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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 3-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.

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 information technology implementation (PPACA, 1561); evidence-based treatment (PPACA, Sec. 4105); workforce development (PPACA, Title V, Sec. 5001–5701); and quality management (PPACA, 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 (el-Guebaly, 2012; Mechanic, 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

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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

Table 1
Summary of health reform readiness index categories, conditions and indicators.

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

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.