Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

4-3-2024

Strategies for Maintaining the Financial Viability of Behavioral Health Programs

Antonia Alford
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Accounting Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Management and Human Potential

This is to certify that the doctoral study by

Antonia Alford

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Levita Bassett, Committee Chairperson, Doctor of Business Administration Faculty

Dr. Yvonne Doll, Committee Member, Doctor of Business Administration Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2024

Abstract

Strategies for Maintaining the Financial Viability of Behavioral Health Programs

by

Antonia Alford

MBA, Rosemont College, 2012

BS, Drexel University, 1997

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

April 2024

Abstract

Behavioral health providers' (BHPs) lack of successful strategies to create viable processes has the potential for losses in revenue. BHP leaders are concerned with their financial viability in maintaining organizational sustainability and growth. Grounded in Andersen's behavioral model of health services, the purpose of this qualitative multiple-case study was to explore the strategies that BHP leaders used to create viable processes to mitigate losses in revenue. The participants were six BHP leaders with 3 years of experience in successful revenue-generating strategies. Data were collected using semistructured interviews and a review of quality management plans. Through thematic analysis, three themes were identified: (a) staffing retention, (b) business pivot strategies, and (c) community outreach. A key recommendation is for BHP leaders to review their current business model and create or update their quality management plans annually with staff to foster more significant attention to cost controls and service outputs. The implications for positive social change include the potential for BHPs to maintain the availability of services for the communities they serve to improve the quality of life for the individuals seeking behavioral health services.

Strategies for Maintaining the Financial Viability of Behavioral Health Programs

by

Antonia Alford

MBA, Rosemont College, 2012

BS, Drexel University, 1997

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

April 2024

Dedication

I dedicate this study to my late mom; you were always my biggest supporter when I began this journey. I could not have completed this journey without the memories of your love, support, and encouraging me to not give up. You always remained positive even when I thought I would not make it through, but I have fulfilled your promise. I love and miss you and know you are smiling down at me. To my daughter, I love you and appreciate all the support during a difficult time in my life. My brothers, I love you very much. We went through some rough times during this journey, and we have persevered because of the love and support for each other. My late dad, you have always told me to continue my education, it will take you far. Even though you earned your wings at the beginning of my college career, you have always been a part of my college journey. As always, I thank God for giving me the strength to complete this journey and move on to the next chapter of my life.

Acknowledgments

I am extremely thankful for the support of my Committee Chair, Dr. LeVita Bassett. You encouraged and inspired me to stay focused and rise above the challenges of this journey. Your direction and guidance made me see that I can finish strong even when faced with many edits in this process. Thank you so much for all you have done to keep me moving during this process. Additionally, thank you to my second committee member, Dr. Yvonne Doll, for your feedback to improve my academic voice and writing. Finally, I would like to thank the Walden staff, the librarians, the writing center, and fellow scholars who have been a support system that has elevated this journey to the level of excellence achieved during my academic journey and for the communities that participated.

Table of Contents

List of Tables v

Section 1: Foundation of the Study 1

Background of the Problem 2

Problem and Purpose 3

Population and Sampling 3

Nature of the Study 4

Research Question 6

Interview Questions 6

Conceptual Framework 6

Operational Definitions 8

Assumptions, Limitations, and Delimitations 9

Assumptions 9

Limitations 9

Delimitations 10

Significance of the Study 10

Contribution to Business Practice 10

Implications for Social Change 11

A Review of the Professional and Academic Literature 11

The Andersen Model 12

Social Behavior Theory 16

Medicaid 17

ACA and Health Insurance 22

Behavioral and Mental Health 24

Health Insurance Exchange 25

Health Care Expanded Coverage 27

Quality of Care 29

Financial Impact of ACA 30

Insurance Policy Changes 32

Social Improvement 33

Approaches to Treatment 35

Human Services Access 36

Funding Strategies 40

Information Technology 41

Funding Changes 43

Retention of Consumers 44

Fiscal Trends and Programs 45

Drug Indicators 48

Service Organization Performance 49

Employers' Health Care Expenses 50

ACA Costs and Financing 51

Faith-Based Organization Funding 53

Transition 57

Section 2: The Project 59

Purpose Statement....59
Role of the Researcher....60
Participants....61
Research Method and Design....63
Research Method....63
Research Design....65
Population and Sampling....68
Ethical Research....69
Data Collection Instruments....70
Data Collection Technique....71
Data Organization Technique....72
Data Analysis....72
Reliability and Validity....74
Reliability....74
Validity....74
Transition and Summary....76
Section 3: Application to Professional Practice and Implications for Change....77
Introduction....77
Presentation of the Findings....78
Theme 1: Staffing Retention....78
Theme 2: Business Pivot Strategies....81
Theme 3: Community Outreach....85

Applications to Professional Practice 88

Implications for Social Change 89

Recommendations for Action 90

Recommendations for Further Research 91

Reflections 91

Conclusion 92

References 93

Appendix: Interview Protocol 118

List of Tables

Table 1 *Strategy Viability Themes* 77

Section 1: Foundation of the Study

The effects of job loss, pension declines, and business stability have led to increased depression, suicides, foreclosures, and drug use (Guerra & Eboreime, 2021). In times of recession and other economic instability, beginning with the Great Depression and several recent economic downturns, behavioral health needs have increased in the United States, while services for behavioral health treatment may have decreased (Coe & Enomoto, 2020). In the state of Pennsylvania, the funding requirements of behavioral health providers (BHPs) in Philadelphia have increased due to the recent economic downturn, and as the economic downturn continues, the need for services will likely increase, potentially leaving treatment providers unable to meet the demands for needed services.

BHPs wanting to effectively deliver evidence-based practices (EBPs) to serve the needs of clients require knowledge of the strategies they can use to sustain revenue sources and pay the costs associated with EBP provision. BHPs face difficult decisions regarding whether to implement complex EBPs in the communities in need of these services (Stewart et al., 2015). Changes in the financing of community mental health have altered the organization and delivery of publicly funded services over the last 60 years (Stewart et al., 2015). The amount of Medicaid funding available for mental health programs is often less than the amount available in the private marketplace, and substantial cuts in state aid to BHPs since the financial crisis of 2008 have created increasing financial stress for BHPs (Stewart et al., 2015). BHPs presently in operation may need to be more efficient than ever, particularly if they take on the additional cost of

EBPs. Accordingly, program leaders need to be proficient in the adoption of effective business practices.

Background of the Problem

The Department of Behavioral Health and Intellectual Disability Services (DBHIDS) of Philadelphia provides comprehensive behavioral health and intellectual disability services through a network of agencies. Department of Behavioral Health and Intellectual Disability Services (2023) serves as a pass-through grant recipient by receiving funds from both the federal and state governments and then distributing these funds to agencies providing services to clients. DBHIDS depends on these funds to provide the agencies with the revenue needed to serve clients in the Philadelphia area. In recent years, DBHIDS has endured multiple rounds of cuts to human services from both the state ($41 million) and federal governments (City of Philadelphia, 2016). According to their fiscal year (FY) 2016 budget testimony, DBHIDS receives 99% of its funding from the state and federal governments. BHPs can face challenges with decreased funding.

Due to Medicaid expansion, Philadelphia has seen a dramatic increase in the number of individuals using services. FY 2017 was the first full year of operations of behavioral health services since Medicaid expansion, and over 100,000 newly insured individuals were added to the system (City of Philadelphia, 2016). As a result, the FY17 target tends to be higher than the FY15 actual. DBHIDS expected these targets to stabilize and move back down to FY15 numbers over the next 5 years (City of Philadelphia, 2016).

The BHPs' expansion of services provided to consumers may be dependent on the strategies developed to sustain revenue. As the number of consumers needing access to services has grown, BHPs have struggled to maintain or increase the revenue needed to provide these services. Leaders of the BHPs require knowledge of revenue strategies they can use to provide services while maintaining their ongoing efforts to remain vital in the community.

Problem and Purpose

The specific business problem was that BHP leaders lacked successful strategies to create viable processes to mitigate losses in revenue. The purpose of this qualitative multiple case study was to explore the successful strategies that BHP leaders used to create viable processes to mitigate losses in revenue.

Population and Sampling

I gathered the stories of six BHP leaders from three different Philadelphia County, Pennsylvania service environments regarding the processes they used in their business model and their successful strategies. The three environments were mental health, intellectual disabilities and drug and alcohol. The planning, organization, and management practices were the focus of the data collection.

I used snowball sampling and purposeful sampling with inclusion criteria requiring that the participants had at least 3 years of experience and evidence of successful revenue generation. After receiving Walden University Institutional Review Board (IRB) approval, I initially invited individuals by email to participate in the research study, and when they agreed to take part, I sent them a consent form. I preconsulted with

the agency leaders to get their approval to conduct interviews. A written summary was used to inform the agencies of the details of the study and the ethical requirements that were met and would be adhered to over the course of the study.

I conducted interviews to gain further knowledge regarding the providers' business practices. The goal of the study was to determine if there could be transferability in processes among different types of behavioral health operations so they can become more efficient and effective in their operations, thereby mitigating losses in revenue. The leaders' experiences provided me with a better understanding of the providers' operations.

Nature of the Study

The three primary research methods are qualitative, quantitative, and mixed methods (Crossman, 2019). A qualitative researcher collects nonnumerical data and seeks to interpret meaning from these data to understand social life through the study of targeted populations or places (Crossman, 2019). The qualitative method was appropriate to understand and interpret the experiences of individuals pertaining to the problem being addressed in the study. A quantitative researcher uses numerical data to identify large-scale trends and employs statistical operations to determine causal and correlative relationships between variables (Crossman, 2019). This method was not appropriate for the current study because numerical data and the examination of the relationship between variables would not have addressed the research question. Mixed methods is an approach to inquiry that includes both qualitative and quantitative methods (Tariq & Woodman,

2019). A mixed-method approach was not appropriate for this study because only the qualitative method was necessary to explore the various strategies.

Five potential qualitative research designs are case study, narrative, phenomenology, ethnography, and grounded theory. The case study design involves a deep understanding of multiple types of data sources (Yin, 2018). The case study design is used to provide explanatory, exploratory, or descriptive results (Yin, 2018). The goal of this study was to provide descriptive results of management's views on the impact of continuity of behavioral health services and how they serve the clients of behavioral health agencies in Philadelphia. With the narrative design, a researcher uses in-depth interviews to weave together a sequence of events, usually from just one or two individuals (Sauro, 2015) The narrative design was not appropriate for the current study because there were six participants involved in the study. The phenomenological research design is used to describe an event, activity, or phenomenon (Sauro, 2015). This design was not appropriate for this study because I did not focus on an event or activity based on human lived experiences. The ethnographic research design is used to immerse oneself in the target participants' environment to better understand the goals, cultures, challenges, motivations, and themes that emerge (Sauro, 2015). An ethnography was not appropriate for the current study because I did not immerse myself in the participants' environment to study strategies to decrease revenue that BHPs faced in sustaining funding sources. The grounded theory design is used to provide an explanation or theory behind the events (Sauro, 2015). This design involves constant movement between data collection and analysis to develop a theory, which was not appropriate for the current study.

Research Question

The research question guiding this study was: What business strategies do BHP leaders use to create viable processes to mitigate losses in revenue?

Interview Questions

1. What are the best strategies you are implementing when funding fluctuation has a major impact on staffing levels, access to service, and quality of service?
2. What business strategies are you using to sustain your business to create viable processes to mitigate losses in revenue?
3. If there were limited resources available, how did they have an impact on providing behavioral health services?
4. How do you maintain the quality of services for consumers even with the decrease in state and federal funding?
5. How has your business model evolved when referring to consumer services with available resources?
6. What additional information can you provide to help me understand your strategies to create a viable process to mitigate losses in revenue?

Conceptual Framework

I used Andersen's behavioral model of health services as the conceptual framework for this study (see Aday & Andersen, 2014). The original model was developed in 1974 by Ronald Andersen to account for health services use with a focus on individuals (Aday & Andersen, 1974). Since the inception of Andersen's behavioral model, there have been many variations of the model used for research regarding access

to health care services and utilization of accessible services (Aday & Andersen, 2014). The variations included expanding the model to include current policy, resources, organizations, and more public health funding (Aday & Andersen, 2014). The Andersen model has been previously used to examine access to health services by focusing on understanding any challenges patients have when seeking health care. In this study, I employed the model as a lens through which to view current research in financial stability for BHPs and BHPs' ability to sustain services for patients that would benefit from living their lives in a resilient manner.

Andersen's model can be used to explore the determinants of an individual's health services utilization, access to health services, and the facilitation of equitable access to health services (Chen & Gu, 2021). In other words, the model is used to understand and explain why and how people used certain types of health services. In the model, access to medical care is reviewed and integrated into a framework that may affect the characteristics of the delivery system and the population at risk to bring about changes in the utilization and satisfaction of health care services (Aday & Andersen, 1974). The Andersen behavior model of health services use was applicable as the conceptual framework for the current study because it allowed me to measure the funding indicators (i.e., government funding, business strategies, and policies) against the outcomes of various resources (i.e., participant responses, available consumer services, and budget impacts) to determine if access to services are related to the financial stability of BHPs. I used the population and sample studied as indicators of the utilization and satisfaction outcomes in the Andersen model.

Operational Definitions

Behavioral health: The connection between the behavior and health of the mind, body, and spirit. The habits affect mental and physical health and wellness (Salveo Integrative Health, 2021).

BHP: Programs that seek to support the most effective treatment method by providing services to people with common mental illnesses and substance use disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

EBP: Practices used to review, analyze, and translate the latest scientific evidence. The results involve the best available research, clinical experience, and patient preference (Dang et al., 2022).

Fee-for-service: A system of insurance payment in which a doctor or other health care provider is paid a fee for each particular service rendered (Pennsylvania Department of Human Services, 2019).

Financial viability: The ability to generate sufficient income to meet operating payments and debt commitments as well as where applicable, to allow growth while maintaining service levels (Registrar of Community Housing, 2010).

Managed care: A health care delivery system organized to manage cost, utilization, and quality (SAMHSA, 2019).

Medicaid: A government program administered by the states per federal requirements to provide health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities (Centers for Medicaid and Medicare Services, 2019).

Pass-through entity: A nonfederal organization that receives federal dollars and passes those dollars along to subrecipients (Watterworth, 2015).

Pay-for-performance (P4P): In health care, also known as value-based payment, comprises payment models that attach financial incentives/disincentives to provider performance (NEJM Catalyst, 2018).

Public managed care: A type of health insurance that contracts with health care providers and medical facilities to provide care for members at reduced costs (Managed Care, 2019).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions should be explicitly stated in the study as beliefs that things that are accepted true by researchers and peers (Aspers & Corte, 2019). In other words, assumptions cannot be controlled because certain aspects of a study are true given the theory and phenomenon under investigation, participants, statistical test, and research design (Aspers & Corte, 2019). My first assumption was that the participants would provide honest answers to the research questions and would have the expertise and knowledge to answer the interview questions. I also assumed that the participants would share their strategies for remaining viable in providing behavioral health services even when there is a financial impact on their funding sources.

Limitations

The limitations of the study are those characteristics of design or methodology that impacted or influenced the interpretation of the findings that the researcher cannot

control (Theofanidis & Fountouki, 2018). A limitation of the study was that Medicaid changed the reimbursement structure, which affected revenue strategies. Other limitations were that the participants were willing to participate in the study by sharing their experiences of revenue generating strategies within the same industry which affected the outcome of the study.

Delimitations

Delimitations are boundaries that are set by the researcher to control the range of a study (Theofanidis & Fountouki, 2018). The boundaries are created before any investigations are carried out to reduce the amount of time or effort spent in certain unnecessary, and perhaps even unrelated, areas to the overall study (Theofanidis & Fountouki, 2018). The delimitations of this study were the geographical area, the BHPs' responses to the interview questions, and the behavioral health services selected. The focus was only on the Philadelphia area, which limited how other areas of Pennsylvania were impacted by the study. Additionally, I focused only on substance abuse services while other services were excluded from the study.

Significance of the Study

Contribution to Business Practice

The social and financial aspects of substance abuse treatment services, when adequate funding was available to providers, resulted in adequate services being provided to clients. Substance abuse treatment funding from private sources has declined, while funding from state and local government sources has more than tripled (Buck, 2011). The United States invests a sizable amount of money on treatments for mental health and

substance treatment estimated at $135 billion in 2005, or 1.07% of the gross domestic product (Buck et al., 2011). The need for substance abuse treatment has increased in the United States due to unemployment, foreclosures, and financial depression (Buck, 2011). Many substance abuse treatment facilities appear to lack the administrative and infrastructure support necessary to meet the requirements of mainstream health care financing and management (Buck, 2011). Drug abuse is estimated to cost U.S. employers $276 billion a year and 76% of people with a drug or alcohol problem are employed (Palmer, 2012). The goal of this study was to provide BHPs with viable solutions to maintaining their level of quality service while successfully maintaining a consistent funding flow for current and future fiscal years.

Implications for Social Change

Reduced funding has negatively constrained the social and financial adequacy of substance abuse treatment services able to provide services to patients. A qualitative method can explore a study that viewed improved revenue sourcing with a resolution for funding sources, adequate treatment, and social stability of substance abuse treatment services. This study may result in positive social change by helping BHPs provide consistent services for all who seek treatment. The availability of services is key for patients to maintaining a positive outlook on social change.

A Review of the Professional and Academic Literature

The purpose of this literature review was to provide a comprehensive summary of s the published facts that are relevant to this study. I identified the sources for the literature review with the trend analysis method, and this section includes a summary, a

critique or analysis, evidence-based articles, and an application of those sources (see Leite et al., 2019). Conducting this literature review helped me determine which articles demonstrated current knowledge and identify gaps in the field.

I reviewed sources that were both directly and indirectly related to my topic to compile as much information as possible to support this study. The following databases were searched to locate literature for this review: ProQuest, Science Direct, EBSCO Host, and Sage Premier. The keyword search terms used were *financial stability, behavioral health providers, Andersen model, Medicaid,* and *governmental funding.* This study was focused on the business strategies and financial stability of BHPs in the current economy and how they retain their level of services at their current budget levels.

The literature review is organized into the following topic themes: the conceptual framework of the Andersen model, social behavior theory, Medicaid, social improvement, funding redistribution, approaches to treatment, funding strategies, information technology, funding changes, retention of consumers, fiscal trends and programs, drug indicators, service organization performance, employers' health care expenses, cutback management, Affordable Care Act (ACA) costs and financing, drug safety, and the role of public funding.

The Andersen Model

I used the Andersen model to examine challenges to accessing health services through health services utilization. The Andersen model was originally developed in 1974 by Ronald Andersen to predict or explain an individual's use of health care services (Aday & Andersen, 1974). The model is focused on an individual's predisposition to use

acute health care services as well as the enabling factors that facilitate use and influence the need for care (Andersen, 1995). With the model, Andersen aimed to understand how and why people use health care services, assess the inequality of access to health services, and create policies for equitable access to care (Bradley et al., 2002). Andersen (1995) expanded the model in 1995 to assess measures of access (e.g., equitable, inequitable, effective, efficient) to understand the environment (i.e., external or health care system) that impacted access and utilization of health care services. The expansion of the behavioral model focused on the efforts to improve access and quality of services across the continuum of care. The expanded Andersen model addressed factors that assist in the understanding of why individuals and families use health services, which also defines and measures equitable access to health care (Andersen, 1995). The model's health status outcomes allow for the extension of measurements of access to health policy and reform.

Several studies have used Andersen's model. Travers et al. (2020) used the Andersen behavioral model of health services use to describe factors associated with the use of long-term services and supports (LTSS) among African American and older White adults between 2006–2010. The Andersen model was applied to understand both the relevancy factors of older adults who currently use LTSS versus those who intend to use LTSS. The researchers also explored differences among race/ethnic groups in this analysis (Travers et al., 2020). The link with actual use included LTSS losses and changes, tangible support, capability to provide informal support, and accessibility of informal support. Their results showed the racial differences in the decision to use nursing home services (i.e., 45% of African Americans 45% versus 24% of Whites) and

the racial makeup of LTSS use to avoid burdening one's family (was greater among African American older adults than among older White adults; Travers et al., 2020).

Hsieh and Shannon (2005) used three approaches to analyze the outcomes of the racial makeup of LTSS. The first approach was a conventional content analysis, which allowed codes to flow to the data set. In the second approach, they reviewed the codes from the first approach with a second researcher to map the original dimensions within Andersen's model by using a direct analysis approach. In the third approach, the same two researchers used the codes that failed to map to the model to merge and finalize the codes to create dimensions and themes according to the data collected. The validity of the findings was established by using the classical content analysis approach to quantify the codes created. The classical content analysis approach is used when there are a lot of codes to decipher the ones that are the most important (Leech & Onwuegbuzie, 2007). Classical content analysis is used to code and create categories to be analyzed. The researcher counts the number of times each code is utilized and deductively includes descriptive information about the data. The results of Leech and Onwuegbuzie's (2007) study of the strengths of qualitative data were determined by the competence of the analysis that was utilized.

There are multiple ways in analyzing qualitative data, but there needs to be at least two data analysis tools utilized to triangulate results. The qualitative data analysis process will become more rigorous by using multiple types of analysis (Leech & Onwuegbuzie, 2007). Qualitative researchers should pay attention to an array of

qualitative analysis tools to learn and use them diligently for data collection results to become more appealing to researchers in the field of psychology and beyond.

The qualitative method has become integral in health services research. The most used model regarding health care service utilization is Andersen's behavioral model of health services use (Lederle et al., 2021). There are three core factors that identify health care utilization: predisposing, enabling, and need factors (Lederle et al., 2021). The predisposing factors focused on age and education, the enabling factors focused on income and hospital density, and the need factors focused on health status. These core factors may facilitate or impede an individual's access to health care services. Lederle et al. (2021) identified that contextual characteristics, individual characteristics, health behaviors, and outcomes determine access to health care. Contextual characteristics are based on circumstances and the environment; a person's life circumstances identify individual characteristics, health behaviors are focused on an individual's personal practices, and outcomes are identified by an individual's health status and consumer satisfaction. There were 6,319 search results of Lederle et al.'s (2021) study that identified 1,879 publications using the Andersen behavioral model of health services use. According to Lederle et al., the most used methodological approach was quantitative (89%), and only 77 studies employed the qualitative approach. In these studies, the behavioral model of health services use was employed to justify the theoretical background (62%), data collection (40%), and data coding (78%).

Using the Andersen model in qualitative studies was criticized for lacking cultural or psychosocial factors (Lederle et al., 2021). In the analysis of the qualitative health

services study, Lederle et al. (2021) compared the application of different and older models of health care utilization that can hinder health services research. Their results showed that there will need to be future research, whether quantitative or qualitative, that will account for the most current and comprehensive behavioral model of health services use.

The Andersen model was appropriate for the current study because health services utilization was reviewed with BHPs. The expansion of services provided to consumers by BHPs has increased, so the revenue generated from these services provided will be dependent on the strategies developed to sustain revenue. The number of consumers needing access to services has grown, so BHPs are struggling to maintain or increase the revenue needed to provide these services (Fry, 2021). I used the Andersen model to evaluate the behavioral health services when interviewing the purposely selected leaders of the BHPs to gather their knowledge of revenue strategies used to provide services to maintain their ongoing efforts to remain vital in the community. The findings of the study may contribute to the strategies of BHP leaders to reduce costs and increase referrals, which may improve their revenue-sustaining strategies to provide quality services to the community.

Social Behavior Theory

The social behavior theory was developed by Albert Bandura (1986) to explain human behavior. Bandura stated that there is a three-way reciprocal model with three factors that interact with each other: personal factors, environmental influences, and behavior. In the social behavior theory, concepts, and processes from cognitive,

behavioristic, and emotional models of behavior change were synthesized, so the model can be readily applied to counseling interventions for disease prevention and management (Bandura, 1986). Bandura explained that people learn not only through their own experiences but also by observing the actions of others and the results of those actions.

I did not use the social behavior theory as the conceptual framework for the current study because the participants would have needed to be observed, and observing others was not the type of data collection used in this study. In social behavior theory studies, researchers observe the behavior of the participants and record what is learned from participant observation (Fussel et al., 2009). Collecting data through interviews with purposely selected participants provided me with a transparent lens to view and better understand the research problem. The current climate of increasing performance expectations and diminishing resources creates new dilemmas for substance abuse treatment providers, policymakers, funders, and the service delivery system (Fussel et al., 2009). When using the social behavior theory, data are collected by observing participants to learn and better understand their experiences and less of the data collection efforts are focused on the financial resources, regulations, and accreditation that is tied to state funding (Fussel et al., 2009).

Medicaid

The Medicaid program is available in all states to provide health coverage to millions of Americans (Pennsylvania Medicaid Program, 2022). Medicaid covers children, pregnant woman, parents, seniors, and individuals with disabilities

(Pennsylvania Medicaid Program, 2022). Depending on the state, the Medicaid program will cover all low-income adults below a certain income level. Although it is a state-run program, Medicaid is governed by federal Medicaid law and regulations. Under the Patient Protection and ACA of 2010, health insurance was made more affordable and accessible with changes in the way care was organized, delivered, and paid for (Carpenter, 2010).

Health care reform would allow Medicare and Medicaid to institute payment incentives that could support delivery system reforms. These reforms could slow the growth of health care costs and improve the quality of care. If payment reforms are successful, they will be adopted by private insurance plans, creating even more incentives for hospitals, physicians, and other providers to work together to improve the health care system.

The Patient Protection and ACA (2022) ensured that all Americans have access to quality and affordable health care and created the transformation within the health care system necessary to contain costs. The Congressional Budget Office determined that the Patient Protection and ACA is fully paid for by providing health care coverage to more than 94% of Americans (Patient Protection and Affordable Care Act, 2022). There was a $900 billion limit set by President Obama established by bending the health care cost curve and reducing the deficit over the next 10 years and beyond (Patient Protection and Affordable Care Act, 2022). The Patient Protection and ACA of 2010 and its expansion for Medicaid individuals earning less than 133% of the federal poverty level have led to more health care provisions (Abraham et al., 2011). The provisions also expand to

uninsured, lower-income Americans who do not have access to employer-based coverage (Carpenter, 2013). The Patient Protection and ACA of 2010 has since provided more services for individuals that are not covered under employer-related coverage (Abraham et al., 2011). The access to more services has increased the need for more providers to accommodate the need to provide quality care to individuals that are eligible.

The ACA contains numerous provisions to reduce health care costs, improve quality, and expand coverage (Carnevale Associates, 2013). The ACA offers new funding mechanisms, including integrated care and payment models. The financing for providers under the ACA will expand clients, expand coverage, and integrate care coordination. The ACA also provides rights and protections that make health coverage fairer and easier to understand as well as providing premium tax credits and cost-sharing reductions which make health care insurance more affordable. The law also expands the Medicaid program to cover more people with low incomes that will provide more choices in health care access options.

Beginning in 2014, the ACA provided one of the largest expansions of mental health and substance use disorder coverage in a generation, including 62 million Americans (Beronio et al., 2013). Medicare's Shared Savings Program has the potential to change the delivery of health care for accountable care organizations (Bennett, 2012). The reduction in expenditures and improved quality of care is the main incentive for creating accountable care organizations, explained the Patient Protection and ACA (Maniam et al., 2013).

The ACA has expanded Medicaid coverage to nearly all adults, including incomes up to 138% of the federal poverty level (i.e., $17,774 for an individual in 2021) (Smiljanic, 2022). The ACA has also provided states with a federal matching rate for the expansion in population if a state participates (Smiljanic, 2022). States that participate in the expansion of the Medicaid program must continue to consider the costs and benefits of expansion. Individual states also determine whether to pursue expansion through innovative Section 1115 waivers (Smiljanic, 2022).

Under the ACA, the effects of state Medicaid expansion have also had an impact on the self-employed (Lee & Winters, 2022). Health insurance coverage rates increased overall, especially for the self-employed, which strengthened over time (Lee & Winters, 2022). Medicaid expansion did not affect the self-employed, but there were significant health insurance benefits for the self-employed with low incomes because of the expansion. Small business owners would otherwise have faced difficulty obtaining health insurance due to their low income (Lee & Winters, 2022). Due to the various provisions of the ACA, the rates for health insurance coverage have increased in both expansion and nonexpansion for the self-employed (Lee & Winters, 2022). There were also larger increases in Medicaid expansion states. The major social cost of poor health insurance access for the self-employed is the reduction in health insurance coverage rates and improved health insurance access that can improve the health and well-being of the self-employed and their families.

The rate of uninsured Americans has reached the lowest of 8% in 2022 (Stasha, 2022). There were over 50 million Americans who were uninsured before the ACA (also

called the Obamacare Act) and after the law was enacted, there were 39 million who have free access to a series of preventive medical services (Stasha, 2022). There is a high percentage of uninsured individuals that come from low-income homes, and 1 in 5 uninsured adults did not seek medical care due to the high costs. The ACA has helped millions of Americans gain access to health insurance and seek medical treatment without going into debt (Stasha, 2022). Kenney et al. (2012) discussed that the steep declines in the uninsured population under the ACA will depend on high enrollment among newly Medicaid-eligible adults. By using 2009 the American Community Survey to model pre-ACA eligibility, there have been 4.5 million eligible uninsured adults (Kenney et al., 2012). There is a 67% participation rate for adults, which is 17 percentage points higher than the national Medicaid participation rate for children (Kenney et al., 2012). There have been variations in Medicaid participants across socioeconomic and demographic subgroups. Kenney et al. estimated that there will be significant increases in coverage under ACA, and there will be sharp increases in Medicaid participation among adults. The increased Medicaid participation will also affect health care provider's ability to provide access to quality health care to individuals that are now eligible to receive the services needed. The funding is available to providers because of ACA for eligible participants.

The ACA objective is to broaden health care coverage in the United States to an estimate of 16 million newly insured individuals on Medicaid. Wilensky (2013) examined the Medicaid expansion outlined in the United States ACA. There is still the unknown aspect of how many states will participate in the ACA (Wilensky, 2013). The

initial court ruling imposed a significant penalty that would cause the state to lose all additional money associated with the expansion but the existing Medicaid money (Wilensky, 2013). As of November 2022, there are 40 states (including DC) that have adopted the Medicaid expansion and 11 states have not adopted the expansion (Norris, 2022). The federal government funds nearly all the cost of Medicaid expansion. The states that are not a part of the Medicaid expansion program are missing out on significant federal funding. The total amount spent has been more than $305 billion between 2013 and 2022 (Norris, 2022). Currently, Medicaid expansion is optional for states without losing their current Medicaid money, but states who do not participate in the Medicaid expansion will not receive the expansion money.

ACA and Health Insurance

The implementation of the 2010 U.S. ACA has little impact as a financial risk-management strategy on purchasing health insurance. Financial aspects of the law include health insurance mandates and penalties, tax increases for high incomes, and excise tax on high-cost health insurance plans (Cordell & Langdon, 2012). The ACA reduced the risk for clients not being able to obtain medical coverage at a reasonable price. ACA also created many regulatory and legislative actions and changes in the health insurance market.

West Virginia spent far less on public health interventions than on curative care. In FY 2023 the United States spent $1.9 trillion on domestic and global health programs and services (Cubanski et al., 2023). The breakdown of funds spent were as follows: Medicare accounted for 13%, Medicaid and Children Health Insurance Program (CHIP)

accounted for 10%, other domestic health spending accounted for 4%, hospital and medical care for veterans was 2%, and global health was 0.1% (Cubanski et al., 2023). The difference in funding between preventive and curative care is the focus on short-term rather than long-term economic benefits. West Virginia's per capita income is below the national average, which results in Medicaid becoming good business for the state (Kent & Rutsohn, 2010).

The per capita budget for West Virginia may be used to compare Pennsylvania's per capita budget allocation with Medicaid expansion expenditures. Per the U.S. Census Bureau, West Virginia's direct general expenditures were $17.8 billion in FY 2020 or $9,941 per capita (Urban Institute, 2023). West Virginia's combined state and local general revenues were $18.6 billion in FY 2020, or $10,389 per capita, and National per capita general revenues were $10,933 (Urban Institute, 2023). The payment methods and incentives to promote integrated care delivery models are under the Patient Protection and ACA. The providers' team uses intePatient delivery models to coordinate patient care, health technologies, quality monitoring, and payment incentives. A review of the evidence of integrated care delivery models can be used to advance health system change, which included patient-centered medical homes, accountable care organizations, and primary care and behavioral health integration. Value-based health care can be encouraged based on quality health care and financial incentives such as pay-for-performance and gainsharing (Eldridge & Korda, 2011). The comparison of West Virgina and Pennsylvania budget showed how different states account for and handle their budget allocations for preventive and curative care funding.

ACA provided many provisions that were not allowable before the ACA was implemented. The ACA expansion include essential health benefits that include ambulatory/emergency services, hospitalization, maternity/newborn care, mental health/substance abuse services, prescription drugs, rehabilitative/habilitative services and devices, laboratory services, preventive/wellness services, chronic disease management, and pediatric services, including oral and vision care (Medicaid and CHIP Payment and Access Commission, 2022). Those opportunities under the ACA will allow more insured people, reimbursable services, integrate care with new technology, confront chronic conditions, and adopt evidence-based interventions.

States work closely with the Centers for Medicare and Medicaid Services to ensure that these programs are correctly implemented. The states are allowed to offer alternative benefit plans that may be less comprehensive than benefits offered to other Medicaid beneficiaries (Medicaid and CHIP Payment and Access Commission, 2022). The decision that states make will help to align their alternative benefit plans with Medicaid benefits. The expansion of services created more opportunities for people to access all their medical needs. Mechanic (2012) examined how the ACA, along with Medicaid expansions, offers the opportunity to redesign the nation's highly flawed mental health system. This redesign will provide opportunities to create new programs and tools that will broaden the Medicaid Home and Community-Based Services.

Behavioral and Mental Health

The changes in mental health coverage under the Patient Protection and ACA of 2010 have extended mental health services and have expanded into broader developments

in health care. Any new implementations to improve behavioral health services will take input from the provider and client (Mechanic, 2011). Improvements are expected in the quality of behavioral health care but will be managed more stringently than other medical and surgical services. The mix of treatments and interventions will be difficult to measure as well as the difficulties in implementation due to uncertainties ahead (Mechanic, 2011). As a result of the ACA bundled payment systems and the promotion, accountable-care organizations were created.

The ACA's Medicaid expansion increased insurance coverage which included mental health care for low-income Americans. The ACA Medicaid expansion covered an unmet need for mental health care (Han et al., 2020). The evidence of the impact of the expansion of insurance coverage for use of mental health services among low income and minority populations was lacking. Data were collected on low-income adults (< 138% of the federal poverty line) between 2007 and 2015 by the Medical Expenditures Panel Survey (Han et al., 2020). Han et al. (2020) compared people in states with expanded Medicaid to people in states that did not have expanded Medicare coverage. There was an increase in annual outpatient visits for mental health services by 0.513 (.053-.974) visits per person from states with Medicaid Expansion (Han et al., 2020). The results suggested that the Medicaid Expansion had an impact on utilization of outpatient mental health services with the increase in the number of people and visits using mental health services.

Health Insurance Exchange

The ACA impacted states and their residents differently once implemented. Data from March 2010 Current Population Survey was used to forecast the percentage of state

residents eligible for expanded Medicaid and exchanges (Richardson & Yilmazer, 2013). The results suggested that the percentages will vary significantly between Medicaid and subsidized exchange eligibility. The variation in uninsured rates among the Medicaid population was due to several factors (economics, demographics, and state policies). The shape of the projected health insurance will be due to Medicaid eligibility rules, employer's health insurance, and poverty rates. The ACA builds upon the existing health care system by creating health insurance exchanges and coverages of private insurance companies. The ACA also improves upon existing public programs (Medicaid and Medicare) and changes to the program will go through under the ACA (Thompson et al., 2011).

The ACA has assisted various ethnic groups. The association between the implementation of the ACA and Latinx's use of behavioral health services in the United States were examined. The National Mental Health Service Survey responses were collected from 2010, 2014, and 2016 and were used to examine the number and proportion of outpatient Latinx admissions to Medicaid expansion (Rosales et al., 2021). The survey showed that there was an increase in Latinx admissions after ACA implementation in 2014. However, 2 years postimplementation in 2016, Latinx admissions levels were lower than before the health care reform (Rosales et al., 2021). Despite the decrease, behavioral health safety net organizations served more Latinx than behavioral health service organizations outside the safety net. The expansion of Medicaid has been adopted by behavioral health safety net organizations to strengthen the Latinx communities they serve.

Health Care Expanded Coverage

From 1992 to 2009, states increased their Medicaid efforts due to the promise that they would sustain their programs and possible expansion authorized by the ACA (Cantor et al., 2013). The data sample was collected based on outcomes before the implementation of ACA in years 2011 through 2013 and after the implementation of ACA in years 2014 through 2016 (Levine et al., 2022). The current years were not analyzed because changes to ACA were made by the Trump Administration reduced the number of individuals with insurance and Medical Expenditure Panel Survey lacked the key variables related to quality of care after 2016 (Levine et al., 2022). The utilization or cost of primary care increased for those with lower income versus those with higher income (change from 65% to 66% versus change from 80% to 77%) and total out-of-pocket expenditures decreased for those with lower income vs those with higher income (change from $504 to $439 versus from $757 to $769; Levine et al., 2022). There must be an adequate number of primary care physicians available to meet the increased demand for medical care because of the expansion of coverage. The dangers of increased primary care visits are a possible collapse of the mental health and addictions safety net due to the high demand for behavioral health services.

In 2009, the National Council approved an agenda that focused on accountability of patient care for mental illness and addiction, cost-based plus financing, funds to support investments, and support for research-based education and prevention practices (Rosenberg, 2009). The National Council focused on single points of accountability for continuity of care for people with serious mental health illnesses and addictions. There is

a federal mental health funding stream that supports mental health and treatment services for the uninsured. Clinical excellence is financed by cost-based-plus financing (Rosenberg, 2009). Accountability for outcomes will be shared with the consumers to shed light on how the difference they make in the lives of the consumers they serve. The single points of accountability for continuity of care for mental health and addictions will be with the National Council's Health Care Collaborative Project that bridge together behavioral health and primary care organizations to offer a bidirectional approach. The integration of behavioral health can address the needs of the clients in a primary care setting. The skilled staff that delivers clinical excellence is supported by cost-based-plus financing. High-quality services are dependent upon skilled staff being paid adequately. Thus, low salaries created low recruitment and low retention and will create a quality crisis for behavioral health care.

To illustrate the importance of the ACA, in January 2019, Virginia expanded Medicaid under the ACA. The expansion substantially increased income eligibility up to 138% of the federal poverty level (Lyu & Wehby, 2019). Lyu and Wehby (2019) examined the effects of Virginia's Medicaid expansion in 2019 on health insurance coverage, access to care, and health status by employing a difference-in-differences and a synthetic control design (Lyu & Wehby, 2019). The data that came from American Community Survey from 2016-2020, included health insurance and access to care, and health status came from the 2016–2020 Behavioral Risk Factors Surveillance System sample. The samples were limited to non-elderly adults with income below 138%. The insured rate increased in 2020 due to the large increase in Medicaid coverage among

individuals within 100-138% of FPL but there were no changes in both income groups concerning private coverage after the expansion. There was a decline in necessary medical visits due to costs for individuals below 100% and within 100-138% FPL in 2020 and no change in health status outcome. The findings showed increased insurance coverage among poor adults with improved access. There is a missed opportunity for other states that have not decided to expand Medicaid programs to improve coverage and access among their low-income individuals (Lyu & Wehby, 2019). The states that did not participate in the Medicaid expansion program provided more individuals to be eligible for the increased poverty levels. The expansion will provide more individuals with access to quality health care and providers with increased funding to accommodate the increased health care visits.

Quality of Care

Public managed behavioral health care continues to grow, which has raised concerns about effects on the services being provided. One in five Americans as well as half of the nation's births are insured in Medicaid (Montoya et al., 2020). Medicaid recipients are currently enrolled in a health maintenance organization. Health maintenance organization supporters argued that insurance costs can be lower while maintaining quality access to care. There were 32 studies of Medicaid managed care conducted between 2011-2019 and the results of the study found that there were state-specific cost savings and increased access or quality to care under Medicaid managed-care programs (Montoya et al., 2020). The services were compared with clients who are funded through public managed care and other types of funding sources. Montoya et al.

(2020) showed the results that public managed care does not restrict access to outpatient treatment but should be monitored to ensure that clients are received adequate treatment as individuals.

The Network for the Improvement of Addiction Treatment (NIATx) provides alcohol and drug treatment programs to apply process improvement strategies and make organizational changes to improve the quality of care (Capoccia et al., 2009). A framework is provided by NIATx to address the six dimensions of quality of care regarding the treatment of alcohol, drug, and mental health disorders. NIATx provides an overview of how the behavioral health field can adapt and respond to the increased demand for quality care (Capoccia et al., 2009). In 2008, there were 22.2 million people that had substance dependence, and subtracting the number of people in Alcoholics Anonymous and institutional therapy, left an estimated 19.3 million people in need of treatment (Cook, 2010). The cost-efficient approach to relapse has two views. The first view is the least learning necessary for the primary care physician to provide satisfactory services to the many that need treatment. The second view is the reduced availability of clinical resources needed to address the socio-economic impact of relapse.

Financial Impact of ACA

The P4P programs were introduced by the ACA to improve the quality, safety and efficiency of care provided to Medicare beneficiaries. Medicare’s P4P financial risk to hospitals is substantial but the positive impact of these programs has been mixed (Waters et al., 2022). The consistent improvements in targeted or non-targeted quality and safety measures were not associated with Medicare P4P programs. The mortality rates were

getting worse after the introduction of Medicare's P4P programs. There is minimal effect of Medicare's hospital P4P programs on quality and safety but there is an increase in mortality in the administrative cost of monitoring and enforcing penalties. Centers for Medicare and Medicaid Services should consider redesigning the P4P programs before any expansion (Waters et al., 2022). The P4P design cost calculations are straightforward, and the savings are higher with increased participation. This type of evidence-based approach can be implemented with no large upfront investment.

Substance abuse treatment will become a part of primary care under the ACA. There will be more prevention, early intervention, and treatment options that will conclude better results with less expensive outcomes (Vimont, 2013). Providers should treat the full spectrum of the disorder, including people who are in the early stages of substance abuse. The treatment program's approach to providing quality service must include the consumer's input on their recovery. In the U.S. municipalities, EBPs are a frequent approach that closes the quality chasm in behavioral health treatment. The municipalities are investing in EBPs as the primary way to improve the quality of care that they deliver to individuals. EBPs will not be successful in behavioral health treatment if basic organizational needs are not met in the fiscal environment. Unless there is adequate financing, EBP approaches to improving quality are likely to fail as well as not addressing the fiscal challenges in community mental health and substance use services (Stewart et al., 2021). Quality of care cannot be provided with limited financing to EBPs, which in turn will affect individual access to quality care. The goal of EBPs is

to be successful in delivering the services to individuals but with lack of funding the goal will not be met due to fiscal challenges.

Insurance Policy Changes

The Inflation Reduction Act (IRA) and the extended American Rescue Plan Act (ARPA) increased the health insurance tax credits. This made people with incomes below the 400% of the federal poverty level and extended eligibility for people with higher incomes to purchase through the marketplace. The ARPA subsidies will keep 3.3 million people from becoming uninsured (Holahan & Simpson, 2022). Although the Build Back Better Act did not pass legislation, one provision was included in the Inflation Reduction Act which was an extension of ARPA premium subsidies, which was scheduled to expire on January 1, 2023, and is now extended through 2025. There are five reform policies that could continue to make coverage more accessible: (a) filing the Medicaid gap in nonexpansion states, (b) reducing the employer affordability threshold, (c) adding a $10 billion reinsurance fund, (d) increasing the federal Medicaid matching rate in expansion states, and (e) enhancing and funding marketplace cost-sharing subsidies. The reform with the greatest impact on coverage would be filling the Medicaid gap (which would reduce the number of uninsured by 1.9 million) and improving cost-sharing subsidies (which would reduce the number of uninsured by 1.5 million) in 2023 (Holahan & Simpson, 2022). The reform policies would reduce the number of uninsured from 28.5 million to 24.8 million in 2023. Expansion states will be provided with fiscal relief due to cost-sharing subsidies and funding reinsurance enhancements.

Social Improvement

Health and social services contributions to a patient's overall health outcome play a vital role in employment success. There has been research on whether targeted health and social services contribute to improved physical/mental health and employment. The results showed that need-service matching contributes to improved health and social outcomes (Andrews et al., 2011). With the ACA being implemented, there has been an increase in funding for the providers as well as better access for patients to receive treatment for conditions like substance abuse (Abraham et al., 2017). The ACA provides greater access to substance abuse treatment through coverage expansions, regulatory changes in existing insurance plans, and requirements for treatments to be offered with medical and surgical procedures (Abraham et al., 2017). States have an arsenal of tools that is allowed under the ACA to address substance abuse disorders of which many states have taken full advantage of the reform in treatment options (Abraham et al., 2017). The arsenal of tools will provide overall better treatment options for patients with providers having the ability to increase their treatment options for better results.

The DBHIDS in Philadelphia County, Pennsylvania uses Transformation Tools to make decisions to improve on services that are provided. The Transformation Tools is a comprehensive system that has a network of community provider agencies and collaborates with numerous other social agencies and key stakeholders (DBHIDS, 2023). DBHIDS has trained its staff to embrace and implement a vision of recovery, resilience, and self-determination. The direct relationship between customer satisfaction and the organizational culture of a business is the key to improving its customer satisfaction level

by aligning its culture with customer satisfaction (Kordnaeij et al., 2012). Kordnaeij et al. (2012) conducted research to examine if the performance and effectiveness output of a company is directly related to the organization's culture. There were four areas the research focused on: (a) involvement, (b) consistency, (c) adaptability, and (d) mission. Kordnaeij et al. believed that if organizations review their cultural strategies and implement what works for them, customer satisfaction will increase.

The categories of enablers and barriers to funding objectives were developed to adapt a methodology for successful project implementation and to identify factors associated with successful project implementation. There were 127 records accessed for completed projects funded by Alcohol, Education and Rehabilitation Foundation from 2002-2008. The records provided for evidence base project implementation in alcohol and other drugs fields. The finding results showed that those supportive relationships with partner agencies and communities, skilled staff, and consumer or participant input were associated with successful project implementation (MacLean et al., 2012). Health care leaders are experiencing an increasingly rapid pace of health reforms because there is a growing need for bidirectional integration for primary care and behavioral health. Integrating primary care and behavioral health care presents an opportunity for expanding the model of care in the communities (Rosenberg, 2012). Specialty addiction professional expertise is for people living with addictions. The reason for this is to improve the overall opportunity for recovery and better overall health and cost savings for health care systems.

Approaches to Treatment

There are many health care prevention approaches. A study was done on prevention systems for community-level reductions in drug use and antisocial behaviors. The study was conducted between 2003 and 2008 with a random selection of 24 towns in the United States and 928 community leaders with either Communities That Care (CTC) intervention or control conditions (Rehew et al., 2013). There were reported higher levels of adoption of a science-based approach to prevention and higher usage of funding desired for prevention activities among CTC leaders. The results indicated that CTC implementation produced an enduring transformation of the prevention system, which produced long-term reductions in problem behaviors. The CTC system was examined to determine if 1.5 years later the prevention system had sustained effects. The findings indicated that CTC implementation produced an enduring transformation of important prevention systems (Rhew et al., 2013). Prevention systems construct intervention programs that may produce long-term reductions in problem behaviors.

The payment methods and financial incentives became a powerful influence on the provider and health performance of both public and private payers and purchasers (Brucker & Stewart, 2011). The state of Maine explored the results of implementing performance-based contracting within the substance abuse treatment system to determine if the performance had improved (Brucker & Stewart, 2011). The analysis included a design to examine utilization and payment structure, timeliness of access to outpatient substance abuse services, and discharge data from prior years. The results showed that performance was poorer after implementation and no difference with the completion of

treatment. The implementation of Performance Based Cost succeeded in tracking performance measures in the state of Maine to determine whether gains were made. Performance Based Cost improved accountability and increased focus on access to and retention in treatment.

Patient Protection and ACA encourages payment methods and incentives to promote integrated care delivery models. Provider teams coordinate patient care; monitor, and assess the quality of health information, and pay and financial incentives to encourage value-based health care (Eldridge & Korda, 2011). The current climate of increasing performance expectations and diminishing resources creates new dilemmas for substance abuse treatment providers, policymakers, funders, and the service delivery system (Fussel et al., 2009). As a result of the interviews with substance abuse authorities (SSAs), they are concentrating more effort on evidence-based practice implementation that will improve the internal functions of the facilities. There were fewer efforts on the financial resources, regulations, and accreditation that were tied to state funding (Fussel et al., 2009). SSAs can track the number of states engaged in contracting and EBP acceleration efforts over time. State agencies, treatment providers, and policymakers benefited from knowing how other states responded to the call for increased EBP adoption.

Human Services Access

There has been a need to assess human services to prioritize services that will address the unmet and under-met needs of the community. Nonprofits' role in conducting human service needs assessments will relieve the government health and human services

administration of this responsibility (Eschenfelder, 2010). Due to economic challenges, the role of nonprofits in community-based research has been relevant in prioritizing limited resources and services along with public organizations. There are strategies that drug treatment agencies use when assessing their current plan and ways to improve the service they provide (Rieckmann et al., 2010). The strategies used are the development of assessment tools, manualized treatments, and evidence-based treatments that are compiled to create practice guidelines to support treatment services.

Organization, staffing, and service are the three variables used to adopt new technologies in structural transformations in substance abuse treatment (Rieckmann et al., 2010). The data gathered from the organization, staffing, and services variables created two outcome variables, which were practice guidelines and assessment tools. The results showed increased use of assessment tools also increased the use of practice guidelines. The researchers intended to provide substance abuse treatment providers with a framework that will guide them when adopting new strategies in the treatment of substance abuse (Rieckmann et al., 2010). In a time of shrinking public and private dollars, collaboration between public organizations, not-for-profits, private providers, community groups, and government agencies has become a new strategy.

Collaboration has become a catchword among private and government agencies in the Mid-South region. Interagency collaboration has become a necessary tool to deliver services effectively and efficiently while legitimizing their funding sources (Word, 2012). This collaboration has also resulted in further outreach opportunities that were not available due to overlooked or reduced services. There is less concern about

overdelivering services effectively and efficiently but as a response to the current economic climate.

New dilemmas such as service quality and service access were created due to the increase in performance expectations and diminishing resources for substance abuse providers, policymakers, funders, and the service delivery system. Alexander et al. (2011) used a sample of outpatient substance abuse treatment units to examine how public managed care and services affect clients. The providers focused on improving the internal functions of their services such as transportation, resource-intensive services, and therapy sessions (Alexander et al., 2011). The state funding efforts that were tied to resources, regulations, and accreditation were given less attention. The providers compared client services funding types, which were public managed care and other types of funding, to the amount of treatment provided to the clients. The results showed that public managed care does not restrict access to outpatient treatment but should be monitored to ensure that clients receive adequate treatment as individuals.

The Latino population in the United States is disproportionately affected by substance use, HIV/AIDS, violence, and mental health issues (SAVAME). A study was conducted to gain a better understanding of the network of SAVAME services for Latino immigrants in Philadelphia (Martinez-Donate et al., 2022). The participants included providers that are working in Latino-serving organizations providing SAVAME services (Martinez-Donate et al., 2022). There is a growing need for integrated strategies to reduce their impact on SAVAME services. The data collected used purposely selected participating interviews that were analyzed using thematic coding and grounded theory.

The Latino-serving providers who lived in Philadelphia perceived that there is a large need for availability, accessibility, and adequate need for SAVME services for Latino immigrants. There were gaps in mental health and substance use services because of insufficient funding for these services. The barriers that were identified as the reason for access to services included (a) lack of health insurance, (b) immigration status, (c) limited English proficiency, (d) stigma surrounding SAVAME issues, (e) and limited knowledge of available services (Martinez-Donate et al., 2022). The providers also noted the scarcity of well-trained, culturally competent, and ethnically providers reduced the adequacy of SAVAME services for Latino immigrant clients. Other factors that came into play that limited many Latino serving providers to adopting a system for the prevention and treatment of SAVAME services.

In the United States, the Latino populations are disproportionately affected by SAVAME. As a result of the need for SAVAME integrated strategies, there are calls for changes in the structure of funding streams and communitywide strategies to foster collaboration across SAVAME providers working with Latino immigrant clients (Martinez-Donate et al., 2022). Latino-serving providers had challenges in meeting the needs of mental health and substance use disorders due to insufficient funding streams to support these services. The main barriers among providers and community members are the lack of knowledge of available services. Communitywide coalitions fostered collaboration with SAVAME providers to work with Latino clients to improve barriers and strengthen the network of Latino-serving organizations. Service providers' goal is to meet the needs of all communities with behavioral health services with adequate funding

available which was SAVAME goal for the Latino community. The goal of this study is to examine the challenges of the providers within the aspect of adequate funding availability to provide adequate services to clients.

Funding Strategies

Human services organizations funding decisions are critical in supporting the community. Those funding decisions are made by giving grants that include mental and physical health. Community engagement brings valuable benefits to the decision-making process when determining the needs of the community problems (Farwell & Handy, 2021). Organizational leader funding decisions outline a deeper understanding of the grantee 's needs and challenges that will provide greater effectiveness (Farwell & Handy, 2021). There are challenges with achieving the goals of the participants that can stem from the recruitment processes, grant maker motivations, and sensitivity to staff roles.

The current climate needs of EBPs were assessed to increase performance expectations while reducing funding resources. Diminished resources have created new problems for substance abuse treatment providers, policymakers, funders, and the service delivery system (Fussel et al., 2009). The findings from interviews with representatives from 49 state SSAs showed results aimed at EBPs. The implementation strategies included more efforts in education, training, and infrastructure development, and fewer efforts on financial mechanisms, regulations, and accreditation (Fussel et al., 2009). SSAs used EBPs as a criterion in their contracts with providers, and just over half tie EBP use to their state funding. Oregon is the only state with that mandate's treatment expenditures for EBPs followed by North Carolina that followed suit within their current resources.

Leaders and managers of governmental and not-for-profit human service organizations face a special challenge because they are expected to break even or show a small recovery of revenues over expenses (Sorensen et al., 2010). Substance abuse treatment providers in the State were faced with a funding crisis due to the State's reimbursement rate at only 53% of the cost of services (Sorensen et al., 2010). There were efforts made to increase the reimbursement rate, meanwhile governmental and not-for-profit providers were prepared by creating 30 mechanisms to cope with any financial losses. These mechanisms provided a financial bridge until the rate adjustments were in place.

Information Technology

There is a need for data management capabilities to improve substance abuse treatment programs. The data management capability of providers to determine how they can improve their system resulted in a need for expertise, training, and funding to improve substance abuse treatment programs (Ford et al., 2011). The barriers for providers to achieve better data management included a lack of integrated information technology systems; limited funding, time, and staff to implement information technology-related changes (Ford et al., 2011). The challenges that drug and alcohol treatment agencies face when trying to improve their infrastructure to meet growing technological and organizational demands can be improved with better data management systems.

Increased performance monitoring improvements have been led by health care reform. The four areas of technological improvement in substance abuse treatment are (a)

health information technology for publicly funded services, (b) electronic medical records, (c) identifying barriers and facilitators to implementing technology, and (d) discussing applications with private and international agencies (Wisdom et al., 2010). The intended results can improve outcomes in the areas of cost-effectiveness, provider time savings, and quality improvement. Barriers exist when implementing health information technology in substance abuse treatment programs. Health information technology infrastructure in substance treatment can facilitate increased incentives, evidence, and implementation guidance.

Primary care practices need practical guidance on the steps they can take to build behavioral health integration (BHI) capacities, particularly for smaller practice settings with fewer resources. BHI capacities are needed for smaller primary care sites throughout New York to utilize a framework of core components of BHI and technical assistance (Goldman et al., 2022). Semistructured interviews and focus groups were conducted at 6 months and 12 months during site visits with a stakeholder roundtable to address broader issues. The data were analyzed using qualitative thematic analysis (Goldman et al., 2022). The results showed that there was successful engagement with the framework and active participation in the planning and advancing of BHI operations. The current practices with existing onsite BHI are (a) services, (b) identified champions, (c) early and sustained training, and (d) involvement of providers and administrators. This success was due to collaborative agreements with external behavioral health providers and to successfully receive reimbursements for BHI services (Goldman et al., 2022). There have been challenges across sites with advanced health information technologies as well as

financing and policy factors that are critically important to advance integration efforts (Goldman et al., 2022). BHI practices vary in size, resources, and partnerships. The BHI helped leaders and policymakers organize their efforts to their specific context to identify opportunities to advance payment and policy. Significant additional investments by primary care practices and policymakers are needed in order for BHI to expand.

Funding Changes

Currently, funds for services come from block grants and under the ACA, funding will come through Medicaid and the private health insurance system. The changes that will take place with the ACA implementation will change how substance use disorder treatment will receive funding and the types of services that are reimbursed (Freese, 2011). Due to ACA, there will be immediate changes and challenges in the billing system for Medicaid-related services. Instead of billing based on filling beds, providers track and bill by specific services.

Mental health has recently gained increasing attention on the global health and development agendas and has led to calls for an increase in international funding. The two categories of development assistance for mental health (DAMH) characteristics differed in terms of largest donors, largest recipient countries and territories, and sector classification (Gribble et al., 2021). Some projects were reviewed manually and put into two categories dedicated entirely to mental health and projects that mention mental health. The characteristics of the projects were based on the donor, recipient, and sector has undertaken cumulatively and yearly (Gribble et al., 2021). There were consistent findings that the top donors accounted for over 80% of all funding identified. The

recipients were predominantly conflict-affected countries and territories. The shifting of international development put priorities and political drivers in the sector classification (Gribble et al., 2021). DAMH significant amount of funding was directed toward conflict settings and relevant emergency response. The increased funding for DAMH should be directed towards the understanding of funding drivers for both emergency and general health settings.

The DAMH showed that significant amounts of funding were directed toward conflict settings and relevant emergency response by a small majority of donors. The results of DAMH were minimal because of international assistance for mental health, donors, recipients, and sector characteristics. The study showed that a better understanding of a request for increased funding should be grounded in an understanding of funding drivers and directed toward both emergency and general health settings (Gribble et al., 2021). International assistance for mental health demonstrated patterns of donor, recipient, and sector characteristics to favor emergency conflict-affected settings. The request for increased funding was directed toward both emergency and general health settings.

Retention of Consumers

Many adolescents entering substance abuse treatment do not stay for the full prescribed treatment. The barriers to the retention of the adolescent treatment program have a perception of the relationship between the adolescent, parent, and treatment staff (Gogelet al., 2011). A study with 87 participants included adolescents, parents, and staff from three residential substance treatment agencies in two states. The data collected were

organized into themes by the respondent type. The results from the participants reported barriers to treatment by facilitators' communication and relationships. Treatment facilities staff may rely on crisis management interventions instead of employing strategic and evidence-based treatment. The staff underestimated their own influence because there were more barriers to treatment than facilitators and see the options to be limited when treating adolescents. The crisis management may lead to staff burnout and staff attitudes could hinder treatment participation.

Previous researchers showed that longer periods of treatment had an improved effect on the client's outcome. Walker (2009) explored the relationship of the characteristics between drug-addiction treatment programs and better outcomes based on the length of treatment. The characteristics of the client and the program were collected from a national survey of outpatient drug addiction treatment programs with a range of services (Walker, 2009). This range of services is attributed to better outcomes of treatment for the client. When drug addiction treatment programs offer a range of services, there is a positive relationship between the length of time in treatment and number of counseling sessions.

Fiscal Trends and Programs

The increasing societal heterogeneity, changing demographics, and increased public debt have led to fiscal constraints on state welfare programs. There has been a convergence of trends in social services due to new public management ideas and the reinventing of government (Henriksen et al., 2012). The differences in trends in convergence among Denmark, Germany, and the United States focused on the welfare

state activity in the social services and related health care areas on how the third-party sector delivered services. All three countries had the same problems, pressures and policy ideas that were conceptualized with four dimensions: ideas, regulation, a mix of providers, and revenue mix (Henriksen et al., 2012). The transformation of social services in Denmark, Germany and the United States has been very difficult to observe the trends because each of the countries have a different starting point. All three countries' trends seem to coincide and arrive at the same place with a mix of providers, regulatory structuring, and the financing or revenue mix.

Corrections-based substance abuse treatment programs hold some favorable potential in the reduction in the prevention of crime. United States costs in drug addiction are approximately $81 billion a year and only $3.4 billion is spent on prevention or treatment (Reyes, 2009). Reyes (2009) identified that between 1980 and 1997 drug offenders increased by 1,040% due to HIV transmission due to drug injection. This resulted in the need for evidence-based evaluation for international corrections-based substance treatment programs. Similar countries saw similar results from the same kind of drug treatment programs. A report on HIV transmission among people who inject drugs in 120 countries, about 81% of the countries support a harm reduction approach and 65% have or will implement a methadone program (Reyes, 2009). Methadone maintenance is a long-term treatment that requires money and staff. Short-term and reenrollment clients are an enormous cost to clinics (Sullivan, 2013). The countries reviewed were United States, Belgium, Canada, Taiwan, and Scotland and the study

concluded that there was no apparent difference among these countries on whether or not the substance abuse treatment programs achieved the prevention of crime or drug use.

Legal drug prices in the United States can be compared to Europe and other regions. In 2011, generic legal drug use rose 80% and saved patients $193 billion, which could lead to renewed efforts by Congress to enact legislation (Wechsler, 2012). Generic drug use is part of the efforts to control drug prices for rare and serious conditions. The health system payment reform involves the delivery, financing, and analysis of health care. Community-based mental health initiatives are uniquely positioned to understand the mental health needs of their communities that are relevant and culturally appropriate.

There are challenges in mental health initiatives in low- and middle-income countries. There is inadequate funding, barriers to demonstrating impact, and difficulty engaging with stakeholders (Larrieta et al., 2022). The Ember Mental Health program established 12-month partnerships with community-based mental health initiatives in low- and middle-income countries to support them to address these challenges, grow, and achieve sustainability (Larrieta et al., 2022). A study was conducted with 11 initiatives from March 2020 to March 2021 to analyze time points throughout the Ember Mental Health partnership. The findings indicated that the initiatives benefited from (a) side-by-side mentorship, (b) skills strengthening and strategic thinking, (c) occasions to network experts with mental health professionals, and (d) support for team empowerment. This combination of initiates created recommendations for funders and stakeholders to support community-based mental health initiatives in low- and middle-income countries. The collaborative partnerships showed that it is possible to support the initiatives to address

the mental health needs of communities (Larrieta et al., 2022). Accounts of global mental health projects highlight the strain in underinvestment in mental health services.

The impact of innovations maximizes the expertise in the field with more flexible and long-term funding needs. There needs to be further innovation in global mental health to tackle the rising burden of disease and to address the needs of their communities. Expanding investment into Coordinating Board for Mental Health Issues (CBMHI)s across diverse contexts must be accompanied by longer funding cycles and further diversification of the mechanisms by which funding is currently granted. Funding requests can be made more accessible at the grassroots level, for example, through increased flexibility in the format and requirements of applications and reporting processes to funding bodies that account for limited resources—not limited impact—to increase access to services quickly.

Drug Indicators

The goal of European Monitoring Centre for Drugs and Drug Addiction is to improve comparability data across member countries to share data regarding patterns of problem drug use, drug related infectious diseases, drug related deaths and mortality of drug users, and demand for drug treatment. European Monitoring Centre for Drugs and Drug Addiction collected data on the five key drug indicators. The indicators were general population surveys, drug-related infectious diseases, drug-related deaths, mortality of drug users, and demand for drug treatment. These indicators were used for comparing statistics of the community's day-to-day drug problems and treatment outcome measures (Loughran & McCann, 2011). The indicators are a summation of an

individual's experience with drug problems but do not answer the question of how it affects the communities. The community drugs are studied to review the contribution of traditional indicators of drug problems and the community data is used to identify possible community indicators of drug problems.

Service Organization Performance

The business performance of a company has a direct effect on its competitive advantage in its industry. The results from the public accounting services firms' study on business performance (achievement of sales and profit objectives) did not suggest that the service organization will have a competitive advantage because of the relationship between learning orientation and business performance in public accounting services firms (Martinette & Obenchain-Leeson, 2012). Survey questions were created to test the framework of the relationship between learning orientation and the effects on business performance. The results of the study found that there is a direct relationship between learning orientation and business performance in a service organization. The survey-based research methodology that was used allowed the researchers to determine that competitive advantage moderates the relationship established between learning orientation and business performance in service-reliant organizations (Martinette & Obenchain-Leeson, 2012). In conclusion, as learning orientation increases, so does performance and competitive advantage also increase. This analogy can be applied to all service type organizations with a goal of providing quality service.

Nonprofit organization revenue diversification plays a key role in business sustainability. A proven framework from The Baldrige Excellence Framework for Health

care was used to assess Nonprofit Behavioral Health Organization's (NBHO) organizational components of leadership, strategy, and operations (Hurt, 2021). Hurt (2021) examined the revenue diversification practices and challenges of international, behavioral health, and nonprofit organizations. The type of data collected included a review of current revenue diversification, semi structured interviews with three senior-level leaders in the organization, and a review of select organizational documents. Major themes were created for revenue diversification decision-making that included organizational culture, brand awareness, weighing the pros and cons, and leadership involvement. The overall recommendations helped NBHO address potential gaps in its current revenue diversification strategies and increase long-term sustainability (Hurt, 2021). The positive social change contributes to the decision-making challenges in best practices of nonprofit revenue diversification (Hurt, 2021). When a behavioral health organization provides training, support, and resources for staff, there will be continued business sustainability practices to ensure continued provision of behavioral health services.

Employers' Health Care Expenses

When employers offer employees substance abuse help, the employees need to cope with drug abuse, this reduces time away from work and allows the employees to focus on their jobs. Employees' coping with drug and alcohol abuse are less productive and create increased costs for health care expenses to employers (Palmer, 2012). Employees who are substance impaired are more likely to be involved in a workplace accident which costs employers between 25% to 200% to replace the employees. The loss

is not just in monetary costs but institutional knowledge, service continuity, and coworker productivity which is in relation to employee turnover (Palmer, 2012). NBHO increased their brand awareness by promoting positive social change through community connections. The brand awareness creates potential new clients, retention of current clients, and new revenue sources. NBHO increased communications has been accomplished through the networked coordinator system, increased feedback strategies, and increased funding opportunities for direct mental health services. The successful strategies of NBHO to increase brand awareness can provide financial stability and ongoing sustainability.

ACA Costs and Financing

The ACA is improving health care while reducing health care costs. The ACA encourages hospital administrators to coordinate care, improve care quality, and save money by reducing post-acute care costs. The Centers for Medicare and Medicaid Services bundled payment initiative offers providers four payment models (Reynolds, 2011). This initiative has significant risks and limits financial benefits will dissuade most providers from participating in this program. ACA is highly favored by Americans by 55% (Miller & Moffit, 2020). The goals achieved by the ACA include (a) expanding coverage and access to care, (b) creating competition in each states' insurance markets, and (c) reducing the costs of health insurance and health care costs for families (Miller & Moffit, 2020). The ACA created expansions of coverage through federal insurance subsidies and Medicaid enrollment, but the ACA law was sold as a cost-control measure. During the process of implementing the ACA law, the transfer of regulatory authority

went from the states to the federal government for individual and small group insurance markets.

SAMHSA 2012) was established in 1992 and directed by Congress to effectively target substance abuse and mental health services to the people most in need. SAMHSA researched in these areas more effectively and more rapidly in the general health care system. SAMHSA continues to make strides to improve the delivery and financing of cost-effective services to advance and protect the Nation's health. SAMHSA provides prevention services for targeting early risk factors that can improve behavioral health outcomes for children and young adults. SAMHSA also services military families, homeless individuals, and families with mental and substance abuse disorders to transition into permanent supportive housing. The strategic plan of SAMHSA’s is to emphasize a more person-centered approach to better meet the behavioral health care needs of individuals, communities, and service providers.

EBPs are essential to address the public health and societal impacts of adolescent substance use disorders. The costs associated with EBP implementation and sustainment need effective financing strategies and direct financial resources (Dopp et al., 2022). There are two types of U.S. federal grant mechanisms (financing strategy) and organization-focused or state-focused granting of funds. The data was collected from 85 organizations in 19 states from organization-focused grant recipients in 2012 and 82 organizations in 26 states in 2014 for analysis (Dopp et al., 2022). The results from the research may have direct and practical implications for behavioral health administrators, policymakers, implementation experts, and the public. This new knowledge will directly

inform financing strategies and sustainment to support large-scale, sustained EBP delivery in behavioral health (Dopp et al., 2022). Behavioral health administrators, policymakers, implementation experts, and the public will gain new knowledge in financing strategies to sustain EBP while advancing implementation science. The advanced knowledge in EBP may provide different outcomes of two federal financing strategies for penetration and sustainment. The goal is to increase the availability of high-quality adolescent substance use disorder treatment while advancing implementation in EBP.

Behavioral health care leaders are required to understand how public and private financing mechanisms interact through multiple systems and financing streams. The added value to publicly funded behavioral health care systems is to understand better how their resource streams work (Stuart, 2003). The results will be achieved when behavioral health care administrators take a new approach to the considerations behind funding decisions and payment mechanisms (Stuart, 2003). The new approach and understanding of how the financing mechanisms work, what they create, and what they cause is essential for BHP leaders to make decisions about complex resource streams.

Faith-Based Organization Funding

The expanded use of faith-based organizations (FBOs) as providers of publicly funded services has been a high point among policymakers, practitioners, and portions of the general public since it was established in 2001 and remains focused with implementing faith-based policies. FBOs have participated in publicly funded programs since the Charitable Choice statute was enacted. The Charitable Choice was enacted

during the Clinton administration and then additional faith-based initiatives were implemented by the Bush administration (Kramer, 2010). The framework for evaluation was to assess the appropriateness of public funding for behavioral health services delivered by FBOs, to address the many challenges they face in the communities that they serve. The analysis discovered that there are two issues that FBOs face: (a) the programmatic and systemic effects of new FBOs, and (b) the content and effectiveness of faith-infused services. For FBO to increase awareness of their programs, there were considered classification issues, measured effects of faith-infused services, and the transferability of faith-based interventions across religious sectors that was applied to satisfy constitutional issues and client choice.

To address these issues, the FBOs must provide a profile of services and who gets served; and identify interventions appropriate for public funding. To satisfy constitutional issues and client choice, FBOs addressed classification issues, measured the effects of faith-infused services, and the transferability of faith-based interventions across religious and secular applications (Kramer, 2010). The public interest in FBOs has expanded because of the special expertise, special capabilities of staff, or the content of services. The service content and better outcome measures provided by FBOs have been traditionally publicly funded. It is difficult to make funding decisions without knowing how religion interacts with program operations and the services delivered to clients (Kramer, 2010). A rigorous evaluation has been required to define the cost-effectiveness analysis to determine whether FBO interventions are measurably effective. President Obama's administration identified programs that work, programs that deliver services

within the requirements of the law, regulations, and other agreements under which received public funding (Kramer, 2010). Faith-based and community organizations have the burden to demonstrate to delivery system with public funding to improve the quality and quantity of services and broaden access to underserved populations. The delivery system will improve the overall efficiency of the system.

In conclusion, health inequities are well documented across the United States. The health inequities stem from policies and practices created by the government to distribute power and resources, such as housing, education, employment, environmental amenities, and health services (Fleming et al., 2021). Government-funded public health agencies are given the responsibility to eliminate health inequities and improve population health. The government and taxpayers subsidized both policies that cause health inequities and the public health agencies' ability to address them has created a paradox (Fleming et al., 2021). The overburdened network of national, state, and local public health agencies in the United States addresses traditional public health services while also addressing the national opioid epidemic, chronic diseases, and racial/ethnic health disparities. Public health agencies are also responsible for improving the health of communities with increasingly less equipped funding, governance structure, and resources. The budget cuts on all levels of public health system addresses the harm to the communities they service. Only 3% of $3.36 trillion spent annually goes towards health care in the United States (Fleming et al., 2021). The underfunding of health care was exposed by the COVID-19 pandemic. The public health agencies need to address reduction in health inequities and

improving overall population health by adopting a foundational cause approach with the use of data, people, and power to overcome the public health funding paradox.

Federal spending on programs that improve the health for people with low or moderate incomes has been projected to decrease through 2029 (Fleming et al., 2021). The federal budget has proposed shifting massive health costs to the states. The strained states and municipalities have been affected the most with the shifts of costs that they are cutting spending that was meant to improve population health. Even with federal relief funds and states reserves, states struggles have increased to fund critical public services due to the COVID-19 pandemic even with federal relief funds and state reserves. Without federal support, most states will face an estimated $510 billion budget gap, which may cause states to cut education and health care and may delay recovery and undermine public health (Fleming et al., 2021). If government-funded public health agencies are looking for ways to reduce health inequities and improving overall population health, there needs to adopt foundational cause approach and use data, people, and power to collectively overcome the public health funding paradox.

A critical barrier to implement and sustain evidence-based practices (EBPs) has been identified as insufficient funding. Increased access to funding has been recognized as an implementation strategy to create policies to earmark access to taxes (Purtle et al., 2023). The revenue collected can only be spent on specific activities, which is a common mental health financing strategy. The earmarked revenue strategy could improve the reach of EBPs (Purtle et al., 2023). The revenue strategy project aims to (a) identify all jurisdictions in the United States that have implemented earmarked taxes for mental

health and catalogue the tax design; (b) characterize experiences they had while implementing earmarked taxes among local (e.g., county, city) mental health agency leaders and other government and community organization officials to assess their perceptions of the acceptability and feasibility of policy implementation strategies; and (c) develop a framework to guide earmarked tax designs, inform the selection of implementation strategies, and disseminate the framework to policy audiences (Purtle et al., 2023). The revenue project uses the Exploration, Preparation, Implementation, Sustainment framework to determine and process tax implementation to examine the acceptability and feasibility strategies which could support earmarked tax policy implementation. The earmarked tax revenue for EBPs will be used in different contexts for the types of strategies that could be most readably deployed to improve the reach of EBPs.

Transition

In Section 1 of the Foundation of the Study, the focus was on the problem that behavioral health agency leaders faced when there is a loss of revenue to take care of behavioral health clients and their inability to service funding sources. The role executives play was critical in having the skills and knowledge to create viable processes to mitigate the lost revenue. This section provided the background and sources that support the researcher's journey in conducting this study in an ethical manner that provided a better understanding of the behavioral health system processes. Section 1 also provided the problem and purpose statement, a review of the academic literature and the nature of the study. The reader and participants reflected upon the reason and results of

this study in Section 2. Section 2 focused on methodology, case study design, data collection, and data analysis.

Section 2: The Project

I conducted this operational study looking for improvements in the current best practices in place with the goal of developing an understanding of BHP leaders' policies and procedures and how the leaders measure value. I gathered agency data on the revenue processes as they relate to their business model. The three types of BHPs in the current study are mental health, drug and alcohol, and intellectual disability. Each participant described their success strategies for planning, organizing, and managing, thereby highlighting their current business strategy. The goal of this study was to determine if there could be transferability in processes among different types of behavioral health operations so that they can become more efficient and effective in their financial business operations.

Purpose Statement

The purpose of this qualitative multiple case study was to explore the successful strategies that BHP leaders used to create viable processes to mitigate losses in revenue. I selected a case study as the research design to address the specific business problem regarding sustainability for BHPs. The target population consisted of six managers of BHPs in Philadelphia who developed and implemented successful strategies to create viable processes to mitigate the loss of revenue. The implications for positive social change included the potential for managers of BHPs to use the results of this study to help identify strategies to create viable processes to mitigate losses in revenue. BHPs who sustained revenue sources were able to provide consumers with more options for

behavioral health services that enabled the consumers to improve the quality of their lives.

Role of the Researcher

As the primary research instrument, I conducted semistructured interviews with the directors and managers of three behavioral health agencies that addressed the areas of revenue and the impact on providing services as a result of any revenue change. I had no previous relationships with the topic, participants, or research area for this study. As the researcher, I had the responsibility to protect the participants in the study while placing their welfare above the interests of science and society. The *Belmont Report* is the leading work involving ethics and health care research (Sims, 2010). The primary purpose of the *Belmont Report* is to protect subjects and participants in clinical trials or research studies (Sims, 2010).

As the researcher, my responsibility was not just to follow regulatory or legal requirements, but it was imperative that I conducted this study according to universal ethical principles and norms. I provided the appropriate research protocols approved by the research ethics committees of the Walden University IRB. I provided a consent form to each of the participants that explained the study, any risks, and information protection procedures. The proposal for this study was approved by Walden University IRB before I proceeded with the interviews and data collection. The interviews provided me with a transparent lens to view and understand the problem through the participants' unbiased opinions based on their personal experience and views. I interviewed the participants

with curiosity and without a preset opinion by engaging with the research and being objective in my writing.

Through maintaining confidentiality and anonymity, I assured the participants of the privacy of their data (see Saunders et al., 2015). The anonymity of the participant responses ensured that the participant could provide their responses in the interview without any pressure. To ensure that the participants could be interviewed without pressure, I informed them that the information would be kept confidential and that they would not be identified in the study. If the participants did not want to share parts of the interview, I did not include this information in the study. The data collected and the member checking process helped me gain more of an understanding of the participants' business strategies for success and how they handled the loss of revenue within their respective agencies.

I prepared an interview protocol (Appendix) that provided the details of the interview regarding the participants, time and location, the study, time limit, and the member checking process. The interview protocol was a way for me to keep track of the requirements that were needed to follow when collecting the data from participants.

Participants

The purpose of this qualitative multiple case study was to explore the successful strategies that BHP leaders used to create viable processes to mitigate losses in revenue. The three environments I explored were mental health, intellectual disabilities, and drug and alcohol. The planning, organization, and management practices were the focus of the data collection. I interviewed six BHP leaders from Philadelphia County, Pennsylvania

(i.e., two participants from each of the three environments outlined above). I established a working relationship with the participants by being the only contact person from beginning to the end of the interview process. The participants were informed that their responses may have an impact on other similar participants' future sustainability plans. I gained permission to collected data from the participants via the consent form, which was completed by participants prior to conducting the interviews. I also obtained approval (#10-20-23-037426) from the Walden University Institutional Review Board (IRB) before conducting the interviews and collecting data. Receiving IRB approval ensured that I followed ethical guidelines while conducting this study.

I used snowball sampling and purposeful sampling with the following inclusion criteria participant recruitment: (a) had a minimum of 3 years of experience, (b) resided in Philadelphia County, Pennsylvania, and (c) had evidence of successful revenue generation. I initially emailed the participants with an invitation to participate in the research study, and if they agreed to take part, I sent them a consent form and set up the interview. I gained an understanding of the selected BHP leaders' policies, procedures, and how they measured the value by analyzing and comparing the results of the interviews.

In qualitative studies, an interview is a way for researchers to collect data through asking questions of the participants to understand the participants' thought processes (Stuckey, 2013). The use of open-ended questions provided the participants with the opportunity to offer more insight by responding in their own words. The interview was

audio recorded and later transcribed to ensure that all the data had been captured to ensure accuracy (see Stuckey, 2013).

Research Method and Design

There are three types of methods that a researcher can use: qualitative, quantitative, or mixed methods (Crossman, 2019). There are many qualitative research designs, including case study, narrative, phenomenology, ethnography, and grounded theory. The data collection technique was also selected based on the research method that was chosen. I reviewed the literature that explained the three research methods and some of the qualitative research designs to determine the best method and design for the study.

Research Method

The qualitative method was appropriate for this study because I wanted to understand and interpret the experiences of behavioral health leaders pertaining to their successful strategies for the creation of viable processes to mitigate losses in revenue. Qualitative research involves collecting and analyzing nonnumerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences and can be used to gather in-depth insights into a problem or generate new ideas for research (Bhandari, 2022). A researcher is considered the instrument because they observe, interpret, and analyze during the data collection process (Bhandari, 2022). The data collected and analyzed are filtered through the researcher's own lens. A qualitative researcher focuses on the humanistic or idealistic approach by understanding people's experiences to generate nonnumerical data (Pathak et al., 2013). Qualitative research is used in other

research fields beyond the social sciences and humanities to view data more extensively (Pathak et al., 2013).

The quantitative method is a set of strategies, techniques, and assumptions used to process numeric patterns (Coghlan & Brydon-Miller, 2014). A researcher uses the quantitative method to gather a range of numeric data to conduct simple to sophisticated statistical analysis of the data collected. The quantitative methods used to collect data are questionnaires, structured observations, or experiments (Coghlan & Brydon-Miller, 2014). The purpose of the quantitative method is to generate knowledge and create an understanding of the social world. The quantitative method is used by social scientists and communication researchers to observe occurrences and phenomena that affect individuals (Allen, 2017). The quantitative method is used to study a specific sample population and relies on data collected to examine questions about the sample population (Allen, 2017). I did not use the quantitative method because numerical data and the examination of the relationship between variables would not have addressed the research question in this study.

A mixed method approach was not appropriate for this study because only one method (i.e., qualitative) was needed to explore the various strategies. Mixed-methods research combines quantitative and qualitative to answer the research question (George, 2022). Mixed methods can help the researcher gain a more complete picture of the problem and the results of the study. This method is often used in the behavioral health and social sciences (George, 2022). Mixed-methods research may be the right choice if the research does not sufficiently support or answer the research question with

quantitative or qualitative data alone. Mixed methods can be very challenging because the researcher combines both qualitative and quantitative research in the data collection process, and for this reason, is a less common method among researchers (George, 2022).

Research Design

The case study design involves a deep understanding of multiple types of data sources. The case study design is used to provide explanatory, exploratory, or descriptive results (Sauro, 2015). I selected a multiple case study design for the current study. The case study is an exploratory analysis that is used when the goal is to provide an answer to "how" questions about a certain phenomenon (Yin, 2018). I used multiple sources of evidence in this study. Multiple sources of evidence have proven to be rated higher in terms of overall quality than those that relied on a single source of information (Yin, 1994).

I also considered using a narrative design. With the narrative design, a researcher uses in-depth interviews to weave together a sequence of events, usually from just one or two individuals (Sauro, 2015). This design was not appropriate for the current study because there were six participants. In a narrative design, human experiences are explored and conceptualized in textual form to develop an in-depth meaning of the participants' rich experiences. The researcher works with a small sample of participants by interviewing them on the topics of interest, and the design may involve the analysis of written documents. As a mode of inquiry, the narrative design is used by researchers from a wide variety of disciplines (Josselson, 2022).

The phenomenological research design is used to describe an event, activity, or phenomenon (Sauro, 2015). This design was not appropriate for the current study because I did not focus on an event or activity based on human's lived experiences. The phenomenological design is used to understand and describe the essence of the phenomenon, and I did not use this design because I was not investigating everyday human experiences or did, I have any assumptions about the phenomenon. The phenomenological researcher uses the participants' lived experiences to gain deeper insights into how the participants understand those experiences. The phenomenological researcher may also assume that people use a universal structure or essence to describe their experience (Sauro, 2015). To clarify the participants' feelings, perceptions, and beliefs, the phenomenological researcher interprets the information that is being studied by bracketing prior assumptions (Delve, 2022). The phenomenological research design is commonly used because the researcher collects data about the participants' lived experience, gains a deeper understanding of how human beings think, and expands a researcher's knowledge about a phenomenon (Delve, 2022).

The ethnographic research design is used to be immersed in the target participants' environment to understand the goals, cultures, challenges, motivations, and themes that emerge (Sauro, 2015). This research design was not appropriate for the current study because I did not immerse myself in the participants' environment to study BHP leaders' strategies to decrease the loss of revenue that they are facing in sustaining funding sources. In ethnographic research, the aim of the researcher is to gain a better understanding of a particular group (Kramer & Adams, 2017). Ethnographic research is

both a process and a product (Kramer & Adams, 2017). The researcher is doing the process by actively participating in the group to gain an insider's perspective and to have experiences similar to the group members. The researcher will then create an account based on the data collection of the participation, interviews, and analysis of the documents and artifacts (Kramer & Adams, 2017).

The grounded theory design is used to provide an explanation or theory behind the events being studied (Sauro, 2015). The grounded research design involves constant movement between data collection and analysis to develop a theory that was not appropriate for the current study. Grounded theory can use both qualitative and quantitative data-generating techniques that set out to discover or construct theory from data that are systematically obtained and analyzed using comparative analysis. It is a complex research design because it is structured yet flexible and is used when little is known about the phenomenon under study (Tie et al., 2019). The most defining characteristic of grounded theory is that the data are grounded in theory by obtaining (a) the history, (b) main genres, and (c) essential methods and processes employed in the study (Tie et al., 2019). The researcher must demonstrate the interplay between the methods and processes in grounded theory, and this involves meticulous methods and processes as well as systematic modes, procedures, and tools used in data collection (Tie et al., 2019).

Data saturation is an essential element in research work. Data saturation is the point when the researcher makes the judgment that they can stop sampling the different groups that are in a selected category (Saunders et al., 2018). Data saturation, or when

there are similar instances repeatedly in the data, means that no additional data has been found in the sample selected and no further data collection/analysis is necessary (Saunders et al., 2018). I ensured data saturation for this study by continuing to interview BHP leaders who had successfully implemented strategies to create viable processes to mitigate losses in revenue until no new data emerged.

Population and Sampling

I interviewed six Philadelphia County behavioral health leaders from three separate agencies to gain knowledge of their business strategies and models in relation to financial and service stability when there is fluctuation in funding. The three agencies comprised three different types of services being offered (i.e., mental health, intellectual disability, and drug and alcohol). This type of participant selection provided a comparative perspective on how their financial operations may be similar or different for each type of service being provided (see Lo et al., 2020). The participants' planning, organization, and management practices were the focus of the interviews.

The reason for the selection of six sample participants was to ensure data saturation. The "information power" is a guide for selecting an adequate sample size (Malterud et al., 2016). Information power indicates that the more information that the sample holds, which means the study is relevant, the lower number of participants is needed (Malterud et al., 2016). Data saturation indicates that no new information is being attained. The determination of a sample size depends on (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy. The sample size is established in the planning and data collection section of the

study (Malterud et al., 2016). Sampling strategies benefit a qualitative study by providing new knowledge by shifting from the amount of input to the content of input. The assessment of the sample that can answer the research questions is vital at all stages of a research project: planning, execution, and dissemination (Malterud et al., 2021). The concept of information power suggests that sample assessment can be an alternative to the use of saturation to discontinue data collection.

Ethical Research

I ensured that my study is ethical. A preconsulting with the BHP agency leaders was needed to get a verbal yes or no for their participation and data collection. A written summary was given to inform the agency leaders of the details of the study and the ethical requirements that are needed before the researcher can proceed with the interviews (The Belmont Report, 1979). The participants could withdraw at any time. There was no penalty if the participants decided not to participate in the study. There were incentives for participating in this study.

The protection of the participants is paramount (The Belmont Report, 1979). I respected and treated each participant fairly and with compassion. I collected detailed data information and used easily understood information in the consent form. The data will be stored securely in my locked desk at my residence for 5 years to protect the rights and confidentiality of the participants. There will be no names of individuals or organizations included in this study. The participants were coded as P1 = Participant 1, P2 = Participant 2, etc. as to mask their identity.

Data Collection Instruments

I was the data collection instrument. I provided interview questions to six individual participants in three behavioral health agencies (mental health, intellectual disability, and drug and alcohol) in Philadelphia. In my data collection process, I used semistructured interviews and company documents. I provided an overall review and comparison of the implementation of best practices regarding the use of funds in relation to their services. I used an interview protocol to assess data collection (see Appendix). The interview protocol provided details of the interview regarding the participants, time and location, details about the study, transcribing time limit, and member checking. The interview protocol was a way for me to keep track of the requirements that were needed to collect the data from participants.

To ensure the reliability and validity of the data collected, I created a verbatim transcript no later than 48 hours after each interview took place. I also synthesized the interview responses and created a member-checking document. I then shared the document with each participant (Birt et al., 2016). I requested copies of budgets and service outputs from the BHP leaders to support the data collected from the interviews. The various methods of delivery (Zoom interview or face-to-face) of the interview questions depended on what worked best for the participant. This data collection method provided the data behind each agency's budget process and helped answer my research questions.

Data Collection Technique

The data collection technique for the interviews was based on the interview questions will be zoom interviews. The participants interviewed at an agreed-upon time to conduct the interview. The conduct of the interviews was at the convenience of both the participant and the researcher. The disadvantage of this study design was that there were approvals needed from the agencies prior to the interview process and I requested that the individuals provide any documents needed to support the study. The agency documents masked any identifying information about the participants and the organization. Before the data from the interviews were analyzed, the information was checked for accuracy by using member checking. Member checking is a technique that validates the participant's responses by exploring the credibility of the results (Birt et al., 2016).

Member checking was used by providing the study participants with the results of their interview to check for accuracy and to verify that the researcher captured their experiences as intended. I performed member checking by verifying the responses with the participants to ensure that I captured their responses accurately. If there were any corrections needed, they were completed at that time and verified again with the participants that their response is correct. Once the study participant confirmed the accuracy of their interview, the results from the interview and documents provided were grouped and compared among the six participating providers. This comparison provided an overview of processes that each participant followed when structuring services and preparing their budgets.

Data Organization Technique

The data collected from the interviews was tracked by creating a log that includes the questions and responses of each participant. A cataloging system can be used as an additional tool to highlight important similarities and comparisons because of the interviews. I used the interview questions to create procedure characteristics of each of the participants based on the data collection and analysis of that data which became obvious during the interview results. Once approved by the participants and IRB, the data will be stored for 5 years in my locked desk at my residence. The data were organized by coding the data collected from the BHP leaders' interview answers. I used this coding system to interpret, organize and structure their answers by themes and patterns. This provided transparency and validity accuracy and decreased bias in the study.

Data Analysis

I analyzed the data using Yin's (2018) thematic data analysis. The five steps for data analysis are (a) compile database, (b) disassemble data, (c) reassemble data, (d) interpret data, and (e) conclude data. I analyzed the data collected by cataloging the responses of BHPs for similarities and differences based on the research question. A cataloging system is an analysis tool for identifying similarities and differences among the participants to identify the important strategies that are being used when reviewing objectives for their agencies (Rollo & Chiacchio, 2022). A comparative analysis of the data collected provided a detailed view of the results from the interview of the participants' responses. A comparative analysis compares similar items to one another to

view their differences and commonalities to gain a better understanding of the problem being addressed (Rollo & Chiacchio, 2022).

I compared each of the agencies' views on the problem that executives in these agencies have experienced and their shared their knowledge to create viable processes to mitigate the lost revenue. In this study, a multiple case study was used as the design and various data sources were collected and analyzed in order to gain a better understanding of the business problem. The qualitative research method allows the researcher to visualize the case study through multiple lenses and facets of the phenomenon that will be revealed from the results. Erlingsson and Brysiewicz (2017) stated that an analysis of qualitative research is useful to deepen the human experience in a multiple qualitative case study. The primary focus in a multiple case study is the researcher's ability to describe the results from the vast amounts of clear and concise data collection from the participants. The call for changes in the structure of funding streams and communitywide strategies can create collaboration across providers to provide successful business strategies to serve the client needs (Martinez-Donate et al., 2022). The data analysis for this doctoral study addressed the research question pertaining to the doctoral study.

After analyzing the collected data, I used the NVivo software tool was used. NVivo is a software tool used for qualitative data analysis by researchers to describe, evaluate and interpret social phenomena from the data collected (Elliott-Mainwaring, 2021). NVivo assisted the researcher in organizing, analyzing, and visualizing the data by finding the patterns to facilitate and identify principal themes for my doctoral study. A color-coding analysis was utilized to differentiate between each response of the

participants and each case to cross-analyze within the doctoral study. The correlation between utilization and funding needs can be used in how the business strategies are created by BHP leaders, which may lead to lost revenue and client services.

Reliability and Validity

Reliability

Reliability in qualitative research lies in the consistency and exact replicability of results (Leung, 2015). Reliability describes how far a particular test, procedure, or tool, such as a questionnaire, will produce similar results in different circumstances, assuming nothing else has changed (Roberts & Priest, 2006). The dependability of the study relies on the data from the participants (Roberts & Priest, 2006). The data was extracted from firsthand knowledge of the participants' views regarding the agency's revenue processes. The information was gathered by analyzing the participants' responses to the question responses in the interview. The results were reviewed with the participants for accuracy and verified during member checking. I reviewed the interview responses with the participants to ensure that I recorded the responses accurately. A follow-up interview with the participants gave the participants an opportunity to not only review the previous responses but to add any additional information pertaining to the research questions.

Validity

Validity in qualitative research is the "appropriateness" in the use of the tools, processes, and data to determine if the research question is valid for the desired outcome (Leung, 2015). Credibility is the first criterion that must be established in trustworthiness. It is the most important aspect or criterion for the researcher to clearly link the research

findings to the reality of truth in the research findings (Statistics Solutions, 2022). To ensure the credibility of my study, I verified the answers provided by participants responses with a transcript review followed by member checking for a better understanding of the problem.

I ensured transferability. Transferability in qualitative research is equivalent to or a replacement is synonymous with generalizability and external validity (Coghlan & Brydon-Miller, 2014). The transferability of the results was enhanced by having a detailed process to obtain the data including using an interview protocol (Appendix), using semistructured interviews, and having a detailed process to code and analyze data. These details helped in ensuring that all readers understood the results provided and other researchers could replicate the data if needed. The interview results were reviewed with the participants for accuracy and verification to confirm data interpretation between the participant and the researcher.

I ensured confirmability. Confirmability is trustworthiness that a researcher must establish (Nyirenda et al., 2020). The criterion for confirmability is the confidence level of the research study's findings that are based on the participants' narratives and not the researcher's biases (Nyirenda et al., 2020). I ensured confirmability by verifying the findings with the participants. I verified the collected data with the participants to ensure their provided interview responses were accurately recorded and interpreted.

The researcher's goal was to achieve data saturation. Data saturation is when a researcher reaches a point in their analysis when additional sampled data will not lead to more information that is related to their research question (Saunders et al., 2018). Data

saturation was achieved after the process of interviewing the participants and using follow-up requests for new information among the participants. I sought out updated and new data/documentation from the participants during the review portion of the interview. According to Roberts and Priest (2006), reliability and validity are ways of demonstrating and communicating the rigor of research processes and the trustworthiness of research findings. The results of the research should be helpful to the reader and not misleading.

Transition and Summary

In Section 2 of the study, the focus was on the strategy for the researcher, participants, and data collection techniques that support the foundation of the project. The researcher's role was crucial in guiding how the data would be collected. A detailed explanation of which participants were interviewed and why and how they will be chosen was discussed. The ethical consent process has been discussed to ensure that the researcher follows IRB rules in protecting the participants. Section 2 has provided the background and sources that support the researchers journey in conducting this study in an ethical manner that will provide a better understanding of the behavioral health system processes. The results, findings, and conclusions from the data collected will be further discussed in Section 3 provides the reader with the outcome as to why the problem exists in the behavioral health system and recommendations for success.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple case study was to explore the successful strategies that BHP leaders use to create viable processes to mitigate losses in revenue. The results indicated that BHP leaders focused on strategies that can lead to increased revenue that will decrease any losses or deficit in their budgets. I used semistructured interviews as well as review of service rates and quality management plans to triangulate the data collected. Three themes emerged from the data analysis (see Table 1). The first theme was staffing retention strategies to retain new staff and keep current staff with the revenue collected. The second theme was business pivot strategies that were created to increase referrals for new services, which increases revenue. The third theme was community outreach to inform the communities that the BHP serves of the services that they provide. The three themes aligned with the conceptual framework of Andersen's behavioral model of health services (see Aday & Andersen, 2014).

Table 1

Strategy Viability Themes

Central themes	Number of participants	Percentage of participants
Staffing retention	6	100%
Business pivot strategies	6	100%
Community outreach	6	100%

Participants for this study were six BHP leaders in Philadelphia County, Pennsylvania. The focus of the data collection was the participants' planning, organizing, and management practices. I analyzed the data by utilizing Yin's (2018) five-step

process. I limited the exposure of each of the participant's responses and business throughout this section because of the confidentiality that was required for this study.

Presentation of the Findings

The research question for this qualitative study was: What business strategies do BHP leaders use to create viable processes to mitigate losses in revenue? I analyzed the business strategies that were revealed during the participants' interviews and organized them into three themes. These themes aligned with the conceptual framework of the Anderson model. Andersen's model is used to explore the determinants of an individual's health services utilization, access to health services, and the facilitation of equitable access to health services (Chen & Gu, 2021). I employed the conceptual framework of the Andersen model to understand and explain how certain types of health services are used. The goal of BHPs is the ability to sustain services for patients, and this was the focus of my application of the Andersen model in the current study.

Theme 1: Staffing Retention

The first theme that was identified was staffing retention. All six participants shared that staffing is a major challenge. The need for more staffing and retaining the staff that they currently have is critical to remain viable in behavioral health services. The participants described how important it is to increase staffing levels and the effects that staffing levels have on providing services to their clients. States have often limited funding for community-based services for those who qualify for waiver (Donner, 2023). According to the Office of Developmental Programs, as of 2022, there were 12,389 people on the waiting list for waiver services (Pennsylvania Department of Human

Services, 2022). According to Participants 1, 2, 4, and 5, service for people with disabilities on the waiver list must be provided with services by law to those who qualify. There are no such requirements for home and community-based services.

Participant 1 explained that a staffing shortage was not a problem 15 years ago. When the agencies' revenue is affected, raises in employees' salaries will also be affected, which in turn affects the retention rate of current staff. The underfunding from the state has made it difficult to retain or hire the needed direct support professionals (DSPs) and support coordinators. Participant 2 explained that staff do not get paid as much, and it is difficult to incentivize people to be a DSP, but they maintain the quality of services for their clients. The challenge to hire or retain employees was worsened by the COVID-19 pandemic. Participant 1's strategies for retaining staff are to give incentive payments to staff that go above their work levels and who cover extra caseloads. All the participants' current staff take on more duties than they were hired for because of the staffing shortages. Their caseloads have increased to ensure that all their clients' services are being provided. The SCs are supposed to have a caseload of 30; however, they now have a caseload of 90. The state is not offering enough funding to the services, and the results are decreased funding causing difficulties in hiring staff.

Participants 2 and 4 noted that the ratio of staff to individuals is based on whether they are attending the day program at the agency or going out into the community. Participant 2's ratio to staff is two to three individuals per staff and that is regulation based for safety measures. Participant 4's ratio of staff to individuals is in a group of 1 to 4 or when they are in a consolidated group of 1 to 5. The issue with ratios is that if they

are short staffed, then every staff member will have more individuals to support, which could result in the staff splitting up the group. The short staff in ratio may result in the individuals not being able to go out in the community. The split leaves behind three people that need to be covered and accounted for. If the participants do not have enough staff to accommodate many outings, they can only do a few outings.

The study participants do whatever they can to provide the same level of service to the clients despite employee shortages. The state has set up rules for nonprofit providers in general to what they can do. It does not matter if the agency is struggling, BHPs are still supposed to meet all the state deadlines and are still supposed to provide the same level of service whether things are tough or not. Sometimes, the agencies must figure out creative ways to make that happen. Participant 1 pulled in supervisory staff to fill some of the gaps. Participant 1 reported receiving a little extra money to help with recruiting, but the additional recruiting funds were not enough. According to Participant 1, they used a recruiting agency to augment their own recruitment for staff, but they had to put the recruitment agency services on hold because they were not finding superior people or people that were going to stay long in the position and the recruiting fee was expensive. The recruitment fee was $8,000 per staff person for a 90-day work guarantee. According to Participant 1, the fee is a lot of money to pay a recruiting agency that was not doing any better than BHP was doing on their own. Participant 1 moved to Plan B because the recruitment agency was not going to work in the long term.

Staffing challenges could result in agencies turning away new referrals and discontinuing services. The Andersen model is used concerning different behavioral

health illnesses such as mental health, drug and alcohol and intellectual disability. The predisposing factors enabling the use of behavioral health services are income, medical insurance, and living location. The studied population has a strong influence on the direction of the factors (Alkhawaldeh et al., 2023). DSPs provide a range of support in a variety of services, and SCs oversee the budget of the individuals that the agency serves in their communities. The DSP turnover rate is disruptive to the lives of the clients they serve because of the lack of stable and reliable support, which can impact day-to-day outcomes. Wages are the main factor with retention rates of DSP and the agencies' vacancy rates (Pettingell et. al, 2022). The participants' hiring must factor in the costs of hiring and training new employees and offering incentives, bonuses, wage increases, and benefits.

Theme 2: Business Pivot Strategies

The second theme that was identified was business pivot strategies. Participants 1, 2, 4, and 5 shared their business strategies to remain viable and discussed how they pivoted their business to increase revenue and sustain their agency during many challenges with staffing shortages and stabilized rates from the state. Pennsylvania Governor Josh Shapiro and his administration announced that the Department of Human Services updated the data used to set rates for home and community-based services for Pennsylvanians with intellectual disabilities and autism (Pennsylvania Pressroom, 2023). The governor recognized that DSPs are called on to do so much while there is a shortage that has put a strain on the industry. The Department of Human Services sets the rates through the Office of Developmental Programs, and a fee schedule is established for rates

for providers of Medicaid home and community-based service programs. These home and community-based service programs serve individuals with intellectual disabilities and autism by helping them safely live in their community among their family and peers.

Participant 1 has a quality management committee and quality management plan that works on specific outcomes to increase the number of people for competitive employment and increases the number of people that choose the life sharing option, which supports individuals with Intellectual Disability (ID) to live with qualified adults who provide support in their home rather than group residential housing, while struggling with employee turnover. There are other counties outside of Philadelphia who have less turnover because their options for employment are decreased, which resulted in employees staying longer. Participant 1 reported that they are trying to keep their billable units up to mitigate losses in revenue by cutting down their expenditures. Participant 1 relocated outside of Philadelphia with half the space to reduce the cost of rent. The new location includes everything except for electricity. Participant 1 also moved to a less expensive billing provider in September 2023 that is cloud based to reduce costs of the servers, server upkeep and maintenance costs. The strategies are always being reviewed to look for ways to cut costs that will increase revenue and maintain their quality of service.

Participant 2's source of revenue is received from individuals with intellectual disabilities and autism who are receiving Medicaid waiver funding. Participant 2's funding streams have a series of caps which are: (a) first cap max up to $41,000, (b) second cap max up to $81,000, and (c) the third one is capless. Participant 2 looks at the

individual's funding cap and determines how often the individual can attend their program per week. The cap limit determines how often they can attend the program and what type of service they are eligible for in the individual's approved budget. The more days a week the individual attends the program, the more the agency's revenue increases. Participant 2's ongoing revenue is based on the individual maintaining their continued involvement in the program. The agency loses revenue if the participant passes away, loses their waiver eligibility, or moves out of the area and they cannot be transported to the agency in a timely manner. Participant 2 has some individuals who have been coming to the program for upwards of 30 years, and many individuals have been coming for 10 and 20 years. The participants who attend the program often stay because of the improved quality of life that the program offers.

Participant 4's agency provides mental health and ID services with 12 residential services on the mental health side. They reported that there is not a lot of support for residential services, the rates are low, and the demand for that level of care can be burdensome for an organization. The reason their agency can sustain its business is by not taking on the burden of residential service in its ID program. There is a blank rate for all residential services in mental health services, but on the ID side, they call it individualizing the rate per individual. According to Participant 4, some clients have psychiatric challenges, and some clients have behavior challenges. The client could get a rate based on the number of units, then the agency bases that rate on the number on how high the client score is for behavioral services. If a person is in a Needs Group 4, the highest level, they could live in a residential service. The provider might receive

anywhere from $800 to $900 dollars a day, up to $1,200 a day. When the clients sign up for the day program, they have flat rates. Participant 4 thinks losses are mitigated by staying small with their services. This year, the rates for the day program are the highest they have been, and Participant 4 hopes to finish out the year with less of a financial deficit than in previous years.

Referrals are important to the agencies' revenue streams. Since the agencies are short staffed, Participant 5 keeps track of the flow of referrals that come in from other support coordinator organizations (SCOs). The SCOs' primary responsibility is to locate, coordinate, and monitor needed services and supports for waiver eligible participants. SCOs also monitor the health, safety, and service delivery of the individual (Pennsylvania Department of Human Services, 2023). Each client has an individualized support plan that is reviewed so that the agency can schedule a facility tour with the SCO as soon as possible, even with the staffing shortage. The process conducted by Participant 4 is a way to keep the flow of client intake moving to receive more funding. This process is done in an organized manner to keep track of new clients.

The goal of all six participants is to bring in clients who would be viable for 4 or 5 days a week because that helps with the billing process. Participant 4 has increased the number of individuals in their Community Participation Support from 25 to 34 individuals. When the program shut down in 2020 due to the COVID-19 pandemic, there were only 12 participants who came back. The other clients were afraid to come to the program because they were afraid, they would get sick. Client attendance is what funds the day programs, so if clients do not attend, the agency will have a revenue loss. It can

be a challenge for all six participants to stay on top of the workflow with staffing shortages and a decrease in client referrals. The agency tries to keep things streamlined and organized to make sure that staff have structure so that managers can focus on the referrals and interviewing new staff coming onboarding.

A person's decision to use health services is influenced by certain factors, including income, access to free services, and the availability of services. Anderson's behavioral model provides a structure to use to understand the utilization of health services and the factors that impact a person's decision regarding existing health care (Alkhawaldeh et al., 2023). Streamlining and organization helps to make sure that managers can eliminate any operational inefficiencies and keep the program running smoothly.

Theme 3: Community Outreach

The third theme that was identified was community outreach. All six participants reported that word of mouth is how they continue to remain viable in the communities that they serve. According to Participant 2, the Pennsylvania Department of Human Services does not like day programs, and they believe that everyone that can work should work. All the participants do not share in the state's view. Participant 2 stated that the Pennsylvania Department of Human Services would like to see day programs decreased and diminished because they believe *it is a money pit*. If the client is working, the burden of state funding will be put back on the individual. People with an ID often do not feel welcome in certain spaces, do not feel cared for it, and do not feel safe. Often, people with ID are not safe. However, people with ID feel safe when they are in a setting where

they can be with their peers throughout the day, socialize with their peers, and go with staff to a set place daily and have a set routine. Participant 2 stated that community outreach is important to the survival of the behavioral agencies to promote the services that are available to people with ID, autism, and mental health challenges.

Participant 4 explained that the city and state are not helpful, so their agency tries to be innovative in how they provide services by remaining visible in the community. Participant 4 applied for grants that were needed (e.g., a wheelchair ramp outside of the client home). The agencies have established relationships with several outside organizations that are willing to help with the agencies' needs.

Participant 4 also stated the clients look to support coordinators to ask for help because caregivers' ages are anywhere from 70 to 90 years old, and they have their own health issues. The caregivers were lifting and helping to care for their loved ones. The system shifted over time where the caregivers who have been caretaking for a long time are the ones who really need the support and that is where the agencies are most of the time. The participants networking in and outside of the community increases awareness of the services they offer and that has increased referrals to their agency. The participants are creative and innovative to get the things that they need for their clients.

Participant 5 stated their "staff has varied out into the community to do more outreach to SCOs" and their employees try to be more varied in terms of going out into the community and doing a little more outreach to SCO's. Participant 5 promote their business in the community and at job fairs. The participants get their name out in the community by offering community supports programs and supported employment

programs. All six participants want to be more active and more grassroots oriented in campaigning. In the sense of promotion and advertising, all six participants always have business cards for distribution whenever there is a referral and when referrals from family members come in to tour the facility. This type of personal promotion is done as much as possible to be more varied in terms of where they send their staff in the community so that people know the agency/organization has a presence. Participant 4 stated, "staff have made shirts for our clients so that when they go out for volunteering opportunities it gets their name out in the community. People can see their logo and say, 'hey these are the Philly meadows.'" There have been increased visits by SCOs to the agency due to promotions and staying on top of referrals.

There are ID agencies that have been closing or losing clients in their supported employment and day programs. Community outreach strategies have resulted in remaining in business by supporting current and new clients in the community. Participant 5 reported, the CEOs business model has been promoting where possible their points of pride and their strong local reputation since the 1980s.

Community and environmental factors shape the use of health services. The factors that shape health care include demographics, characteristics of a community, the physical environment, health-related measures, and indices of population health (Alkhawaldeh et. al., 2023). The ID side can be challenging with the service needs of the clients. The agencies strive for success by managing the day-to-day needs of the clients by remaining open.

I triangulated the data collected with semistructured interviews, review of available budget rates and data quality management plans to enhance the credibility of the study. Using multiple sources of data ensures that data triangulation and validity is reached in the case study (Yin, 2018). The themes were developed based on methodological triangulation and coding of the data collection. Triangulation increases the credibility and validity of research findings. Credibility refers to trustworthiness and validity is concerned with accuracy (Arias, 2022). Methodological triangulation promotes several different data collection methods to provide a balanced explanation to readers with a variety of methods with the validation of data (Noble & Heale, 2019). The results of the study can be explained through triangulation leading to the same results to give more confidence in the research findings.

Applications to Professional Practice

The findings of this study may provide BHP leaders with examples of successful strategies they can use to create viable processes to mitigate losses in revenue. The six participants of this study identified that staffing retention, business pivot strategies, and community outreach are important factors when implementing strategies for mitigating losses in revenue. The ongoing workforce crisis in the BHP field is a supply and demand issue. To address the demand and supply for DSPs a significant pay increase is needed to establish balance between employees and clients (Spreat, 2022) The impact of local, state, and federal government rates on the ID industry is a contributing factor of the workforce crisis. The demand for ID services (demand) and the supply of DSPs have grown parallel with 90% of the demand being met over the past 30 years (Spreat, 2022).

Moreover, increasing pay for staff retention, increasing rates for services, and increasing outreach is a successful approach to reducing losses in revenue.

This study provides BHP leaders with examples of business pivot strategies to remain viable to provide service to their clients. DSPs and SCOs may benefit from pivot strategies of behavioral health services to successfully increase referrals to improve the promoting of quality of services being offered to the ID community. Moreover, the agency can incorporate pivot strategies and community outreach as part of their business model to enhance client service. The state and federal legislative bodies can create a workable solution by providing fiscal support to disability advocates. Fiscal support will be essential in the sustainability of the behavioral health system (Spreat, 2022). The results of this study could be relevant across BHPs by providing examples of business pivot strategies to remain viable in the behavioral health business. BHPs implement successful strategies that may improve staffing retention, increase awareness that retention problems exist, and improve competitive advantage among clients who seek behavioral health services.

Implications for Social Change

The communities may benefit from the results of this study through increased awareness of the quality services that BHPs provides. BHP leaders face challenges in long term systemic underfunding of ID services and this situation will only end when interests of the legislators increase funding for behavior health services (Spreat, 2022). Policies to expand Medicaid coverage of home and community based are needed to address social determinants for behavioral health services (McGinity, 2023). Population-

based global budgeting approaches for health care have the potential to improve behavioral health services by incentivizing to control costs while simultaneously improving the services to the population they serve. Expanding reimbursement policies for peer support specialists are needed to help peers navigate treatment and support services (McGinity, 2023). BHP leaders have a fiscal responsibility to manage finances, operations, and staff effectively and efficiently. The positive social change for this study may improve the communities that the behavioral health providers serve due to providing consistent services for all who seek treatment. The availability of services is the key to maintaining a positive outlook on social change.

Recommendations for Action

BHP leaders should review their current business model and create or update their quality management plans annually with staff to foster greater attention to cost controls and service outputs. The input from staff on business strategies to remain viable in the community should be shared to create self-efficacy among employees. BHP leaders who invest into further developing innovative and creative ways to increase referrals, retain staff, and maintain quality of service may have increased awareness of the social impact in the communities they serve. The service needs of the clients are the most important factor among BHP leaders and reaching this goal will take successful strategies to be implemented. I provided a summary of my findings so that the business problem could be addressed. The goal of this study is to share the successful business strategies that BHP leaders have implemented to remain viable and reduce losses in revenue.

Recommendations for Further Research

This qualitative multiple case study was designed to explore business strategies BHP leaders use to create viable processes to mitigate losses in revenue. The findings of this study hve shown that further research may be applied to other leaders in different industries. The study's findings support that BHP leaders can create viable processes to mitigate losses in revenue by pivoting their business, community outreach, and increasing staff. The limitation of the study was the small sample size was used. The data collection was limited to the interviews, agencies website, service rate amount, quality management plan and specific health care business situations. The participants only represented a small group within a larger number of participants in their industry. The study was restricted to only Philadelphia county in Pennsylvania. The recommendation is a data collection for a larger group of BPH leaders that would include multiple counties in Pennsylvania who may may provide additional data for successful business strategies.

Reflections

My doctoral study has been a long and challenging process emotionally. The road that I traveled has been both stressful and exciting. I am very thankful that I was able to take this DBA journey by gaining experiences both personally and professionally. The support that I received from family and friends is tremendously appreciated. While the completion of my doctoral study is the greatest accomplishment in my life, it has also been one of the hardest moments in my life.

When I started writing this study, I hoped that the findings from the data collection would showcase the importance of behavioral health agencies and the business

strategies that are used in an industry where quality service is the key to being successful. This study has expanded my knowledge of different business strategies for BHP leaders. I learned that BHP leaders must consistently be creative and innovate in their business strategies while facing many challenges in staffing and remaining visible in the community. I also learned that BHP must provide the needed services no matter how much funding they receive because their rates are determined by the state. The governor of Pennsylvania is currently reviewing and assessing the current rates for behavioral health services that employ DSPs. There is a waiting list for waiver eligible individuals, and in 2023, the governor signed a budget that helped an additional 850 individuals get off the waitlist. The review of rates gives BHP leaders hope that the behavioral health community is being heard by the governor so that service needs will be addressed soon.

Conclusion

The effects of personalized budgets for people with disabilities are measured in terms of well-being, service satisfaction, and unmet needs. The personalized budgets were found to be more cost-effective than alternative options. The possible higher costs of personalized budgets may be outweighed by additional benefits of employment services and day programs that will increase the quality of life for BHP clients. The BHP leaders evaluate their services and staff, adjust where needed, and identify creative ways to remain viable in the industry to increase their success rate, which will have an impact on the community that they serve.

References

Abraham, A. J., Andrews, C. M., Grogan, C. M., D' Aunno, T., Humphreys, K. N., Pollack, H. A., & Friedman, P. D. (2017). The affordable care act transformation of substance use disorder treatment. *American Journal of Public Health, 107*(1), 31-32. https://doi.org/10.2105/AJPH.2016.303558

Abraham, J. M., Hofer, A. N., & Moscovice, I. (2011). Expansion of coverage under the patient protection and affordable care act and primary care utilization. *Milbank Quarterly*, *89*(1), 69–89. https://doi.org/10.1111/j.1468-0009.2011.00620.x

Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health Services Research*, *9*(3), 208-220. https://www.ncbi.nim.gov/pmc/articles/PMC1071804/

Aday, L. A., & Andersen, R. M. (2014). Health care utilization and behavior, models of. *Encyclopedia of biostatistics*. https://doi.org/10.1002/9781118445112.stat05316

Alexander, J. A., Chuang, E., & Wells, R. (2011). Public managed care and service access in outpatient substance abuse treatment units. *The Journal of Behavior Health Services & Research*, *38*(4), 444-463. https://doi.org/10.1007/s11414-010-9230-y

Alkhawaldeh, A., ALBashtawy, M., Rayan, A., Abdalrahim, A., Musa, A., Eshah, N., Abu Khait, A., Qaddumi, J., Khraisat, O., & ALBashtawy, S. (2023). Application and use of Andersen's behavioral model as theoretical framework: A systematic literature review from 2012-2021. *Iranian Journal Public Health, 52*(7), 1346-1354. https://doi.org/10.18502/ijph.v52i7.13236

Allen, M. (Ed.) (2017). *The Sage encyclopedia of communication research methods.* (Vols. 1-4). SAGE Publications, Inc. https://doi.org/10.4135/9781483381411

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1–10. https://doi.org/10.2307/2137284

Andrews, C. M., Cao, D., Marsh, J. C., & Shin, H. (2011). Improving health and social outcomes with targeted services in comprehensive substance abuse treatment. *The American Journal of Drug and Alcohol Abuse*, *37*(4), 250-258. https://doi/org/10.3109/00952990.2011.591016

Arias, V. M. M. (2022). Principles, scope, and limitations of the methodological triangulation. *Investigacion Educacion Enfermeria*, *40*(2). https://doi.org/10.17533/udea.iee.v40n2e03

Aspers, P., & Corte, U. (2019). What is qualitative in qualitative research. *Qualitative Sociology, 42*(2), 139-160. https://doi.org/10.1007/s11133-019-9413-7.

Bandura, A. (1986). *A social foundation of thought & action: a social cognitive theory* (1st ed.). Prentice Hall.

Bennett, A. R. (2012). Accountable care organizations: Principles and implications for hospital administrators. *Journal of Healthcare Management, 57*(4), 244-254. https://doi/org/10.1097/00115514-201207000-00005

Beronio, K., Glied, S., Po, R., & Skopec, L. (2013). *Affordable Care Act will expand mental health and substance use disorder benefits and parity protections for 62 million Americans.* http://www.aspe.hhs.gov

Bhandari, P. (2022). *What is qualitative research? Methods & examples.* https://www.scribbr.com/methodology/qualitative-research/

Birt, L., Scott, S., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation. *Qualitative Health Research*, *26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Bradley E. H., McGraw, S. A., Curry L., Buckser, A., King, K. L., King, K. L. Stanislav, V. K., & Andersen, R. (2002). Expanding the Andersen model: The role of psychosocial factors in long-term care use. *Health Services Research*, *37*(5), 1221–1242. https://doi.org/10.1111/1475-6773.01053

Brucker, D. L., & Stewart, M. (2011). Performance-based contracting within a state substance abuse treatment system: A preliminary exploration of differences in client access and client outcomes. *The Journal of Behavior Health Services & Research, 38*(3), 383-397. https://doi.org/10.1007/s11414-010-9228-5

Buck, J. A. (2011). The looming expansion and transformation of public substance abuse treatment under the affordable care act. *Health Affairs*, *30*(8), 1402-1410. https://doi.org/10.1377/hlthaff.2011.0480

Buck, J. A., Coffey, R. M., Levit, K. R., Mark, T. L., & Vandivort-Warren, R. (2011). Changes in our spending on mental health and substance abuse treatment, 1986-2005, and policy implications. *Health Affairs*, *30*(2), 284-292. https://doi.org/10.1377/hlthaff.2010.0765

Cantor, J. C., Famham, J., & Thompson, F. J. (2013). States' commitment to Medicaid before the Affordable Care Act: Trends and implications. *Inquiry*, *50*(1), 71-84. https://doi.org/10.5034/inquiryjrnl_50.01.04

Capoccia, V., Cotter, F., Gustafson, D., & McCarty, D. (2009). Improving care for the treatment of alcohol and drug disorders. *Journal of Behavioral Health Services & Research*, *36*(1), 52-60. https://doi.org/10.1007/s11414-008-9108-4

Carnevale Associates (2013). *The Affordable Care Act: Shaping substance abuse treatment. Examining the financing and provision of substance abuse treatment.* Addiction Treatment Forum. https://www.carnevaleassociates.com/our-work/overview.html/article/2013/04/26/the-affordable-care-act-shaping-substance-abuse-treatment

Carpenter, C. E. (2010). Delivery systems and payment reforms are essential to make insurance affordable. *Journal of Financial Service Professionals, 64*(6), 28-31. https://national.societyoffsp.org/

Carpenter, C. E. (2013). The Affordable Care Act after the Supreme Court decision. *Journal of Financial Service Professionals*, *66*(6), 27-29. http://www.financialpro.org

Centers for Medicaid and Medicare Services. (2019). *Medicaid.* https://www.medicaid.gov/medicaid/index.html

Chen, C., & Gu, D. (2021). Andersen model. *Encyclopedia of gerontology and population aging*. Springer Link. https://doi.org/10.1007/978-3-319-69892-2_876-1

City of Philadelphia. (2016). *Five year financial and strategic plan for fiscal years 2017-2021*. https://www.phila.gov/media/20160721124416/FY17-21-five-year-plan-proposed-march-2016.pdf

Coe, E. H. & Enomoto, K. (2020). *Returning to resilience: The impact of COVID-19 on mental health and substance use.* https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/returning-to-resilience-the-impact-of-covid-19-on-behavioral-health

Coghlan, D., & Brydon-Miller, M. (2014). *The SAGE encyclopedia of action research* (1-2). SAGE Publications. https://doi.org/10.4135/9781446294406

Cook, D. H. (2010). A discourse about the institutional handling of the substance abuser's penchant to relapse. *The International Journal of Sociology and Social Policy, 30*(9/10), 486-498. https://doi.org/10.1108//01443331011072253

Cordell, D. M., & Langdon, T. P. (2012). Financial planning under the Affordable Care Act. *Journal of Financial Planning*, *25*(9), 30-31. https://www.financialplanningassociation.org/article/journal/SEP12-financial-planning-under-affordable-care-act

Crossman, A. (2019). *An overview of qualitative research methods.* Virginia Wesleyan University. https://www.thoughtco.com/qualitative-research-methods-3026555

Cubanski, J., Biniek, J. F., & Neuman, T. (2023). *FAQs on health spending, the federal budget, and budget enforcement tools.* Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/faqs-on-health-spending-the-federal-budget-and-budget-enforcement-tools/

Dang, D., Dearholt, S., Bissett, K., Ascenzi, J., & Whalen, M. (2022). *Johns Hopkins evidence-based practice for model* (4th ed.). Sigma Theta Tau International. https://www.hopkinsmedicine.org/evidence-based-practice/models-tools.html

Davern, M., Klerman, J. A., Ziegenfuss, J., Lynch, V., & Greenberg, G. (2009). A partially corrected estimate of Medicaid enrollment and uninsurance: Results from imputational model developed off linked survey and administrative data. *Journal of Economic & Social Measurement, 1,* 219-240. https://doi.org/10.3233/JEM-2009-0324

Delve (2022). *Phenomenological research design.* https://delvetool.com/blog/phenomenology

Department of Behavioral Health and Intellectual Disability Services. (2023). *About us: Promoting recovery, resilience, and self-determination.* https://dbhids.org/about/organization/

Donner, R. (2023). *Disability services facing staffing crisis. Mosaic real life. Real possibilities.* https://www.mosaicinfo.org/blog/advocacy/disability-services-facing-staffing-crisis/

Dopp, A. R., Hunter, S. B., Godley, M. D., Pham, C., Han, B., Smart, R., Cantor, J., Kilmer, B., Hindmarch, G., Gonzalez, I., Passett, L., Wright, K., Aarons, G. A., & Purtle, J. (2022). Comparing two federal financing strategies on penetration and sustainment of the adolescent community reinforcement approach for substance use disorders: protocol for a mixed-method study. *Implementation Science Communications, 3*(1), 1-17. https://doi.org/10.1186/s43058-022-00298-y

Eldridge, G. N., & Korda, H. (2011). Payment incentives and integrated care delivery: Levers for health system reform and cost containment. *Inquiry, 48*(4), 277-287. https://doi.org/10.5034/inquiryjrnl_48.04.01

Elliott-Mainwaring, H. (2021). Exploring using NVivo software to facilitate inductive coding for thematic narrative synthesis. *British Journal of Midwifery 29*(11), 628-632. https://doi.org/10.12968/bjom.2021.29.11.628

Erlingsson, C. & Brysiewicz, P. (2017). A hands-on guide to doing content analysis. *African Journal of Emergency Medicine*, *7*(3), 93-99. https://doi.org/10.1016/j.afjem.2017.08.001

Eschenfelder, B. E. (2010). Using community-based assessments to strengthen nonprofit-government collaboration and service delivery. *Journal of Health Human Services Administration, 32*(4), 405-446. https://pubmed.ncbi.nlm.nih.gov/20433116/

Farwell, M., & Handy, F. (2021). Putting the 'community' in community-based human Service funding: recruitment, motivation, and role negotiation of granting committees. *Journal of Health and Human Services Administration, 43*(4), 420-444. https://doi.org/10.37808/jhhsa.43.4.6

Fleming, P. J., Spolum, M. M., Lopez, W. D., & Galea, S. (2021) The public health funding paradox: How funding the problem and solution impedes public health progress. *Public Health Reports, 136*(1), 10-13. https://doi.org/10.1177/0033354920969172

Ford, J. H., Green, C. A., Mackey, D., Wisdom, J. P., & Wise, M. (2011). Substance abuse treatment programs data management capacity: An exploratory study. *The*

Journal of Behavioral Health Services & Research, 38(2), 249-264. https://doi.org/10.1007/s11414-010-9221-z

Freese, T. E. (2011). Commentary: Substance abuse treatment providers: Act now to get ready for health care reform. Drug Free: *The Newsroom.* https://drugfree.org/drug-and-alcohol-news/commentary-substance-abuse-treatment-providers-act-now-to-get-ready-for-health-care-reform/

Fry, C. E. (2021). Medicaid waivers and access to behavioral health services: What is known and what can be expected. *Psychiatric Services*, *72*(11), 1350–1353. https://doi.org/10.1176/appi.ps.202000865

Fussel, H. E., Kovas, A. E., Rieckmann, T. R., &Stettler, N. M. (2009). Implementation of evidence-based practices for treatment of alcohol and drug disorders: The role of the state authority. *Journal of Behavioral Health Services & Research*, *36*(4), 407-419. https://doi.org/10.1007s11414-008-9122-6

George, T. (2022). *Mixed methods research. Definition, guide & examples.* https://www.scribbr.com/methodology/mixed-methods-research/

Gogel, L., Cavalieri, M., Gardin, J., & Wisdom, J. (2011). Retention and ongoing participation in residential substance abuse treatment: Perspectives from adolescents, parents, and staff on the treatment process. *Journal of Behavioral Health Services & Research, 38,* 488-496. https://doi.org/10.1007/s11414-010-9226-7

Goldman, M., Small, E., Richkin, T., Pincus, H. A., & Henry, C. (2022). Implementation of behavioral health integration in small primary care settings: Lessons learned

and future directions. *Community Mental Health Journal, 58*(1), 136-144. https://doi.org/10.1007/s10597-021-00802-z

Gribble, R. S., Liese, B. H., & Wickremsinhe, M.N. (2021). An analysis of funding patterns in development assistance for mental health: Who, when, what, and where. *Global Mental Health*, *8*(1), 1-7. https://doi.org/10.1017/gmh.2020.30

Guerra, O. & Eboreime, E. (2021). The impact of economic recessions on depression, anxiety, and trauma-related disorders and illness outcomes—A scoping review. *Behavioral Sciences, 11*(9), 119. https://doi.org/10.3390/bs11090119

Guest, G,, Namey, E,, & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *National Library of Medicine, 15*(5), 1-17. https://doi.org/10.1371/journal.pone.0232076

Han, B., Lai, J., & Yu, H. (2020). Impact of the ACA Medicaid expansion on utilization of mental health care. *Med Care, 58*(9), 757-762. https://doi.org/10.1097/mlr.0000000000001373

HealthCare.gov (2022). *Patient protection and Affordable Care Act.* www.healthcare.gov/glossary/patient-protection-and-affordable-care-act/

Henriksen, L. S., Smith, S. R., & Zimmer, A (2012). On the eve of convergence? Transformations of social service provision in Denmark, Germany, and the United States. *Voluntas*, *23*(2), 458-501. https://doi.org/10.1007/s11266-011-922-5

Holahan, J. & Simpson, M. (2022). *Next steps in expanding health coverage and affordability: What policymakers can do beyond the Inflation Reduction Act.* The Commonwealth Fund. https://doi.org/10.26099/4517-t530

Hsieh, H. F., & Shannon, S. E. (2005) Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–88. https://doi.org/10.1177/1049732305276687

Hurt, D. (2021). *Diversifying funding streams for a nonprofit behavioral health organization* [Doctoral dissertation, Walden University]. Scholarworks. https://scholarworks.waldenu.edu/dissertations/10236

Josselson, R. (2022) Narrative research. *Encyclopedia of research design*. https://dx.doi.org/10.4135/9781412961288

Kenney, G. M., Lynch, V., Haley, J., & Huntress, M. (2012). Variation in Medicaid eligibility and participation among adults: Implications for the affordable care act. *Inquiry*. https://doi.org/10.5034/inquiryjrnl_49.03.08

Kent, C., & Rutsohn, P. (2010). An assessment of the economic impact of local boards of health on West Virginia's economy. *Hospital Topics*, *88*(3), 67-74. https://doi.org/10.1080/00185868.2010.507118

Kordnaeij, A., Danaeefard, H., Zali, M., & Vasheghani, S. (2012). The role of organizational culture in customer satisfaction. *European Journal of Economics, Finance & Administrative Sciences, 51*, 146-157. https://www.researchgate.net/publication/289811378_The_role_of_organizational_culture_in_customer_satisfaction

Kramer, F. D. (2010). The role for public funding of faith-based organizations delivering behavioral health services: Guideposts for monitoring and evaluation. *American*

Journal of Community Psychology, 46(3-4), 342-360. http://doi.org/10.1007/s10464-010-9351-8

Kramer, M. W., & Adams, T. E. (2017). Ethnography. *The Sage Encyclopedia of Communication Research Methods*, 457-461. https://doi.org/10.4135/9781483381411

Larrieta, J., Miguel Esponda, G., Gandi, Y., Simpson, N., Biriotti, M., Kydd, A., Eaton, J. & Ryan, G. K. (2022). Supporting community-based mental health initiatives: Insights from a multi-country programme and recommendations for funders. *BMJ Global Health, 7*(5), 1-7. https://doi.org/10.1136/bmjgh-2022-008906

Lederle, M., Tempes, J., & Bitzer E. M. (2021). Application of Andersen's behavioural model of health services use: A scoping review with a focus on qualitative health services research. *British Medical Journal, 11,* 1-13. https://doi.org/10.1136/bmjopen-2020-045018

Lee, J. Y., & Winters, J. V. (2022). State Medicaid expansion and the self-employed. *Small Business Economics*, *59*(3), 925–954. https://doi.org/10.1007/s11187-021-00559-5

Leech, N. L., & Onwuegbuzie, A. J. (2007) An array of qualitative data analysis tools: A call for data analysis triangulation. *School Psychology Quarterly*, *22*(4), 557-584. https://doi.org/10.1037/1045-3830.22.4.557

Leite, D. F. B., Padilha, M. A. S. & Cecatti, J. G. (2019). Approaching literature review for academic purposes: The Literature Review Checklist. *National Library of Medicine, 74*, 1403. https://doi.org/10.6061/clinics/2019/e1403

Leung, L. (2015) Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4*(3), 324-327. https://doi.org/10.4103/2249-4863.161306

Levine, D. M., Chalasani, R. Linder J. A., & Landon, B. E. (2022). Association of the patient protection and affordable care act with ambulatory quality, patient experience, utilization, and cost, 2014-2016. *JAMA Network Open*, *5*(6), 1-12. https://doi.org/10.1001/jamanetworkopen.2022.18167

Liebman, J. B. (2011). Testing pay-for-success bonds. *Public Manager*, *40*(3), 66-68. https://www.hks.harvard.edu/publications/testing-pay-success-bonds#citation

Lo, F., Rey-Marti, A., & Botella-Carrubi, D. (2020). Research methods in business: Quantitative and qualitative comparative analysis. *Journal of Business Research*, *115,* 221-224. https://doi.org/10.1016/j.jbusres.2020.05.003

Loughran, H., & McCann, M. (2011). A case for developing community drug indicators. *Social Indicators Research, 102*(2), 229-244. https://doi.org/10.1007/s11205-010-9672-x

Lunsky, Y., De Oliveira, C., Wilton A, & Wodchis, W. (2019). High health care costs among adults with intellectual and developmental disabilities: A population-based study. *Journal of Intellectual Disability Research, 63*(2),124-137. https://doi.org/10.1111/jir.12554

Lyu, W., & Wehby, G. L. (2019). Effects of Virginia's 2019 Medicaid expansion on health insurance coverage, access to care, and health status. *The Journal of Health*

Care Organization, Provision, and Financing, 59, 1-11. https://doi.org/10.1177/00469580221092856

MacLean, S., Berends, L., Hunter, B., Roberts, B. & Mugavin, J. (2012). Factors that enable and hinder the implementation of projects in the alcohol and other drug field. *Australian & New Zealand Journal of Public Health*. *36,* 61-68. https://doi.org/10.1111/j.1753-6405-2011.00804.x

Maglic. D. R., Holt, W., Daley, T.C. & Rosenblatt, A. (2021). Family organizations in children's mental health systems of care: The challenge of maintaining financial sustainability. *Journal of Behavioral Health Services &Research*, *48*(1), 15-35 https://doi.org/10.1007/s11414-020-09711-7

Mailloux, A. T., Cummings, S. W., & Mugdh, M. (2010). A decision support tool for identifying abuse of controlled substances by forward health Medicaid members. *Journal of Hospital Marketing & Public Relations*, *20*(1), 34-55. https://doi.org/10.1080/15390940903450982

Malterud, K., Siersma, V. D., & Guassora A. D., (2016). Sample size in qualitative interview studies: Guided by information power. *Sage Journal, 26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Malterud, K., Siersma, V., & Guassora, A. D. (2021). Information power: Sample content and size in qualitative studies. In P. M. Camic (Ed.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 67–81). American Psychological Association. https://doi.org/10.1037/0000252-004

Maniam, B, Black, L, Leavell, H. (2013). The financial and economic effects of the Patient Protection and Affordable Care Act (PPACA). *Journal of the Academy of Business & Economics, 13*(1), 201-206. http://doi.org/10.18374/JABE-13-1.15

Martinette, L. A., & Obenchain-Leeson, A. (2012). The relationship between learning orientation and business performance and the moderating effect of competitive advantage: A service organization perspective. *Journal of Service, 5*(1), 43-58. https://doi.org/10.19030/iber.v13i4.8686

Martinez-Donate, A. P., Dsouza, N., Cuellar, S., Connor, G., Zumaeta-Castillo, C., Lazo-Elizondo, M., Yamasaki, Y., Perez, C., Carroll-Scott, A., Martinez, O., & Hassrick, E. (2022). Provider perceptions of availability, accessibility, and adequacy of health and behavioral services for Latino immigrants in Philadelphia: A qualitative study. *BMC Public Health*, *22*(1), 1-15. https://doi.org/10.1186/s12889-022-14066-z

McGinity, B. (2023. The future of public mental health: Challenges and opportunities. *The Milbank Quarterly, 101*(1), 532-551. https://doi.org/10.1111/1468-0009.12622

Mechanic, D. (2012). Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Affairs*, *31*(2), 376-382. https://doi:org/10.1377/hlthaff.2011.0623

Mechanic, D. (2011). Behavioral health and health care reform. *Journal of Health Politics, Policy & Law*, *36(3),* 527-531. https://doi.org/10.1215/03616878-1271207

Mick, S. S., & Shay, P. D. (2013). Post-acute care and vertical integration after the Patient Protection and Affordable Care act. *Journal of Healthcare Management*, *58*(1), 15-27. https://pubmed.ncbi.nlm.nih.gov/23424816/

Miller, B. J. & Moffit, R. E. (2020). Choice, competition, and flexibility, Part I: Post-ACA consumer challenges. *Health Affairs Blog*. https://doi.org/10.1377/forefront.20200813.191190

Montoya, D. F., Chehal, P. K., & Adams, E. K. (2020). Medicaid managed care's effects on costs, access, and quality: An update. *Annual Review of Public Health 41*(1), 537-549. https://doi.org/10.1146/annurev-publhealth-040119-094345

Mulvany, C. (2011). Fiscal proposals have far-reaching implications for providers. *Healthcare Financial Management Association*, *65*(2), 32-36. https://pubmed.ncbi.nlm.nih.gov/21428220/

National Institute of Drug Abuse. (2011). *Drug Facts: Understanding drug abuse and addiction.* https://www.drugabuse.gov

NJEM Catalyst. (March 2018). *What is pay for performance in healthcare?* https://catalyst.nejm.org/pay-for-performance-in-healthcare/

Noble, H., & Heale, R. (2019) Triangulation in research, with examples. *Evidence-Based Nursing*, *22*, 67-68. https://doi.org/10.1136/ebnurs-2019-103145

Norris, L. (2022, November 18). *A state-by-state guide to Medicaid expansion, eligibility, enrollment, and benefits.* https://www.healthinsurance.org/medicaid/

Nyirenda, L., Kumar, M.B., Theobald, S., Sarker, M., Simwinga, M., Kumwenda, M., Johnson, C., Hatzold, K., Corbett, E. L., Sibanda, E., & Taegtmeyer, M. (2020).

Using research networks to generate trustworthy qualitative public health research findings from multiple contexts. *BMC Medical Research Methodology 20*(13). https://doi.org/10.1186/s12874-019-0895-5

Palmer, J. (2012). State of addiction: Substance abuse costs U.S. employers hundreds of billions in health care and productivity losses. *NEWSOK*. https://newsok.com

Pandey, S. K. (2010). Cutback management and the paradox of publicness. *Public Administration Review, 70*(4), 522, 564-571. https://doi.org/10.1111/j.1540-6210.2010.02177.x

Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in Clinical Research, 4*(3), 192-193. https://doi.org/10.4103/2229-3485.115389

Pennsylvania Department of Human Services (2019). *Fee-for-service.* http://www.dhs.pa.gov/learnaboutdhs/wheredotaxdollarsgo/medicalfees/index.htm

Pennsylvania Department of Human Services (2022). *Annual waiting list report. Office of Developmental Programs (ODP).* https://palms-awss3-repository.s3.us-west-2.amazonaws.com/MyODP_Content/Everyday+Lives/ODP+Annual+Waiting+List+Report+2022.pdf

Pennsylvania Department of Human Services (2023). *Service/supports coordinator organizations.* https://www.dhs.pa.gov/ECM/Stakeholders/Pages/Services-Supports-Coordinator-Organizations.aspx#:~:text=Supports%2FService%20Coordinator%20Organizations%20(SCO,%2C%20safety%2C%20and%20service%20delivery.

Pennsylvania Medicaid Program (2022). *What is Pennsylvania Medicaid program?* www.benefits.gov/benefit/1148

Pennsylvania Pressroom. (2023). *Governor Shapiro orders immediate review of fee schedule rates for providers of services for individuals with intellectual disabilities, autism.* https://www.media.pa.gov/pages/dhs_details.aspx?newsid=949

Pettingell, S. L., Houseworth, J., Tichá, R., Kramme, J., & Hewitt, A. S. (2022). Incentives, wages, and retention among direct support professionals: National Core Indicators Staff Stability Survey. *Intellectual Developmental Disabilities*, *60*(2), 113-127. https://doi.org/10.1352/1934-9556-60.2.113

Purtle, J., & Stadnick, N.A. (2020). Earmarked taxes as a policy strategy to increase funding for behavioral health services. *Psychiatric Services, 71*(1), 100-104. https://doi.org/10.1176/appi.ps.201900332

Purtle, J., Stadnick, N.A., Wynecoop, M., Bruns, E. J., Crane, M.E., & Aarons, G. (2023). A policy implementation study of earmarked taxes for mental health services: Study protocol. *Implementation Science Communications, 4*(37). https://doi.org/10.1186/s43058-023-00408-4

Rashid, Y., Rashid, A., Warraich, M. A., Sabir, S. S., & Waseem, A. (2019). Case study method: A step-by-step guide for business researchers. *International Journal of Qualitative Methods*, *18*, 1-2. https://doi.org/10.1177/1609406919862424

Registrar of Community Housing. (2010). *Financial viability.* http://www.rch.nsw.gov.au/

Resnik, D. B. (2020). *What is ethics in research & why is it important?* National Institute of Environmental Health Sciences. https://www.niehs.nih.gov/research/resources/bioethics/whatis/index.cfm

Reyes, C., L. (2009). Corrections-based drug treatment programs and crime prevention: An international approach. *Journal of Offender Rehabilitation*, *48*(7), 620-634. https://doi.org/10.1080/10509670903196082

Reynolds, M. (2011). Medicare bundled payment program: meaningful risk and limited reward. *Healthcare Financial Management, 65*(10), 50-52, 54. https://pubmed.ncbi.nlm.nih.gov/22053642/

Rhew, I. C., Brown, E. C., Hawkins, J. D., & Briney, J. S. (2013). Sustained effects of the communities that care system on prevention service system transformation. *American Journal of Public Health, 103*(3), 529-535. https://doi.org/10.2105/AJPH.2011.300567

Richardson, L. E., & Yilmazer, T. (2013). Understanding the impact of health reform on the states: Expansion of coverage through Medicaid and exchanges. *Journal of Consumer Affairs, 47*(2), 191-218. https://doi.org/10.1111/joca.12005

Rieckmann, T., Fuller, B. E., McCarty, D., & Saedi, G. A. (2010). Adoption of practice guidelines and assessment tools in substance abuse treatment. *Substance Abuse Treatment, Prevention, and Policy*, *5*(4), 1-9. https://doi.org/10.1186/1747-597X-5-4

Roberts, P., & Helena, P. (2006). Reliability and validity in research. *Nursing Standard*, *20*(44), 41-45. https://doi.org/10.7748/ns2006.07.20.44.41.c6560

Robinson, M., Blaise, M., Weber, G., & Suhrcke, M. (2022). The effects and costs of personalized budgets for people with disabilities: A systematic review. *International Journal of Environmental Research and Public Health, 19*(23), 16225. https://doi.org/10.3390/ijerph192316225

Rollo, J. A., & Chiacchio, M. (2022). *Comparative analysis examples & overview.* https://study.com/learn/lesson/comparative-analysis-examples-overview.html

Rosales, R., Takeuchi, D., & Calvo, R. (2021). After the Affordable Care Act: The effects of the health safety net and the Medicaid expansion on Latinxs use of behavioral healthcare in the US. *Journal of Behavioral Health Services & Research*, *48*(2), 183-198. https://doi.org/10.1007/s11414-020-09715-3

Rosenberg, L. (2009). Mental health and addiction policy: What next? *Journal of Behavioral Health Services & Research, 36*(2), 127-128. https://doi.org/10.1007/s11414-009-9167-1

Rosenberg, L. (2012). Primary and behavioral healthcare integration: Threat or opportunity for addiction treatment organizations? *Journal of Behavioral Health Services & Research, 39*(2), 101-102. https://doi.org/10.1007/s11414-012-9278-y

Salveo Integrative Health. (2021). *What is the difference between mental and behavioral health?* https://salveohealth.org/what-is-the-difference-between-mental-and-behavioral-health/

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its

conceptualization and operationalization. *Quality & Quantity, 52*(4), 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: Challenges and compromise in practice. *Qualitative Research, 15*(5), 616-632. https://doi.org/10.1177/1468794114550439

Sauro, J. (2015). *5 types of qualitative methods.* https://measuringu.com/qual-methods/#:~:text=A%20popular%20and%20helpful%20categorization,Qualitative%20Inquiry%20and%20Research%20Design

Schifalacqua, M. M., Shepard A., & Kelley W., (2012). Evidence-based practice: Cost-benefit of large system implementation. *Quality Management in Health Care*, *21(*2), 74–80. https://doi.org/10.1097/QMH.0b03e31824d196f

Sims, J. M. (2010). A brief review of the Belmont report. *Dimensions of Critical Care Nursing, 29*(4), 173-174. https://doi.org/10.1097/DCC.0b013e3181de9ec5

Smiljanic, S. (2022). *27+ Affordable Care Act statistics and facts. www.policyadvice.net KFF. Status of state Medicaid expansion decisions.* https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Sorensen, J. E., Vela, E., & Grant, L. (2010). How to cope with shrinking resources or doing more with less: actual mechanism used by governmental and not-for-profit human service organizations. *The Journal of Government Financial Management*, *59*(2), 58-65.

http://faculty.cbpp.uaa.alaska.edu/afgjp/padm628%20spring%202011/Coping%20with%20shrinking%20resources.pdf

Spreat, S. (2022. How would henry ford fix the workforce crisis in the intellectual disability field? *International Journal of Education and Social Science Research, 5*(3), 337-344. https://doi.org/10.37500/IJESSR.2022.5321

Statistics Solutions. (2022). *What is credibility in qualitative research and how do we establish it?* https://www.statisticssolutions.com/what-is-credibility-in-qualitative-research-and-how-do-we-establish-it/

Stewart, R. E., Adams, D. R., Mandell, D. S., Hadley, T., Evans, A.C., Rubin, R., Erney, J., Neimark, G., Hurfort, M. O., & Beidas, R. S. (2015). The perfect storm: Collision of the business of mental health and the implementation of evidence-based practices. *Published Medical Journal, 67*(2), 159-161. https://doi.org/10.1176/appi.ps.201500392

Stewart, R. E., Mandell, D. S., & Beidas, R. S. (2021). Lessons from Maslow: Prioritizing funding to improve the quality of community mental health and substance use services. *Psychiatric Services*, *72*(10), 1219-1221. https://doi.org/10.1176/appi.ps.202000209

Stuart, G. W. (2003). Financing results and value in behavioral health services. *Administration and Policy in Mental Health*, *3*(2), 85-110. http://doi.org/10.1023/B:APIH.0000003016.99550.7e

Stuckey, H. L. (2013). Three types of interviews: Qualitative research methods in social health. *Journal of Social Health and Diabetes, 1*(2), 56. https://doi.org/10.4103/2321-0656.115294

Substance Abuse and Mental Health Services Administration. (2012). *Department of Health and Human Services: The fiscal year 2012 budget.* https://www.samhsa.gov

Substance Abuse and Mental Health Services Administration (2019). *Managed care.* https://www.medicaid.gov/medicaid/managed-care/index.html

Sullivan, S. (2013). Opioid substitution: Improving cost-efficiency. *Bulletin of the World Health Organization*, *91*(2), 83. https://doi.org/10.2471/BLT.13.117374

Travers, J. L., Hirschman, K. B. & Naylor, M. D. (2020). Adapting Andersen's expanded behavioral model of health services use to include older adults receiving long-term services and supports. *BMC Geriatric,20*, 58. https://doi.org/10.1186/s12877-019-1405-7

Tariq, S., & Woodman, J. (2019). Using mixed methods in health research. *JRSM Short Reports*. https://doi.org/10.1177/2042533313479197

Theofanidis, D., & Fountouki, A. (2018). Limitations and delimitations in the research process. *Perioperative Nursing,7*(3), 155-162. http://doi.org/105281/zenodo.2552022

Thompson, F. J., Gitterman, D. P., & Scott, J. C. (2011). The impact on existing programs. *Journal of Health Politics, Policy & Law.*, *36*(3), 547. https://doi.org/10.1215/03616878-1271234

The Belmont Report (1979). Office of human research protections. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

Tie, Y. C., Birks, M., & Francis, K. (2019). *Grounded theory research: A design framework for novice researchers.* https://doi.org/10.1177/2050312118822927

Urban Institute. (2023). *Project West Virginia.* https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/projects/state-fiscal-briefs/west-virginia

Vimont, C. (2013). Affordable Care Act to provide substance abuse treatment to millions of new patients. *Drug Free: The Newsroom*

Waters, T. M., Burns, N., Kaplan, C. M., Graetz, I., Benitiz, J., Cardarelli, R., Daniels, M. J. (2022). Combined impact of Medicare's hospital pay for performance programs on quality and safety outcomes is mixed. *BMC Health Services Research*, *22*(1), 958. https://doi.org/10.1186/s12913-022-08348-w

Walker, M. (2009). Program characteristics and the length of time clients are in substance abuse treatment. *Social Indicators Research, 36*(3), 330-343. https://doi.org/10.1007/s11414-008-9128-0

Watterworth, M. (2015). *OMB's uniform grant guidance: A deeper dive into pass-through entities' responsibilities for subrecipient monitoring and risk assessment.* https://www.plantemoran.com/explore-our-thinking/insight/2015/01/ombs-uniform-grant-guidance-a-deeper-dive-into-passthrough-entities-respons

Wechsler, J. (2012). New healthcare payment models to shape drug coverage, costs, and expenditures. *The Formulary*, *47*(11), 405-406.

https://link.gale.com/apps/doc/A312290135/AONE?u=anon~e7d91c3d&sid=googleScholar&xid=a32c00af

Wechsler, J. (2010). Risk management and drug safety raise challenges for sponsors and healthcare providers. *The Formulary*, *45*(9), 295-296. https://www.formularywatch.com/view/risk-management-drug-safety-raise-challenges-sponsors-and-healthcare-providers

Wickizer, T. M. (2013). State-level estimates of the economic costs of alcohol and drug abuse. *Journal of Health Care Finance, 39*(3), 71-84. https://pubmed.ncbi.nlm.nih.gov/23614269/

Wilensky, G. R. (2013). Medicaid expansions-will they or won't they? Medicaid expansion is a centerpiece of the plan outlined in the Affordable Care Act (ACA) to broaden healthcare coverage in the United States. *Healthcare Financial Management*, *67*(1), 30, 32. https://go.gale.com/ps/i.do?p=AONE&u=googlescholar&id=GALE|A323142101&v=2.1&it=r&sid=AONE&asid=3ca48f2a

Wisdom, J. P., Ford, J. H., McCarty, D. (2010). The use of health information technology in publicly-funded U.S. substance abuse treatment agencies. *Contemporary Drug Problems: An Interdisciplinary Quarterly, 37*(2), 315-339. https://doi.org/10.1177/009145091003700207

Word, A. K. (2012). Commentary: Interorganizational relationships in program delivery. *Journal of Health and Human Services*, *35*(1), 71-73. https://pubmed.ncbi.nlm.nih.gov/22838057/

Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). Sage

Appendix: Interview Protocol

Selected Participants	Once IRB approval is given, the researcher will contact the selected participants by email or telephone.
Establish the time and location	The researcher will contact the selected participants by email or telephone.
Provide details about the research study to the selected participants	The researcher will explain the details of the research study by providing the purpose of the study and obtain consent form the selected participants.
Conduct the interviews with the selected participants	The researcher will explain the process of the interview and conducting the interview by using a audio recorder.
Transcribe the interview verbatim	The researcher will transcribe the interview date within 48 hours.
Conduct a member check	The research will review the data for accuracy with the selected participants.