Organizational Capacity to Eliminate Outcome Disparities under Health Care Reform

Erick Guerrero, Ph.D. (USC)

Investigative Team
Lawrence Palinkas, Ph.D. (USC)
Thomas D'Aunno (Columbia U.)
Christine Grella, Ph.D. (UCLA)
Gregory Aarons, Ph.D. (UCSD)

NIDA R21- DA035634-01 (PI: Guerrero)
Addiction Technology Transfer Center
Network
Webinar
November 14th, 2014

Main Goal:
Identify how health care reform may impact the organizational capacity of community-based outpatient substance abuse treatment (SAT) to expand services and reduce disparities in care.

Overall impact:
Understand how health insurance expansion impacts SAT capacity to offer mental health and HIV prevention services and consequently improve access and retention among low-income African American and Latino clients.

Program Level +

Client Level

Low Treatment Access & Retention

Problem

Less than 20 percent of individuals who need addiction treatment access such treatment (SAMHSA, 2012). Health insurance coverage, available providers and quality of care issues are among the most common barriers to access and retention among low-income and racial/ethnic minority groups.

Uninsured Rate Among Latino Adults Between July-September 2013 and April-June 2014 by Age, Language Spoken, and Income

Data source: The Commonwealth Fund Affordable Care Act Tracking Surveys.

Michelle M. Doty, PhD, MPH; David Blumenthal, MD; Sara R. Collins, PhD.
Geographic location and delivery of integrated care in minority communities (e.g., co-occurring substance use and mental health disorders)

Limited availability of integrated care in Latino communities. Travel to closest facility is at least 4 miles from Latino communities (Guerrero & Kao, 2013).

Smaller PROGRAMS Die Faster

- From 2006-2009 – 22.5% of small programs closed every year, raising concerns about these programs’ ability to respond to the payment and service delivery expectations of ACA. (Guerrero, Alibrahim, Wu, & Kim, under review)
- These programs are also most likely to serve low-income and racial/ethnic minority communities.

### Mortality

<table>
<thead>
<tr>
<th>Size</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>2.50%</td>
</tr>
<tr>
<td>Medium</td>
<td>3.35%</td>
</tr>
<tr>
<td>Small</td>
<td>22.50%</td>
</tr>
<tr>
<td>Total</td>
<td>7.50%</td>
</tr>
</tbody>
</table>

Community-based providers are organizationally unprepared and ill equipped to contend with the billing management and co-occurring treatment services expected by health care reform (Rawson & McLellan, 2010; Chalk, 2010; Bofari et al., 2008).

Hence, it is critical to identify key capacity factors that may enable programs to provide integrated care, bill Medicaid and have an impact on client treatment outcomes, as proposed by ACA.
Insurance expansion is likely to have a differential impact on access to and retention in treatment among low income minorities, depending on the organizational capacity of programs to meet reimbursement/billing and service delivery expectations.

Explained by neo-institutional, resource dependency and organizational development (leadership and readiness for change) theories, we posit the following:

1) Programs that are better able to respond to the expansion of Medi-Cal will improve staff training and motivation, as well as program billing and reporting technology and expanding service delivery, which may enroll clients faster and engage them longer in services.

2) Bifurcation in quality of care: High-capacity programs (leadership, readiness for change, Medicaid readiness) will expand services and implement benchmarks for access and retention.

3) Client outcome disparities (low access and retention) will be seen in low capacity programs servicing mostly socially and health-related disadvantaged groups (e.g. low income, cultural minority, mental health and HIV risk).
Data was collected from publicly funded SAT programs.
Sample was drawn from service areas covering more than 7 million residents (L.A. County).

Baseline data
- Program data collected in 2010-2011 using random sampling.
- Sample frame drawn from client administrative data with program identifiers to merge data
- Provided by 92% of managers (key informant per program).
- Sampling frame - 408 programs – random sample from 350 programs communities with more than 40% African American and Latino residents in LA county.
- Final sample: 104 programs and 13,328 clients – 21% African Americans, 43% Latinos

Analytic Approach
- Multilevel negative binomial regressions (overdispersed count distribution - # of days)

Measures
- Latent class – Program capacity (leadership, readiness for change, Medi-Cal acceptance).
- Two classes were justified – Low and High capacity – consistent with Moms&Pops and Large Parent Org.
- Leadership – Two subscales: Transformational (seven items, α = .92) and Transactional (two items, α = .77) leadership (Edwards et al., 2010)
- Organizational readiness for change – Texas Christian University measure – 6 scales, α > .89. (Simpson & Flynn, 2007)
- Medi-Cal payment acceptance – Program has a billing system for Medicaid billing and reporting.

RESULTS: Program capacity (leadership, readiness for change and Medi-Cal payment acceptance) strongly related to higher client access and retention.
Findings: Medi-Cal is strongly related to access and retention.

**Wait Time**
- **Organizational Characteristics**
  - Medi-Cal acceptance: IRR = 0.045***
  - Public Funding: IRR = 0.990***
  - License: IRR = 0.402***

**Client Characteristics**
- Client Medi-Cal eligible: IRR = 0.604***

**Treatment Retention**
- **Organizational Characteristics**
  - Readiness for change: IRR = 1.01*
  - Staff attributes for change: IRR = 0.979**
  - License: IRR = 1.148*

**Client Characteristics**
- Client Medi-Cal eligible: IRR = 1.105***

Findings:
Medi-Cal is strongly related to access and retention. Our conceptualization of organizational capacity using leadership, readiness for change, and Medi-Cal payment acceptance was validated in the statistical significant associations with client outcomes.

Program capacity differentiates programs on their ability to reduce client wait time and extend client duration in treatment.

Key capacity factors for access were resource oriented (Medi-Cal payment acceptance, public funding, license) (Neo-institutional and Resource Dependency Theories).

Key capacity factors for engagement (duration) were regulatory and service quality (culturally responsive care).

**Conclusions**

- Our conceptualization of organizational capacity using leadership, readiness for change and Medi-Cal payment acceptance was validated in the statistical significant associations with client outcomes.
- Program capacity differentiates programs on their ability to reduce client wait time and extend client duration in treatment.
- Key capacity factors for access were resource oriented (Medi-Cal payment acceptance, public funding, license) (Neo-institutional and Resource Dependency Theories).
- Key capacity factors for engagement (duration) were regulatory and service quality (culturally responsive care).

**Implication for Practice**
To develop capacity to improve client access and engagement in treatment:
1) Programs need to implement a new system of public insurance billing and reporting.
2) Programs need to invest in directorial leadership development to identify, guide, and supervise program changes and evaluate client outcomes.
3) Programs need to implement policies and practices that are responsive to client’s cultural and linguistic background are essential to engage Latino and African American clients.
4) Finding also inform health care policies to provide funding and training for providers to invest in the program development areas listed above.
Limitations and Next Steps

- Our data relied on a key informant approach not fully capturing reports from more staff.
- Key management practices that enable change were not included in the data.
- Generalizability is limited to urban programs in low-income and racial/ethnic minority communities.

Next step:
- Next stage of grant (R33) will:
  1. Rely on mixed methods and multiple informant approach to fully capture program context.
  2. Provide qualitative data to identify pre-ACA perspectives to respond to change.
  3. We will identify service delivery and payment acceptance changes from 2011 to 2013 (pre-ACA) and observe how these changes impact access and retention among minorities.

Current Papers Under Review


Thanks!
Questions?
References


Guerrero, G. E., in press. Enhancing treatment access and retention: The role of public insurance acceptance and cultural competence. Drug and Alcohol Dependence.


Michelle M. Doty, PhD, MPH1; David Blumenthal, MD2; Sara R. Collins, PhD3 (2014). Uninsured rates for Hispanics. JAMA online.