Time Period 2 (T2), September 1, 2011 through September 30, 2012.

2. Materials and Methods

The HRRI survey was placed on the NIATx website in October 2010 and was available to addiction treatment administrators and providers from around the United States who were interested in completing the survey. A set of health reform resources, along with a link to the HRRI survey, was included in the October 2010 NIATx eNews, an electronic newsletter. The eNews is distributed to a 4,982 member e-mail list developed from the e-mail addresses of participants of NIATx activities. In addition to the eNews announcement, those who registered for the 2011 NIATx Summit and State Associations of Addiction Services (SAAS) National Conference were encouraged to complete the online survey prior to attending the conference in July. Convenience samples were collected between October 1, 2010–June 30, 2011 and September 1, 2011–September 30, 2012 and were compiled using Microsoft SQL Server software. A prominent link to the HRRI survey was present on the NIATx website during this time period. Since only n=4 respondents completed the survey between July 1, 2011 and August 30, 2011, this time period was excluded from the analysis.

The HRRI began with questions about organizational characteristics (addiction services offered, number of patients served per year, and annual budget), and followed with 13 questions on key conditions for health reform readiness. Survey respondents selected an option to best describe their organization's capacity for each condition. Based on the option selected, the index then assigned a readiness level from a four-point scale: 0 = Needs to Begin; 1 = Early Stages; 2 = On the Way; 3 = Advanced. The research team opted against the five-point scales commonly used in organizational assessments (Lehman, Greener, & Simpson, 2002; Cinite, Duxbury, & Higgins, 2009), choosing instead to develop an ordinal scale that provides three progressive options for each condition. A fourth option was added for those organizations that had demonstrated no progress and needed to begin within a condition.

The data was analyzed using Microsoft Excel and SPSS software. An analysis of the organizational characteristics of the survey participants as compared to the population of NIATx participants and national data is described below in Section 3, “Results.”

For data analysis in this paper, the socio-demographic data are reported as percentages. The HRRI measures are reported as means. The study tested for significant differences of $p < .01$ between 1) Time Period 1 (October 1, 2010 – June 30, 2011) and 2) Time Period 2 (September 1, 2011 – September 30, 2012) for each individual HRRI measure. This study also tested for significant differences for the individual HRRI measures, comparing organizations with budgets of greater and less than \$5M for Time Period 1, Time Period 2, and overall (Time Periods 1 and 2). The \$5M budget cut-off was based on information from directors of addiction treatment organizations who helped develop the HRRI. They estimated that an organization needs a budget of at least \$5M to implement and maintain the infrastructure PPACA legislation requires. For the study’s comparison analyses, a Kendall tau-b test of association between ordinal variables was used to test differences.

3. Results

Organization characteristics

Organizations participating—427 organizational surveys were included in the study. In Time Period 1, $n=257$ unique organizations participated. For Time Period 2, $n=170$ unique organizations participated. More organizations ($n=257$) completed the HRRI during the first period, most likely because organizations registering for a national conference (the 2011 NIATx Summit/SAAS National Conference) were encouraged to complete the HRRI as part of the conference planning activity. The potential impacts of health reform were also receiving increased attention across the addiction treatment field at that time.

Substance abuse treatment services provided—Eighty-eight percent of the 427 survey participants provide outpatient services, 46% provide residential treatment, and 38% offer detoxification (Table 2). Only 13% provide vocational support for clients. Primary care services are minimal (8%), but increasing. Comparable national data from the Substance Abuse and Mental Health Services Administration (SAMHSA) 2011 National Survey of Substance Abuse Treatment Services (N-SSATS) shows the percentage of providers offering outpatient services at 81%, residential services at 32%, and detoxification services at 20% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). In comparison, the HRRI sample appears to represent agencies that offer a greater number of services; organizations in the sample offer a higher percentage of the following services: residential (43% study versus 32% nationally), outpatient (88% study versus 81% nationally), and detoxification (study 38% versus 20% nationally). There was just one difference between Time Periods 1 and 2 in levels of care provided: Organizations providing primary care increased from 4% to 13%.

Number of patients served—Forty percent of the participants came from organizations with fewer than 500 patients per year. There were no significant differences between Time Periods 1 and 2 for the characteristics of patients served. An analysis of patients the study organizations serve suggested that the survey population is similar to the population of organizations that use NIATx services, such as its grant-supported learning communities, research projects, and annual conference (the NIATx Summit). This comparison will offer insights into the sample’s organizational characteristics. Organizational statistics from NIATx activities indicates 42% of participants serve fewer than 500 patients per year, 23% serve 500–1000 patients, 20% serve 1000–3000 patients, and 15% serve greater than 3000 patients. A chi-square goodness of fit analysis failed to reject the hypothesis of equal

distribution and found no significant difference between the overall NIATx participant population and the sample that participated in the HRRI study ($p = .243$). The NIATx participant population represents organizations interested in process improvement, willing to implement organizational change, and that have discretionary resources to pay for conferences as well as participate in learning communities or educational events.

Annual budget—Most of the respondents operate on a relatively small annual budget. Just over a third (39%) had an annual budget of \$1–5 million, and another 31% operate on less than \$1 million a year. Only 19% have an annual budget of more than \$10 million. There were also no significant differences between Time Periods 1 and 2 for organizational budget size.

Conditions for health reform readiness

In data combining both time periods, 9 of 13 HRRI conditions had mean responses that scored in the “Needs to Begin” or “Early Stages” range (.5–1.49) (Table 3). Four conditions, Patient/Family Role, Quality Management, Outcomes Measurement, and Holistic (Integrated) Care registered in the lower end of the “On the Way” range (1.5–2.49). In Time Period 2, 5 conditions registered in the “On the Way” designation as compared to 2 in Time Period 1. Ten of the 13 conditions did demonstrate an improvement in their mean scores between Time Periods 1 and 2. However, just two demonstrated statistical difference at the $p < .010$ level between time periods: Holistic (Integrated) Care and Finances. Three others registered a difference of $p < .050$: Patient and Family Role, Outcome Measurement, and Accountability. Three conditions had no improvement in their mean scores between the time periods: Evidence-Based Treatment, Patient Record (electronic health record focused), and Workforce (credentials focused). Table 4 provides the means and standard deviations for survey respondents by time period as well for the test of significance between time periods’ results.

Organizational budget size—The Kendall tau-b analysis compared readiness for each of the HRRI conditions between organizations with less than and greater than \$5 million in annual revenue. Budget size >5 million, for both time periods, was related to greater use of evidence-based treatment, an integrated continuum of care, board of directors, patient health record, quality management and administrative information systems (at $p < .01$) (Table 5). For each of these conditions, there was a significant difference (at $p < .01$) in time periods 1 and 2, except for the patient record condition.

4. Discussion

The HRRI tool analysis revealed that addiction treatment organizations, with large as well as small budgets, are in a low state of readiness for participating in the anticipated post-PPACA implementation health reform environment. Most HRRI scores fell into the “Early Stages” and “On the Way” categories.

Scores for three HRRI conditions related to clinical service delivery and support decreased slightly between Time Periods 1 and 2: Evidence-based Treatment, Workforce, and Patient Record. Clinical capability represents a key non-financial factor health plans consider when deciding whether or not to include a health care provider into their panel of providers. This result could signal a broader trend of diminishing addiction treatment clinical capacity.

Evidence-based treatment: Using evidence-based treatment demonstrates to the public, health plans, hospitals, primary care clinics, and insurance plans that an organization is providing effective clinical care (McLellan, Carise, & Kleber, 2003; Goldman et al., 2001).

Being viewed as providing poor clinical quality hurts an organization's ability to form partnerships with other organizations and health plans that can refer patients to their agency.

Workforce: Clinicians with higher education and/or certification tend to look more favorably on the adoption of evidence-based practices (Knudsen, Ducharme, & Roman, 2007; McCarty et al., 2007). However, less than half of counselors in the addiction treatment field possess an advanced degree (Rieckmann, Farentinos, Tillotson, Kocamik, & McCarty, 2011). Organizations that do not have sufficient credentialed staff with advanced clinical degrees will not be able to participate in the broader set of managed care contracts expected to arise through health care reform (Kubiak & Arfken, 2008). To meet the requirement for a more educated workforce, organizations without enough counselors with advanced degrees is they may have to dismiss less qualified counselors in order to hire counselors with advanced degrees.

Patient Record: Organizations that plan to fully participate in the PPACA-initiated health exchanges will need access to an electronic health record (EHR). For the past decade, community-based Federally Qualified Health Centers (FQHCs) have been expected to implement electronic health records (Buntin, Burke, Hoaglin, & Blumenthal, 2011). Community-based addiction treatment centers will be expected to have the same capacity, although that may be considered unfair since the FQHCs have had considerably more federal governmental assistance to implement electronic health records than addiction treatment centers (Blumenthal, 2010). Fewer than 50% of addiction treatment organizations have implemented electronic health records, and many more addiction treatment centers will need this capacity in order to participate with most health plans (Centerstone Research Institute, 2009; Blumenthal, 2010).

Budget size exacerbates the deficits in organizational health reform. The influence of budget size, for organizations with budgets less than \$5 million, is multidimensional. Smaller organizations are less likely to use evidence-based treatments; implement electronic health records; provide a continuum of care with addiction, mental health and primary care; educate the board of directors about health reform and parity legislation; implement quality management programming; and use administrative information technology. To prepare adequately for health reform, organizations with smaller budgets are going to have to train their boards of directors about the implications of PPACA legislation. Organizations with smaller budgets will also have to make significant changes to evidence-based treatment application and quality management functions. They will also have to provide a broader continuum of care with specialty and primary care in order to provide ongoing appropriate and effective services.

The analysis of HRRRI results did show a significant increase in two of the HRRRI conditions for all budget sizes: Holistic (Integrated) Care and Finances. The Holistic (Integrated) Care condition aimed to measure addiction treatment organizations' relationships with primary care as well as community support services. Organizations could score higher on this condition if they included primary care as part of their health care assessment and delivery, had formal agreements with other health care providers, and had the ability to transfer patients and their records when needed. The increase in this condition suggests that addiction treatment organizations are heeding the message that integrating their services with primary care providers can improve patient care, and suggests that integration efforts are increasing (Padwa, et al., 2012; Rosenberg, 2012). Another indication of the growing integration trend was the increase in organizations offering primary care. Only 4% offered primary care in Time Period 1 compared to 13% in Time Period 2.

The data for the HRRI condition Finances also increased significantly from Time Period 1 to Time Period 2. Organizations that entirely relied on grants changed from 24.6% in Time Period 1 to 20% in Time Period 2. Also, organizations that had at least 90 days in cash reserve and at least 30% of their funding originating from third-party payers increased from 10.8% in Time Period 1 to 26% in Time Period 2. This data suggests that organizations have more cash on hand, are diversifying their payer mix, and increasing contracts with “fee-for-service” payers such as Medicaid and traditional health insurance. This change and the significant increase in offering primary care level of care demonstrate progress in two key areas of reform: increasing integration with primary care and other health care entities settings, and increasing engagement with third-party payers.

4.1 Limitations

The study design had limitations that should be taken into consideration when interpreting the results. Although the results are based on a large sample of organizations (n=427), the results were derived from a convenience sample of visitors to the NIATx website. The NIATx website used to collect the survey information has a process improvement focus and may attract organizations that demonstrate more flexibility to conduct organizational change. Those who completed the survey on the NIATx website also could be considered to be motivated to learn more about PPACA and how it might affect their organization. In addition, the organizations that completed the survey in Time Period 1 may have been more motivated to learn about reform than those who completed the tool in Time Period 2. All these factors could result in the results to over-represent the level of readiness of the addiction treatment field and under-represents the progress made between Time Periods 1 and 2.

Another limitation arose from developing the constructs during a field demonstration project. This process valued provider input and researchers followed their guidance on how to avoid rater fatigue. Accordingly, weaknesses exist in the psychometric properties of the HRRI. First, the tool development process made proper reliability testing impractical. Secondly, validity is compromised for conditions with combined constructs. (For instance, Patient/Family Role includes references to inclusion in decision-making and invitations to clinical sessions.) Although the development process aimed to group related constructs, future research should attempt strengthen the psychometric properties of the HRRI by measuring individual constructs.

4.2 Directions for Future Research

The implementation of health reform provides one of the largest natural experiments on change to the health care system to occur in decades. The research field should be poised to document the changes the PPACA evokes at the individual, organizational, payer, and community levels; why the changes occurred; and determine which changes should be sustained and spread to new locations.

This study, while focused to organizational health reform readiness, underscores the need for additional research on the organizational attributes and capacity organizations need to deliver accessible, efficient, and effective addiction care in the broader health care system. An exploration of these attributes, in the organizational contexts of leadership and patient population characteristics, as well as environmental contexts of payment and policy mechanisms is needed to better understand organizational change and performance.

4.3 Conclusions

Educating and equipping unprepared organizations is imperative if they are to compete and thrive in the rapidly changing environment of health care reform. Addiction treatment

organizations will need to provide patient-centered services, evidence-based treatment, and positive outcomes. They will need to use health information technologies and develop fiscal agility to provide better addiction treatment. Organizations with smaller budgets may have greater needs to prepare for reform. Overall, this HRRI assessment underscores the need for research on organizational capacity in all health care disciplines to assure that the health care infrastructure can support health care needs.

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Table 1

Summary of health reform readiness index categories, conditions and indicators

The survey tool uses a rating scale from “Needs to Begin” (score = 0) to “Advanced” (score = 3), with a progression of organizational competencies (indicators of reform readiness) as possible answers for each Condition question. Table 1 summarizes the scores and progression of organizational competencies for each Condition.

CATEGORY: BUILDING BLOCKS	
Condition	Scale of reform readiness indicators (summary)
Patient/Family Role	0 = Patients and family are not involved in treatment decision-making. 1 = Patients and family are somewhat involved but clinicians make all decisions. 2 = Patients are actively involved in treatment decision-making and goal setting; families are invited to some sessions/events. 3 = Patients and clinicians are full partners in treatment decision-making and goal setting; families are involved in treatment sessions/events.
Evidence-Based Treatment	0 = Does not use National Quality Forum (NQF) practice standards. 1 = Clinicians have access to prescribing medications and learning about NQF clinical interventions through training. 2 = Has on-staff prescribing capacity. Offers in-service training for NQF clinical interventions. 3 = On-staff prescribing capacity is widely used. Has in-service training and mechanisms for reviewing fidelity to NQF clinical interventions.
Accountability for Patient Care	0 = Documents care provided within organization over time. 1 = Documents care provided within organization and elsewhere - information shared by patient. 2 = Documents care provided within organization and elsewhere - information shared by patient and/or other healthcare organizations. 3 = Documents care provided within organization and elsewhere - information shared by patient and/or other healthcare organizations. Patient identifies organization as medical home.
Integrated Continuum of Care	0 = Offers a single level of care. 1 = Controls/has direct access to multiple levels of addiction or mental health care. 2 = Controls/has direct access to all levels of addiction and mental health care. 3 = Controls/has direct access to all levels of addiction, mental health, and primary care.
CATEGORY: YOUR ORGANIZATION (People, Clinical Systems & Services, Business Services)	
Board of Directors	0 = Board is uninformed about parity and health care reform. 1 = Board is informed about opportunities presented by parity and health care reform. 2 = Board is informed and supports staff efforts to take advantage of opportunities presented by parity/reform opportunities. 3 = Board assures all activities take advantage of opportunities presented by parity/reform in finance, operations, human resources, treatment quality, or programming
Workforce	0 = Has < 20% licensed clinicians. 1 = Has > 20% licensed clinicians. Patients have access to medical personnel. 2 = Has > 33% licensed clinicians and > 10% staff are medical personnel. 3 = Has > 50% licensed clinicians and > 15% staff can prescribe medications.
Patient Record	0 = Uses only paper records. 1 = Uses electronic records. 2 = Uses pre-formatted electronic records that integrate into data management and billing systems. 3 = Uses pre-formatted electronic records that integrate into data management and billing systems. Shares clinical information and patient registries electronically with other health care partners.
Holistic (Integrated) Care	0 = Provides only substance abuse treatment. Does not refer to other services. 1 = Provides only substance abuse treatment, and refers patients to primary care and support services. 2 = Provides substance abuse treatment, assesses patients' physical and psychosocial health, and has formal agreements to refer patients to other services. 3 = Provides substance abuse treatment, assesses patients' physical and psychosocial health, and can transfer patients and records to other health/support organizations.
Outcomes Measurement	0 = Collects data on dates and types of service. 1 = Collects data on dates, types of service, admissions, and length of stay. Uses data for process improvement. 2 = Collects data on dates, types of service, admissions, length of stay, and patient functioning during treatment. Uses data for process improvement. 3 = Collects data on dates, types of service, admissions, length of stay, patient functioning during treatment, and outcomes measures. Uses data for process improvement.
Quality Management	0 = Documents quality indicators. Does not have quality management staff.

CATEGORY: BUILDING BLOCKS	
Condition	Scale of reform readiness indicators (summary)
	<p>1 = Documents quality indicators. A staff person monitors requirements for licensing, payer contracts, and accreditation.</p> <p>2 = Documents quality indicators. Monitors requirements for licensing, payer contracts, and accreditation. Has a quality management officer and conducts regular quality reviews.</p> <p>3 = Documents quality indicators. Monitors requirements for licensing, payer contracts, and accreditation. Has a quality management officer. Conducts regular quality reviews, and has a culture of continuous improvement and high level of accreditation.</p>
Patient Health Technology	<p>0 = Does not collect data to use in treatment.</p> <p>1 = Patients complete assessments using electronic media.</p> <p>2 = Patients complete assessments, and have access to records and clinician communication using electronic media.</p> <p>3 = Patients complete assessments, have access to records and clinician communication, and interactive support/direction using electronic media.</p>
Administrative Information Technology (IT)	<p>0 = Has paper and/or electronic systems that do not interact.</p> <p>1 = IT system collects and manages utilization and financial information for billing and accounting.</p> <p>2 = IT system collects and manages utilization and financial information for billing and accounting, and links directly to billing system.</p> <p>3 = IT system collects and manages utilization and financial information. Data system is integrated for management, billing, human resources, and clinical data.</p>
Finances	<p>0 = Revenue mostly from grants. Does not bill third-party payers.</p> <p>1 = Up to 10% revenue comes from third-party payers.</p> <p>2 = Up to 30% revenue comes from third-party payers and organization has cash reserves up to 90 days.</p> <p>3 = Up to 50% revenue from third-party payers and organization has cash reserves up to 90 days.</p>

Table 2

Organizational Characteristics

Trait	Time Periods 1&2 (n=427)	Time Period 1 (10/10–6/11) (n=257)	Time Period 2 (7/11–9/12) (n=170)	Approximate Significance (between time periods)
Patients Served per Annum				
<500	171 (40%)	100 (39%)	71 (42%)	.376
500–999	64 (15%)	41 (16%)	23 (14%)	
1000–2999	111 (26%)	64 (25%)	45 (27%)	
>3000	81 (19%)	52 (20%)	31 (18%)	
Budget Size				
<1M	140 (33%)	79 (31%)	61 (36%)	.640
1–5M	156 (36%)	102 (40%)	54 (32%)	
5–10M	77 (18%)	46 (18%)	31 (18%)	
10M+	54 (13%)	30 (12%)	24 (14%)	
Levels of Care				
Detox	162 (38%)	98 (38%)	64 (38%)	.861
Outpatient	376 (88%)	230 (90%)	146 (86%)	.371
IOP				
Residential	196 (46%)	123 (48%)	73 (43%)	.409
Medication Management	154 (36%)	96 (37%)	58 (34%)	.832
Vocational	57 (13%)	35 (14%)	22 (13%)	.604
Primary Care	33 (8%)	11 (4%)	22 (13%)	.001

Table 3

Percentage Distribution for HRI Conditions

Conditions (n=427)	Needs to Begin	Early Stages	On the Way	Advanced
Building Blocks				
Patient/Family Role	12.5%	29.0%	37.3%	21.2%
Evidence-based Treatment	36.1%	23.6%	34.4%	5.9%
Accountability for Patient Care	24.5%	26.4%	36.3%	12.7%
Integrated Continuum of Care	15.8%	53.1%	19.1%	12.0%
Your Organization				
Board of Directors	37.5%	22.4%	29.2%	10.8%
Workforce	28.8%	45.5%	17.9%	7.8%
Patient Record	41.5%	21.5%	33.5%	3.5%
Holistic Care	9.9%	41.5%	35.4%	13.2%
Outcomes Measurement	22.9%	23.6%	27.5%	26.0%
Quality Management	19.3%	29.7%	27.1%	23.8%
Patient Health Technology	61.1%	34.7%	2.6%	1.7%
Admin. Information Technology (IT)	34.2%	29.0%	25.2%	11.6%
Finance	22.6%	38.0%	21.9%	17.5%

Table 4

Conditions of Health Reform (rank ordered by overall mean)

Condition	Time Periods 1&2 <i>Mean (Std. Dev.)</i>	Time Period 1 (10/10–6/11) <i>Mean (Std. Dev.)</i>	Time Period 2 (7/11–9/12) <i>Mean (Std. Dev.)</i>	Approximate Significance (between time periods)
Patient/Family Role	1.67 (.947)	1.59 (.873)	1.78(1.00)	.024
Quality Management.	1.57(1.05)	1.52(1.03)	1.63 (1.07)	.298
Outcomes Measurement	1.55(1.11)	1.45 (1.07)	1.70(1.16)	.018
Holistic (Integrated) Care	1.52 (.837)	1.43 (.794)	1.63 (1.07)	.002 *
Accountability for Patient Care	1.37 (.994)	1.29(1.01)	1.48 (.964)	.033
Finances	1.35(1.01)	1.23 (.936)	1.51(1.09)	.005 *
Integrated Continuum of Care	1.27 (.860)	1.21 (.798)	1.36 (.959)	.300
Administrative IT	1.13 (.996)	1.13 (.980)	1.15 (1.07)	.424
Board of Directors	1.15(1.03)	1.08(1.01)	1.24(1.05)	.069
Evidence-Based Treatment	1.10 (.936)	1.15 (.891)	1.04(1.01)	.209
Workforce	1.05 (.882)	1.07 (.850)	1.02 (.902)	.456.
Patient Record	.99 (.937)	1.01 (.914)	.98 (.973)	.917
Patient Health Technology	.450 (.623)	.410 (.595)	.500 (.709)	.579

*
= p<.010

Table 5

Level of PPACA Readiness for Organizations Greater/Less than \$5 Million

Variables	Time Period 1 *		Time Period 2 *		Time Periods 1 and 2 *	
	>5M Mean (STD) n=180	>5M Mean (STD) n=77	>5M Mean (STD) n=115	>5M Mean (STD) n=55	<5M Mean (STD) n=295	>5M Mean (STD) n=132
	difference p-value		difference p-value		difference p-value	
BUILDING BLOCKS						
Patient/Family Role	1.57 (.930)	1.62 (.817)	1.77 (1.04)	1.81 (.915)	1.66 (.982)	1.70 (.864)
	.610		.254		.782	
Evidence-based Treatment	1.05 (.878)	1.39 (.948)	.86 (.102)	1.44 (.945)	.97 (.945)	1.41 (.944)
	.002**		.000**		.000**	
Accountability for Patient Care	1.25 (1.01)	1.37 (.989)	1.39 (.968)	1.70 (.925)	1.31 (.994)	1.52 (.972)
	.455		.040		.050	
Integrated Continuum of Care	1.13 (.821)	1.39 (.686)	1.20 (.937)	1.70 (.925)	1.16 (.872)	1.53 (.813)
	.001**		.001**		.000**	
YOUR ORGANIZATION						
Board of Directors	.92 (.945)	1.34 (1.07)	1.13 (1.09)	1.53 (1.04)	1.01 (1.01)	1.42 (1.05)
	.004**		.008**		.000**	
Workforce	1.02 (.913)	1.18 (.743)	.98 (.917)	1.09 (.872)	1.01 (.913)	1.14 (.801)
	.092		.904		.048	
Patient Record	.86 (.906)	1.31 (.872)	.95 (.991)	1.05 (.971)	90 (.943)	1.20 (.923)
	.000**		.312		.002**	
Holistic (Integrated) Care	1.40 (.804)	1.51 (.808)	1.54 (.915)	1.82 (.782)	1.46 (.855)	1.65 (.809)
	.586		.048		.062	
Outcomes Measurement	1.44 (1.09)	1.52 (1.04)	1.59 (1.22)	2.07 (.961)	1.50 (1.15)	1.77 (1.04)
	.863		.067		.025	
Quality Management	1.35 (1.04)	1.86 (.946)	1.43 (1.05)	2.05 (1.00)	1.39 (1.05)	1.95 (.975)
	.000**		.001**		.000**	
Patient Health Technology	.39 (.579)	.45 (.529)	.46 (.710)	.58 (.706)	.42 (.638)	.51 (.615)

Variables	Time Period 1 *		Time Period 2 *		Time Periods 1 and 2 *	
	>5M Mean (STD) n=180	>5M Mean (STD) n=77	>5M Mean (STD) n=115	>5M Mean (STD) n=55	<5M Mean (STD) n=295	>5M Mean (STD) n=132
	difference p-value		difference p-value		difference p-value	
	.157		.416		.090	
Administrative Information Technology (IT)	.97 (.972)	1.52 (.892)	.98 (1.08)	1.54 (.946)	.97 (1.02)	1.53 (.913)
	.001 **		.000 **		.000 **	
Finances	1.15 (.968)	1.38 (.851)	1.46 (1.08)	1.60 (1.10)	1.28 (1.03)	1.48 (.972)
	.013		.385		.052	

* = Kendall tau B significance test within time period;

** = p<.10.