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Improving Coordination of Addiction Health Services Organizations with Mental Health and Public Health Services

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ABSTRACT

In this mixed-method study, we examined coordination of mental health and public health services in addiction health services (AHS) in low-income racial and ethnic minority communities in 2011 and 2013. Data from surveys and semistructured interviews were used to evaluate the extent to which environmental and organizational characteristics influenced the likelihood of high coordination with mental health and public health providers among outpatient AHS programs. Coordination was defined and measured as the frequency of interorganizational contact among AHS programs and mental health and public health providers. The analytic sample consisted of 112 programs at time 1 (T1) and 122 programs at time 2 (T2), with 61 programs included in both periods of data collection. Forty-three percent of AHS programs reported high frequency of coordination with mental health providers at T1 compared to 66% at T2. Thirty-one percent of programs reported high frequency of coordination with public health services at T1 compared with 54% at T2. Programs with culturally responsive resources and community linkages were more likely to report high coordination with both services. Qualitative analysis highlighted the role of leadership in leveraging funding and developing creative solutions to deliver coordinated care. Overall, our findings suggest that AHS program funding, leadership, and cultural competence may be important drivers of program capacity to improve coordination with health service providers to serve minorities in an era of health care reform.

1. Introduction

Roughly half of all Americans will have a behavioral health disorder during their lifetime, the majority of whom will also experience co-occurring health problems; 44% will have at least one co-occurring physical health or mental health condition (Butler et al., 2008). In light of the overlapping nature of these conditions, studies have shown that the most effective treatment addresses physical and behavioral health in tandem through integrated service provision (Blount, 2003; Butler et al., 2008; Grella, Stein, Weisner, Chi, & Moos, 2010). However, there is broad recognition that, at present, integrated care for individuals receiving AHS rarely happens in practice (McLellan & Woodworth, 2014). One recent study found that 69% of AHS programs were only in the early stages of developing an integrated continuum of care or had not even begun such efforts (Molfenter, 2014).

AHS programs face many barriers to effective integration with primary care and other health and behavioral health services (Guerrero, Aarons, & Palinkas, 2014; McLellan & Woodworth, 2014). Two of the main documented barriers are limited capacity to bill public and private insurance that could finance such services (Andrews, 2014; Substance Abuse and Mental Health Services Administration, 2011) and a lack of medical and other professionals needed to provide truly integrated care (Abraham, Knudsen, Rieckmann, & Roman, 2013).

Recognizing these constraints, policy makers have identified a continuum of approaches for improving accessibility and integration of AHS and other health services, ranging from basic coordination among service providers residing in separate locations to colocation of services in a single facility to service integration, in which comprehensive health services are provided in a cohesive manner (Collins, Hewson, Munger, & Wade, 2010; Heath, Wise Romero, & Reynolds, 2013). Ideally, providers will progress along this continuum from coordination to integration. Yet at present, relatively little is known about the organizational and environmental factors that influence AHS programs' capacity to coordinate services with other health service providers. Even less is known about the capacity of AHS programs to respond to the unmet service need for integrated care in racial and ethnic minority communities

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(Guerrero, Aarons, Grella, Garner, Cook et al., 2014; Guerrero & Kao, 2013; Marsh, Cao, Guerrero, & Shin, 2009).

We used a mixed-method approach to explore factors associated with high coordination of mental health and public health services in AHS programs serving low-income racial and ethnic minority communities in Los Angeles, CA, between 2011 and 2013. In this study, public health services were broadly defined to include all health services provided to individuals receiving AHS, including primary care and prevention and treatment of infectious diseases such as HIV and hepatitis. We examined whether AHS programs reported a different frequency of interorganizational coordination with public health and mental health services between these 2 years. Additionally, we explored environmental (outer context) and organizational (inner context) characteristics that may be associated with the likelihood of high coordination. Semistructured qualitative interviews with AHS clinical supervisors were conducted to describe the activities associated with high coordination and explore program efforts to progress along the continuum from coordination to integration.

1.1. Framework

Recent conceptual models of implementation in public sector services (Aarons, Hurlburt, & Horwitz, 2011) have suggested that the implementation of new practices requires addressing outer (i.e., system and interorganizational) and inner (i.e., intraorganizational) context factors that influence the delivery of evidence-based practices (Aarons et al., 2011; Center for Substance Abuse Treatment, 2006, 2009a, 2009b; Damschroder et al., 2009; Simpson & Flynn, 2007). However, there has been limited research exploring how outer and inner context factors contribute to the implementation of coordinated mental health and public health services.

1.2. Outer context factors supporting service coordination and integration

AHS programs rely heavily on their regulatory and funding environment for financial and nonfinancial (e.g., professional expertise) resources, making them vulnerable to the expectations of funders and regulators (D'Aunno, 2006; Guerrero, 2010; Pfeffer & Salancik, 1978). Studies have identified funding, regulation, and accreditation as outer context factors associated with provision of a broad range of evidence-based practices (D'Aunno, 2006; Knudsen, Abraham, & Roman, 2011; Roman, Abraham, & Knudsen, 2011), including coordinated health (Friedmann, Lemon, Durkin, & D'Aunno, 2003) and mental health (Friedmann, Alexander, & D'Aunno, 1999; Guerrero, Aarons, Grella, Garner, Cook et al., 2014) services. However, no studies have examined how outer context factors have affected AHS programs' coordination with public health and mental health services.

In this study, we examined whether funding and regulatory factors shown to be important in prior literature are associated with service coordination among minority-serving AHS programs. We posited that outer context factors will increase AHS programs' likelihood of coordinating with mental health and public health services. Specifically, in hypothesis 1, we posited that higher public funding and receipt of licensure and professional accreditation will be associated with higher odds of high coordination with mental health and public health services.

1.3. Inner context factors supporting service coordination and integration

Research on implementation of integrated care in AHS has also highlighted inner context factors that affect practice implementation. Effective leadership is associated with increased staff buy-in relative to facilitating early practice implementation (D'Aunno, 2006; Edwards, Knight, Broome, & Flynn, 2010; Guerrero, 2010, 2012; Simpson & Flynn, 2007). In particular, staff perceptions of leadership behavior are associated with implementation of mental health treatment practices (Claus, Gotham, Harper-Chang, Selig, & Homer, 2007). The organizational process associated with the implementation of new practices in AHS has also been described and tested using the organizational readiness-for-change framework (Lehman, Greener, & Simpson, 2002; Simpson & Flynn, 2007). This framework highlights the inner context of AHS programs, represented by staff characteristics such as motivation, program resources, and climate.

Implementing coordinated mental and public health services for racial and ethnic minority clients also requires cultural competence. Culturally responsive practices, such as delivering services in a bilingual, culturally diverse, and inclusive setting, are associated with more accurate diagnosis, a positive therapeutic alliance, and greater client satisfaction (Brach & Fraser, 2000; Cross, Bazron, Dennis, & Isaacs, 1989; González, Vega, & Tarraf, 2010; Saha, Komaromy, Koepsell, & Bindman, 1999; Saha, Taggart, Komaromy, & Bindman, 2000; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). However, prior research did not consider the role of organizational cultural competence in AHS programs' coordination with mental and public health services (Guerrero et al., 2013). In light of this, in hypothesis 2 we posited that a higher degree of directorial leadership, readiness for change, and cultural competence will be associated with higher odds of high coordination with mental and public health services.

2. Methods

2.1. Sampling frame and data collection

The sampling frame for both the quantitative and qualitative samples encompassed all 408 AHS programs funded by the Department of Public Health in Los Angeles County, CA, between January 1, 2011, and December 31, 2013. The initial sampling procedure involved a random selection in 2010 of 147 outpatient programs drawn from the 350 programs located in communities with a population composition of 40% or more Latino or African American residents or both in Los Angeles County. Latino residents represent more than 48.3% of the county's population (U.S. Census Bureau, 2014). An outpatient program was defined as a treatment unit that provided at least 75% of its services in an outpatient setting.

2.2. Sample

Data were gathered at two time points from a random sample of program managers and direct-service staff members. Data collection at time 1 (T1) in 2011 relied on clinical supervisors as key informants of program structure and practices, an approach consistent with other exploratory studies (see D'Aunno, 2006; Knudsen, Ducharme, & Roman, 2006; Roman et al., 2011), whereas time 2 (T2) information collected in 2013 included data from an average of three direct-service providers per program (one supervisor and two counselors). T1 data were collected from 147 programs, but we excluded 14 programs that had inconsistent data on variables of interest and 11 programs that had recently closed. Thus, the T1 sample consisted of 122 eligible programs with full and verified information. The final analytic sample used both T1 and T2 data (122 and 112 programs, respectively), resulting in an analytic sample of 234 programs. Sixty-one programs had both T1 and T2 data. The analytic sample excluded 51 programs that had closed, stopped providing services to adults, or changed names at the time of the T2 survey. These included 25 programs at T1 and 26 programs at T2. These 51 excluded programs did not differ from the analytic sample in terms of main independent variables ($p > .05$).

The T2 sample differed from the T1 sample in sample size (122 vs. 112 programs); measures (61 programs had both T1 and T2 measures); and respondent type (one supervisor at T1 vs. one supervisor and two counselors at T2). However, differences at T2 between programs (included and excluded from the T2 survey) and within programs (supervisors versus counselors) were not statistically significant ($p > .05$). Our power analysis using program-level data suggested that data from at