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Brief articles

Longitudinal Examination of Medical Staff Utilization in Substance Use Disorder Treatment Organizations

Dail Fields, Ph.D. [a,*], Paul Roman, Ph.D. [a,b,1]

[a] Center for Research on Behavioral Health and Human Services Delivery, Institute for Behavioral Research, University of Georgia, Athens, GA, USA
[b] Department of Sociology, University of Georgia, Athens, GA, USA

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ABSTRACT

This study examined changes in utilization of medical staff within organizations specializing in treatment of patients with substance use disorder (SUD) at two points in time (2007 and 2010). Utilization was calculated as the number of hours paid weekly for psychiatrists, physicians, nurses, and other medical staff working as employees or on contract. Study data come from a longitudinal national sample of 274 substance use disorder treatment centers. Average utilization of medical staff by these SUD treatment organizations increased by 26% from 2007 to 2010. The results showed that growing SUD treatment centers that obtained more referrals from health care providers, used case managers to coordinate comprehensive approaches to patient care, provided medication assisted treatment (MAT), and that were connected more closely with hospitals made increased use of medical staff over the 2007–2010 period. In 2010, these organizations seem to have been moving in directions consistent with trends forecasted for the SUD treatment environment after implementation of the Affordable Care Act.
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1. Introduction

The Institute of Medicine (2006) has noted that effective treatment of substance use disorders (SUD) requires linkages across multiple components of the health and social welfare systems. While integration of SUD treatment into mainstream medical care has become a major goal, medical staff members are usually not strongly represented in the SUD treatment workforce. Increased presence of physicians and other medically trained staff working within SUD treatment organizations has a potential for improving the quality and comprehensiveness of SUD treatment (Institute of Medicine, 2006), by affording greater availability of medication-assisted treatment (MAT) and by improving the ability to identify and treat co-occurring conditions. Greater integration of SUD treatment has been identified as a priority of the Affordable Care Act (ACA) (Beronio, Po, Skopec, & Glied, 2013; Buck, 2011). Implementation of the ACA and recently enacted parity laws have created potential opportunities for SUD treatment organizations to alter staffing and better address the breadth of treatment offerings (Buck, 2011; Busch et al., 2014; Fields, Roman, & Blum, 2012; Guerrero, Aarons, & Palinkas, 2014). These changes in the SUD environment are expected to offer opportunities for growth and quality improvement for those responsive SUD treatment providers that proactively implement entrepreneurial strategies (Buck, 2011; Knudsen & Roman, 2004; Zinn, Spector, Weimer, & Mukamel, 2008).

The availability of physicians, psychiatrists and other medical staff within SUD treatment settings is critical to the implementation of evidence-based pharmacotherapies within SUD treatment (Knudsen, Abraham, & Oser, 2011; Knudsen, Abraham, & Roman, 2011) as well as for more effective implementation of comprehensive care (Ducharme, Mello, Roman, Knudsen, & Johnson, 2007; Emmelkamp & Vedel, 2006; Etheridge & Hubbard, 2000; Fields et al., 2012). Comprehensive care includes not only treatment components such as formal intake assessment, treatment planning, behavioral therapy, and continuing care, but also primary medical care and other wraparound services (such as mental health care, HIV screening, and financial/legal services) (Ducharme et al., 2007). In particular, the provision of primary medical care as a part of SUD treatment is a key part of ultimate integration of SUD patients within the overall health system (Friedmann, Alexander, & D'Aunno, 1999; Tai & McLellan, 2012). In addition to the legitimization of MAT (Heinrich & Cummings, 2014), utilization of medical staff may also increase the integration of SUD treatment organizations with local primary care providers, increasing readiness of these physicians to refer to their professional peers and thus increasing the likelihood that patients in need of SUD treatment are identified, assessed, and assisted with treatment needs in a timely fashion.

Utilization of physicians and other medical staff may increase adoption of innovations in treatment that go beyond MAT. For example, Knudsen and Roman (2014) found that centers that recently adopted or were planning to adopt treatment innovations of all types were more likely to have one or more physicians on staff or contract compared to treatment centers which had no plans for innovation adoption. It is possible that the presence of trained medical staff contributed to increased levels of professionalism and related willingness to consider

* Corresponding author. Tel.: +1 706 663 2952.
E-mail addresses: dfields@uga.edu (D. Fields), proman@uga.edu (P. Roman).
[1] Tel.: +1 706 542 6090.

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and use evidence-based innovations in SUD treatment. The willingness of treatment providers to adopt new and innovative treatment approaches may prove critical to treatment center growth in the new funding environment created by the Affordable Care Act (ACA). That is, treatment providers with closer ties to other health care sources may be better able to attract patients with newly available insurance coverage for SUD treatment and to obtain patient referrals from primary care and other health care providers (Buck, 2011).

1.1. Previous studies of medical staffing in SUD treatment

The employment of physicians and other medical staff in SUD treatment organizations has been the focus of limited research. Previous studies have examined cross-sectional relationships of organizational variables with dichotomous indicators of the presence of physicians or with counts of physicians and nurses employed or available on contract within SUD treatment organizations. The studies that have focused on counts of the presence of physicians with SUD treatment organizations have found a range of both internal and external forces may facilitate or hinder treatment center utilization of medically trained personnel. Studies have indicated that treatment providers that have greater reliance on public funding are less likely to employ staff physicians than organizations that primarily rely on fee-for-service based revenues such as private insurance, patient direct billings and Medicaid (Knudsen, Oser, Abraham, & Roman, 2012). Publicly funded treatment programs have cited regulatory limitations and allowable cost ceilings imposed by public funding sources as significant barriers to employing medical staff (Knudsen et al., 2011). The presence of physicians has been positively related to organization size, and location in a hospital or community mental health center (Knudsen et al., 2011; Knudsen et al., 2011). The number of physicians and nurses employed or available via contract within SUD treatment centers may be positively associated with the likelihood of provision of MAT or its adoption (Knudsen & Abraham, 2012). In addition, the presence of physicians may be positively associated with a treatment program's size, accreditation, greater reliance on Federal funding and strategy to provide on-site primary medical care (Friedmann et al., 1999; Rodgers & Barnett, 2000).

1.2. Significance of this study

This study adds to the literature in two areas. First it examines the average extent to which SUD treatment providers utilize medical personnel resources on a weekly basis including psychiatrists, physicians, nurses, and other medical personnel. Second, the study longitudinally examines the organizational factors that are related to the extent of change in medical staff utilization across the period 2007–2010. This study builds from previous investigations by incorporating several of these previously studied organizational characteristics related to the medical staffing. These include a treatment provider being based in a hospital setting and providing MAT. Explanations of change in medical staff utilization may also result from trends within SUD treatment providers to engage medical needs of patients and move toward more competitive positions in a changing environment. Hence this study also examines variables that may operationalize these trends over the 2007–2010 period including growth in treatment provider size; the extent to which a center focuses on comprehensive treatment planning using case managers (Graham & Timney, 1990); changes in connection with the health system operationalized as the percentage of patient referrals from healthcare providers; and management foresight operationalized as the extent each organization engages in environmental scanning. The study examines the relationship of this set of organizational variables with the change in the level of utilization of medical staff over the period 2007 to 2010 in a nationally representative sample of 274 treatment providers.

2. Methods

2.1. Sample and procedures

Data for this study were drawn from the National Treatment Center Study (NTCS) a national longitudinal study of treatment organizations which rely on fee-for-service funding for more than 50% of their revenue. The initial sample was selected using a two-stage stratified process. In the first stage, all counties in the USA were allocated to ten different strata based on county population. The counties were then randomly sampled within strata. The total population of specialty addiction treatment centers located within each sampled county was then enumerated, using published Federal and state directories, yellow pages listings, employee assistance program referral directories, survey sampling call lists, and other available sources. Treatment centers were then selected for eligibility screening in proportion to the total number of treatment units identified in each stratum. Telephone screening was used to establish eligibility for the study. Eligibility requirements excluded counselors in private practice, halfway houses, transitional living facilities, methadone maintenance facilities, court-ordered driver education, correctional, and VA facilities.

Data have been collected from organizations every 2–3 years, using face-to-face interviews and written questionnaires. The interview guides and questionnaires were reviewed and approved by the IRB at the home institution of the principal investigator. Interview guides and questionnaires used in the NTCS can be requested by following the contact procedures provided at http://ntcs.uga.edu/. Organizational-level data measured management practices, revenues, patient referral sources, levels of care, and adoption of evidence-based practices.

To maintain sample size across the time periods of NTCS data collection, replacements for organizations that were no longer available from a previous period's sample due to closure or other reasons were randomly selected from updated directories of treatment providers operating in each of the ten original strata. SUD treatment providers selected for replacement were chosen from the same strata in an effort to maintain the representative of the overall sample

The data used in this study were obtained through on-site interviews conducted both in 2007–2008 and in 2009–2010. In 2007–2008, 345 treatment providers participated in the NTCS (87% of those contacted); in 2009–2010, 327 treatment centers participated in the study (83% of those screened for eligibility). Due to attrition between these two periods, 274 treatment organizations provided data in both time periods and thus were available for analysis in this study covering changes in these programs between 2007–2008 and 2009–2010. These 274 participants represent retention of 79% across the two time periods.

We compared the characteristics of the 71 treatment providers not included in the longitudinal sample with the characteristics of the 274 treatment providers providing data in both periods and with the characteristics of the 345 treatment providers providing data in 2007–2008. We found no statistically significant differences between these groups in the percentage hospital based, the percentage providing MAT, the percentage expanding in the past 2 years, number of FTE employees, number of case managers, environmental scanning level, or the percentage of patients referred from health care.

2.2. Measures

2.2.1. Medical staff hours per week 2007 and 2010

During the face-to-face interviews in both 2007 and 2010, the administrative director of each treatment center was asked to provide the number of full-time-equivalent (FTE) psychiatrists, physicians, and nurses employed by the treatment center. In addition, the directors provided the number of hours per week that the center pays for contracted psychiatrists, physicians, and nurses. The directors also reported the number of physician assistants and other medical staff employed by each treatment center. The total medical hours used per week was

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