Organization and Integration Across Systems Serving American Indian/Alaska Native Clients with Substance Abuse Disorders

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Statistics

- Past month illicit drug abuse (SAMHSA 2008)
  11.8% for American Indians vs. 8.2% Caucasians

- Substance dependence (SAMHSA 2008)
  13.4% for American Indians vs. 9.4% Caucasians

- Alcohol induced deaths
  43.6 per 100,000/yr vs. 6.7 general population
  (U.S. Dep. of Health and Human Services [IHS], 2009)
Behind the Stats

Sociocultural & historical factors strongly affect AI/AN health status, access to care, and health seeking behavior, including:

- Poverty, lack of education, rural locations
- Lack of health insurance
  (U.S. Dept. of Health and Human Services, 2006, 2008)
- Mistrust of the US government and of US healthcare systems (Smedley et al. 2003)
- Stigma about addiction and mental health issues (Jones 2006)
Project Goals

- **Assess systems structure** (i.e. funding, selection of practices, state policies), **organization** (i.e. data systems, monitoring outcomes), and **clinical efforts** (i.e. cultural competency training, supervision) aimed at improving the quality of care and reducing disparities in care for AI/AN clients with substance use disorders.

- **Identify and evaluate needed infrastructure, policies, and resources** to successfully implement and sustain strategies, including culturally based models of care, aimed at improving quality of care and reducing disparities in service delivery for AI/AN clients.
Focus of this Presentation

- Integration between Providers and the State, the nature of relationships, and perspectives from each about areas where communication, collaboration, and understanding can improve.

- Where perspectives intersect, pointing to common recognition of needed resources and infrastructure.

- Workforce, data monitoring, resource allocation
Sample

- **State Tribal Liaisons (n=18)**
  Representing 11 different Single State Authorities

- **Treatment Providers (n=22)**
  From 21 different agencies

- Recruited from the 14 states with the highest AI/AN population

- Reservation and Urban
<table>
<thead>
<tr>
<th>Gender</th>
<th>States (%) (n=18)</th>
<th>Providers (%) (n=22)</th>
<th>Total (%) (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>44.4</td>
<td>31.8</td>
<td>37.5</td>
</tr>
<tr>
<td>Female</td>
<td>55.6</td>
<td>68.2</td>
<td>62.5</td>
</tr>
<tr>
<td>Title</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director</td>
<td>38.9</td>
<td>63.6</td>
<td>52.5</td>
</tr>
<tr>
<td>Program Manager</td>
<td>38.9</td>
<td>18.2</td>
<td>27.5</td>
</tr>
<tr>
<td>Clinical Supervisor</td>
<td>0.0</td>
<td>9.1</td>
<td>5.0</td>
</tr>
<tr>
<td>Therapist/Counselor</td>
<td>0.0</td>
<td>9.1</td>
<td>5.0</td>
</tr>
<tr>
<td>Tribal Liaison</td>
<td>11.1</td>
<td>0.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Consultant</td>
<td>11.0</td>
<td>0.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Geographic Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West</td>
<td>33.3</td>
<td>45.5</td>
<td>40.0</td>
</tr>
<tr>
<td>Southwest</td>
<td>33.3</td>
<td>27.3</td>
<td>30.0</td>
</tr>
<tr>
<td>Midwest</td>
<td>16.7</td>
<td>22.7</td>
<td>20.0</td>
</tr>
<tr>
<td>Northeast</td>
<td>5.6</td>
<td>4.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Southeast</td>
<td>11.0</td>
<td>0.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Table 1: Participant demographics
Quantitative Survey

Using a Likert-type scale (‘1=not at all’ to ‘5=extensively’), we asked about the extent to which providers use:

- Psychosocial interventions
- Funding sources
- Data to inform decisions
- Strategies for culturally responsive treatment
- Efforts to address AI/AN concerns
- Cultural competency/diversity trainings
Interviews: SSAs & Providers

SYSTEMS INFRASTRUCTURE
- Communication between IHS, the State, and providers; data reporting

ORGANIZATIONAL CULTURE
- Changes to service delivery to meet AI/AN needs; implementing EBPs; efforts to increase inter-agency communication and collaboration; workforce development

RESOURCE ALLOCATION
- Funding for AI/AN treatment services; access to funds, attitudes about funding, sustainable programs, funding needs
## Results: Emergent Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-Theme</th>
<th>Findings</th>
</tr>
</thead>
</table>
| **Interagency Relations** | Communication & Collaboration (providers, IHS, State) | 1) Many providers felt communication (meetings, correspondence, site-visits, collaboration) with the State and IHS was lacking and did not feel a sense of support from these agencies  
2) Many SSA’s felt communication with providers was good, but poor with IHS |
| **Funding**            | Access to Funds                                | 1) Lack of policy to regulate allocation of state residue dollars  
2) Lack of provider control over funding                                      |
|                        | Effect of Budget Cuts on Care                  | 1) Diminished referrals to evidence-based treatments (EBTs)  
2) Reduction of Cultural-based programs and case management                            |
|                        | Attitudes toward Funding                       | 1) Myths around AI/AN resources perpetuate systemic funding problems  
2) AI/AN attitudes around responsibility of care is problematic for community healing |
| **Workforce**          | Tribal Education                               | SSAs and providers recognized a need for stronger accounting principles and better understanding of funding structures among tribal leaders |
| **Monitoring**         | Data Reporting                                 | 1) Providers felt AI/ANs carry the data reporting burden without the funding benefit & lacked knowledge of how the state uses data  
2) SSAs felt data reporting among AI/AN providers is lacking |

Table 2: Emergent interview themes related to systems integration and resources
Interagency Relations

“I’ve only been here for five years, but that’s the way it’s always been described to me - sort of two completely separate systems.”

-SSA

“The state of [...] has no idea who we are, what we do. All they know is that we bill services.”

-Provider
Interagency Relations

**PROVIDERS**

- Lack of communication and support from the State & IHS
- Diminished site visits due to insufficient funding negatively impacting relationships

**STATE**

- Communication and collaboration with providers good, but poor with IHS
- Often did not know who to contact or if they worked with IHS
- Belief that tribal health care and the State are two separate systems
Interagency Relations

PROVIDERS AND STATE

- Tribes know their communities’ priorities best and may differ from what the State or IHS believes

- SSAs’ role is to inform tribes about options but not to dictate their actions

- Tribal liaisons ensure that state programs that will affect AI/AN communities include AI/ANs in program design, planning, and implementation

- High staff turn-over negatively affects relations between providers, the State and IHS
Funding & Resource Allocation

“There’s a lot of misconceptions on funding... You know, most people feel as though [AI/AN] medical care is all taken care of.”

-SSA

“And so when there isn’t money, the first thing that suffers is prevention. And I personally believe it’s probably one of the more important things we can do.”

-Provider

“It’s really a very back to basics, bones and blood kind of operation.”

-Provider, on state budget cuts
Funding & Resource Allocation

- Most do not receive funding for medication-assisted treatment or wraparound services
- About 1/3 of states and providers we sampled receive funding for aftercare services

<table>
<thead>
<tr>
<th>States and Providers Combined</th>
<th>No (%)</th>
<th>Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Medication</td>
<td>88.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Wraparound Services</td>
<td>80.8</td>
<td>19.2</td>
</tr>
<tr>
<td>Aftercare and Recovery Management</td>
<td>65.4</td>
<td>34.6</td>
</tr>
</tbody>
</table>

Table 3: Funding allocated to states and providers for specific purposes
Funding & Resource Allocation

PROVIDERS

- Desire clear policy for state residue dollars (announcements, eligibility, access)

- Less costly methods of care taking precedence over EBTs like medication-assisted treatment due to lack of funds for uninsured

- Reducing/eliminating case management and prevention work, i.e. cultural-based programs for youth that treat the family system as a whole

- Difficult to access and appropriately use funding due to lack of control

- Too many barriers to access available funds from the State and IHS
“Once they get our numbers, once they get our data, we have no idea where it goes, what they’re doing with it and if they’re counting us.”

- Provider

“We don’t have a good way of tracking what some of the primary care physicians are doing in terms of prescribing.”

- SSA
### Data Reporting

#### PROVIDERS
- More clarity, less redundancy in state data reporting structures
- Different data; flexibility & culturally appropriate ways to report data
- Healing experience is private, may not culturally lend itself to rigorous data reporting
- The burden of reporting without the benefit of increased funding

#### STATE
- Lack of infrastructure among tribal providers negatively impacts data reporting & billing
- AI/ANs are not being counted because providers are not reporting data to the State, affecting resource allocation
Data Reporting

PROVIDERS AND STATE

- Need for more education & support for tribal leaders in grant writing, generating and sustaining funding, profit-making, and billing
- Need for more technical training & assistance for providers in data reporting
- Unstable funding sources & high staff turn-over result in significant breaks in data collection and reporting among providers
Respondents voiced a need for:

- Recognition that culturally-based prevention work is critical to AI/AN Individual & community health and may ultimately prove less costly.
- Increased communication between IHS, the State, providers, & the community, particularly about data reporting and role of data to inform policy & resource allocation.
- Increased education for tribes on creating programs & sustaining funding.
- Increased technical assistance and decreased redundancy in data reporting systems.
- Awareness & flexibility of culturally appropriate ways to document treatment for data reporting and billing.
- Dispel the myth that healthcare for AI/ANs are “all paid for”.