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Effects of Patient Protection and Affordable Care Act on Behavioral Health Access

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This is to certify that the doctoral dissertation by

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2018

Abstract

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by

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MA, Liberty University, 2009

BTh, Bethany Divinity College and Seminary, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

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Abstract

About 50% of adults in the United States suffer from at least 1 mental health challenge in their lifetime. Annually, mental health and substance use disorders cost the United States about $800 billion, leaving individuals with unaffordable cost of care and the nation with diminished productivity and revenue. With the Essential Health Benefits and Medicaid expansion under the Patient Protection and Affordable Care Act (PPACA), healthcare resources were created to address gaps in behavioral healthcare. There is a need to understand how the healthcare law has influenced the availability of behavioral health services and access to needed care. This study explored the lived experiences of 10 behavioral health service recipients to identify the benefits and challenges of the PPACA on behavioral health services. Participants from Anne Arundel County, Maryland, were purposefully selected and interviewed face-to-face. Relative advantage, compatibility, and complexity were characteristics of the diffusion of innovation theory used for the exploration of this research. Based on the interpretive phenomenological approach, Nvivo 11 Pro was used for data coding, management, organization, and analysis. There was the shared belief among participants that the PPACA improved their access to adequate and affordable behavioral healthcare. Effective network of care and having health insurance seemed to have improved health outcomes. Findings from this study highlight issues of common interest to healthcare stakeholders while providing reasonable platforms for objectively addressing complex challenges, which tend to undermine the possibility of adopting policies that could yield positive dividends for all parties involved.

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Dedication

First, I want to use this opportunity to publicly thank my Lord and savior Jesus Christ for saving me and giving me a chance at life. I dedicate this dissertation to the Lord God Almighty, who found it in His infinite wisdom to give me life and the grace to pursue my life's purpose.

I also dedicate this achievement to my late paternal grandmother (Mrs. Emuohwomuerhe Oshegbo), who despite lacking Western education used her gift of oral tradition to teach me the significance of resilience, excellence, and legacy. To my parents and siblings, you are the best family I could have ever asked for. And, finally, to my dearly beloved wife, Gloria Obiajulu Oshegbo. You are my best my friend, my partner in every sense, and the mother of our three precious children (Makarios, Evangel, and Basileus Oshegbo). I am indebted to your sacrifice, love, and dedication to our family. My father was right from the day I introduced you as my wife. He said I couldn't have made any other better choice in my life, and he was right! My life's dream is to bring you joy and fulfillment as we explore our life adventures together.

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Chapter 1: Introduction to the Study

Introduction

My goal in this phenomenological study was to explore the effects of the Patient Protection and Affordable Care Act (PPACA) on access to behavioral healthcare. The relevance of this study was to investigate the extent to which the healthcare reform had influenced the availability of behavioral healthcare services to individuals seeking these types of care. Furthermore, I aimed at identifying how service providers have been able to meet the requirements of the PPACA while expanding access to service users.

Although the PPACA was signed into law in 2010 with the hope of expanding healthcare to the uninsured and underinsured while keeping healthcare cost under control (Lindner, Considine, Davis, Rowland, & Spurlock, 2016), it is a relatively new piece of healthcare legislation (Garfield, Zuvekas, Lave, & Donohue, 2011). As a result, proponents of the healthcare reform have emphasized that much is yet unknown about its effectiveness while working towards improving areas of its challenges.

To explore the unfolding realities of this healthcare reform with regards to how it affects behavioral health access, this study was conducted using a phenomenological method of inquiry to investigate the lived experiences of those who use behavioral health services, as well as those who provide these services, especially since the inception of the healthcare law. Rogers's (2003) diffusion of innovation theory was used as the guiding framework for the exploration of this study. Healthcare reform and behavioral health access were closely examined through three constructs of the diffusion of innovation theory. These constructs are (a) relative advantage, (b) compatibility, and (c) complexity.

Whatever becomes the fate of the PPACA, this study contributes to the literature by providing some insight into the aspects of the healthcare reform that are favorable towards improving behavioral healthcare access. In addition, the framework upon which this study was carried out provides a platform that energizes political will, which advocates for health and behavioral health policies that are compatible with the needs of constituents, seeking efficient and effective healthcare while finding evidence informed solutions for addressing complexities facing the United States' healthcare dilemma.

This chapter includes the background of this study, the problem statement as informed from the literature, the purpose and nature the study, and the research questions used for steering the data gathering process. Next, key terms are defined, as well as the assumptions, limitations, and delimitations of this study.

Background of the Study

Behavioral health problems are comprised of mental health and substance use disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). These disorders could emerge from neurobiological and genetic vulnerabilities and psychological and environmental factors that adversely compromise the daily functioning of individuals affected (Wittchen et al., 2014). Behavioral health disorders affect a significant number of individuals in the United States. According to a 2011 report from the Centers for Disease Control and Prevention (CDC), about 50% of adults in the United States will experience no less than one mental health disorder in their lifetime. Similarly, Hedden et al. (2015) reported that in 2014 alone, about 46.3 million adults ages 18 and older fit the diagnostic criteria for any mental illness in the United States. Put into perspective, about 18.1% of all adults in the United States meet the criteria of any mental illness.

In a report gathered from the National Health Expenditure Accounts, Roehrig (2016) pointed out that mental disorders accounted for the largest health expenditure in 2013, with an annual price tag of $201 billion. Mental illnesses are regarded as the second major factor driving the causes of disease burden in the United States (Pearson et al., 2009). Similarly, substance use disorders are estimated to place an annual cost of $600 billion on Americans annually (Hedden et al., 2015). Irrespective of what form behavioral health disorders assume, there is no doubt they are debilitating to individual sufferers and their families in addition to placing a huge financial burden on the national economy. Despite these realities, behavioral healthcare has historically received lesser attention than physical and other areas of healthcare needs (Chamberlin, 2014; Rowan, McAlpine, & Blewett, 2013; Sundararaman & Redhead, 2008).

A great proportion of those who are affected by behavioral health disorders are unable to access needed care either because they are underinsured or uninsured (Rowan, et al., 2013). Pearson et al. (2009) found that having insurance coverage was one of the most important factors that determined whether people with behavioral health needs sought treatment or not. Similarly, Garfield et al. (2011) pointed out that adults with severe mental health disorders were less likely to seek help due to lack of health insurance. Furthermore, people with severe behavioral health needs are more likely to be individuals within the lower income bracket, dependent on public health insurance programs, and with poorer physical health than the general population (Garfield et al., 2011; Han et al., 2015).

Nationally, the United States has made progress in providing behavioral health treatment services. Nevertheless, there are a marginal proportion of individuals who are unable to access care for behavioral health disorders. For example, in 2014, 15.7 million adults were reported to have experienced a major depressive episode in the past 12 months (SAMHSA, 2015). One-third (33.2%) of this population did not seek any professional care during this timeframe (SAMHSA, 2015). Likewise, the report indicated that within the same given period, of the 21.2 million Americans ranging from age 12 and older who needed treatment for substance use disorders, only 2.5 million individuals received specialized treatment services (SAMHSA, 2015).

There are risks and potential consequences for behavioral health disorders that are ignored and left untreated. Because of the debilitating nature of these disorders or their incipient progression, individuals with these disorders are more likely to experience diminished quality of life, chronic medical conditions, frequent hospitalization, involvement with criminal activities, co-occurring substance use disorders, fatal drug overdose, and even suicide (Colton & Manderscheid, 2006; Han et al., 2015). Colton and Manderscheid (2006) argued that behavioral health disorders run on the same parallel with other physical health concerns and that both should be accorded the same attention. In the same vein, they noted that individuals with behavioral health disorders are more likely to have higher mortality rates and shortened lifespan (Colton & Manderscheid, 2006).

Despite efforts to implement parity laws that allow for equitable healthcare delivery for behavioral health as is the case for physical health, the realization of these efforts has stalled due to loose enforcement of these laws and push back from health insurance companies (Beronio, Glied, & Frank, 2014; Chamberlin, 2014). With the passage of the PPACA, the hopes of attaining expanded behavioral healthcare seem to be near in sight. First, the mandate for upholding and implementing the essential health benefits (PPACA, 2010; P.L. 111-148, 2010; P.L. 111-152, 2010) ensures that major health insurance carriers at minimum offer behavioral health services in their basic plan. This mandate allows individuals to purchase health insurance premiums without restrictive or exclusionary policies for behavioral health services (Beronio et al., 2014; Garfield et al., 2011). On the other hand, other authors suggested that Medicaid expansion under the PPACA would expand healthcare access to individuals who were previously uninsured (Han et al., 2015).

Moreover, these new enrollees under the PPACA Medicaid expansion would be afforded better access to receiving specialized services for substance use disorders and mental health treatment while also mitigating the risks of homelessness and incarceration (Buck, 2011; DiPietro & Klingenmaier, 2013). Some states such as Wisconsin, Texas, and Louisiana among others have opposed Medicaid expansion under the PPACA or declined to accept federal funding made available under the healthcare law (Boulton, 2016). Critics of the healthcare reform and its expansion measures have argued that the legislature lacks constitutional merits for imposing penalties on citizens for lack of compliance with its requirements (Plein, 2014). Others have suggested that the cost of financing the legislation creates an unwarranted tax burden on the general population (Boulton, 2016).

Researchers addressing Medicaid expansion under the PPACA have suggested a significant increase in new enrollment into the healthcare exchange (Han et al., 2015; Kwan, Valeras, Levey, Nease, & Talen, 2015; Sommers, Gordon, Somers, Ingram, & Epstein, 2014). This upward trend has also strongly indicated a larger demand for behavioral health services. While some states are developing their infrastructure to address the prospective increase in the demand for expanded healthcare, others are reluctant to commit to the implementation of state supported expansion initiative due to fear of possible cost (Han et al., 2015). This fear has created uncertainties among behavioral health services users, treatment providers, and advocates on what could become of the fate of this vulnerable population who already feel marginalized in the healthcare industry (Dinan, 2014; Hensley, 2012).

Problem Statement

The PPACA is a comprehensive piece of healthcare legislation signed into law by President Barack Obama in 2012 (Nordal, 2012). Due to Medicaid expansion with the implementation of the PPACA, over 30 million nonelderly noninsured Americans have the opportunity of receiving healthcare coverage through Medicaid (Buck, 2011; Buhite, 2013; Oberlander, 2010; Sommers et al., 2014). Prior to the projected benefits of the PPACA, individuals with behavioral healthcare needs--mental health and substance use disorders--have persistently encountered challenges getting adequate healthcare coverage for behavioral healthcare needs (Mechanic, 2012). Further, Mechanic (2012) identified that the problem of behavioral healthcare access for individuals has been compounded by a lack of integrated behavioral health policies between federal, state, and local municipalities.

The PPACA has been met with fierce opposition by its critics. As a result, there have been many uncertainties regarding its implementation and the feasibility of promoting access to care (Dinan, 2014). More so, there is uncertainty about how this healthcare reform will affect the availability of behavioral healthcare and wellness resources (Buck, 2011; Center for Medicare and Medicaid Services [CMS] & State Associations of Addiction Services, 2013). In preliminary studies where researchers examined the effects of the PPACA on various segments of behavioral health, they found significant operational challenges interfering with the delivery and access to behavioral health services (Han et al., 2015). Similarly, other studies indicated challenges with new enrollment, management of healthcare costs, and potential inadequate access to care (Sommers et al., 2014).

Another concern that has been raised is the fear of moderate increase in insurance premiums and inadequate administrative capacity to meet service needs (Blumberg & Holahan, 2015; Dickson, 2015). Available studies on the possible impact of the PPACA on behavioral health access are based on data from previous Medicaid expansions due to present lack of data on PPACA implementation (Han et al., 2015; Hefei, Druss, & Cummings, 2015; Hensley, 2012). With changes in political climate and administrations, the trajectories of policymaking may be influenced to suite the demands of the majority party in governance. Nevertheless, political preferences may not necessarily reflect the will of constituents (Hensley, 2012), especially vulnerable populations who lack adequate representation in government (Wise & Phillips, 2013).

There is a need in the literature to provide a study exploring a first-hand understanding of stakeholders' experiences, perceptions, and perspectives on access and treatment delivery of behavioral healthcare post the 2014 Medicaid expansion (Dickson, 2015; Hefei et al., 2015). Since no study had addressed these issues and how they affect access to behavioral healthcare in Maryland (Dickson, 2015; Hefei et al., 2015; Kwan et al., 2015), my goal was to explore stakeholders' experiences, perceptions, and perspectives on access to behavioral healthcare and treatment delivery post 2014 Medicaid expansion.

Purpose of the Study

The purpose of this study was to explore the effects of the PPACA on behavioral healthcare in Anne Arundel County, Maryland. The goal of this inquiry was to gather qualitative data to describe how the PPACA is influencing access to behavioral care among service recipients and to identify possible challenges with the implementation of these services by treatment providers since the implementation of the healthcare reform. The implementation of the PPACA is yet evolving as it is a relatively new healthcare reform. In addition, there were limited studies to make conclusive assertions about the impact of the PPACA on access to behavioral care and administrative effectiveness of models proposed for the implementation of proposed regulations. Garfield et al. (2011) postulated that the PPACA would usher in an increase in the utilization of behavioral health services while at the same time driving a shortage of the behavioral health workforce. In addition, they suggested that due to potential operational challenges in the implementation of the essential health benefits clauses in the healthcare reform, there was lack of clarity on what an adequate benefit package would entail for new enrollees (Garfield et al., 2011).

Beyond estimated speculations, there is a need to examine if these mandates are translating into service availability to the intended population. Furthermore, there appeared to be an absence of research in the literature targeted at exploring the experience and perspectives of those who are directly involved and affected by these processes (Hensley, 2012; Sommers et al., 2014). For this reason, a phenomenological qualitative approach was used to get a firsthand account from behavioral care recipients since they are among the primary stakeholders affected by behavioral health policies.

Research Questions

An interpretive phenomenological method (Matua & Van Der Wal, 2015) was used in this study to explore the experiences of behavioral health services users in Anne Arundel County, Maryland. Following are the research questions (RQ):

1. What are the perceptions of behavioral health service recipients on access to needed care in Anne Arundel County?

2. How do behavioral health service recipients in Anne Arundel County describe their access to care since the implementation of the PPACA healthcare reform?

3. How do treatment recipients perceive the quality of behavioral health care since the implementation of the PPACA?

4a. What perceived challenges are treatment recipients reporting with their behavioral health plans since the PPACA went into effect?

4b. What perceived advantages have they observed?

Theoretical Framework

Rogers's (2004) diffusion of innovation theory (DIT) was the theoretical framework used for this study. According to Rogers (2002), diffusion refers to the process wherein certain avenues are used to disseminate innovation to members of a social system. DIT offers a paradigm for examining the process of adopting new or novel ideas within a society over a period of time. It is based on the understanding that when such new ideas are introduced, not every member of that social system may be readily inclined to accept them at the initial stage. DIT offers approaches to understanding how individuals within societies adopt changes to improve upon prevalent practices in a given domain of human endeavor (Ryan & Gross, 1943). Rogers (2004) indicated that diffusion of innovation is a form of universal microprocess of social change that is applicable to numerous disciplines.

I chose DIT for this research because it provided the framework for evaluating PPACA (the innovation) and the elements of the reform that could determine its adoption and implementation into the United States healthcare system. Furthermore, this conceptual framework might inform the characteristics of the reform and the innovative categories of those who are impacted by the adoption of the reform. While consumers of behavioral health services and their families continue to anticipate what lies ahead in the implementation of the PPACA regarding their access to care, behavioral health providers and scholars-practitioners in healthcare continue to scramble for what to expect after the implementation of the PPACA (Makse & Volden, 2011).

Relative advantage, compatibility, and complexity are characteristics of innovations frequently identified as promoting or hindering the adoption of new innovations (Fajans, Simmons, & Ghiron, 2006; Thornatzky & Klein, 1982; Vedel et al., 2013). Using these characteristics to guide the exploration of this study, the intent was to identify current provisions in the PPACA that offer opportunities for relative advantage for behavioral health services. Additionally, I anticipated finding features of the PPACA that are compatible with the current behavioral health infrastructure, while bringing attention to issues that may be perceived as complex requirements of the legislature by the target population of this study.

Using this framework in studying these dynamics offered additional insight to the literature on the factors that drive stakeholders' engagement in the process of healthcare reform and policy adoption (Knudsen & Roman, 2014; Makse & Volden, 2011). There is ample evidence in the literature that healthcare reform in any capacity drives the need for innovative ways to implement the interconnected segments of such mandates (Dawson, Lundebjerg & Connolly, 2010; Walshe & Davies, 2013). The DIT provides insight into the intersection between the PPACA and the adoption processes among stakeholders in this study.

Nature of the Study

For this study, a phenomenological design was used to explore the experiences of behavioral health recipients after the implementation of the PPACA. Phenomenological studies facilitate avenues where participants are able to describe their experiences of the phenomena under study and the meanings they attach to their lived experiences regarding such situations (Hensley, 2012; Moerer-Urdahl & Creswell, 2008; Wise & Phillips, 2013). The phenomenological design of this study provided a framework for facilitating an understanding of how the chosen population has experienced the evolution and the implementation of the PPACA.

There is compelling evidence in the literature suggesting that involving the public or end users of public goods and services in the deliberation of new initiatives promotes better understanding of issues at stake and subsequently active engagement (Freeman, Gergen, & Josselson, 2015; Henriques, 2014; Hossen & Westhues, 2011). With this understanding, the use of the phenomenological method of inquiry became appropriately suitable in this study to understand the perceptions of subsectors of the public with hopes of having better appreciation of the phenomenon under study. The purposeful sampling method was used for selecting the participants for this study (Cleary, Shortfall, & Hayter, 2014). Ten participants were recruited from the Anne Arundel community in Maryland. Flyers for this study were distributed at treatment facilities, healthcare centers, and other community centers in the geographical area. Eligible participants were individuals age 18 and older. These individuals had experiential knowledge of behavioral health services either through personal use of these services or direct knowledge of the phenomenon under study.

Aided with the structured interview protocol, the in-depth face-to-face interview method was used for data collection (see Rubin & Rubin, 2012; Wise & Phillips, 2013).

The interview processes lasted between 30 and 60 minutes. The interviews were audio recorded with the permission of participants, while data gathered were carefully stored to protect participants' privacy and confidentiality. Alongside these processes, NVivo qualitative software was used for data analysis and management.

Definition of Terms

This section contains terms frequently used in this study, including their definitions. Some of the terms are synonymous with other descriptions, especially how they are used by the public. However, they have been included to clarify entries of these synonyms throughout the body of this work.

Behavioral health: This term is used to describe healthcare needs that fall under the categories of mental health and drug and alcohol use disorders (SAMHSA, 2015). The term may refer to each disorder or a combination of the disorders.

Diffusion: The process of communicating and spreading new ideas and insight to stakeholders of a common interest (Rogers, 2004).

Essential health benefits: These are combinations of mental health, behavioral health, and drug and alcohol treatment services that insurance companies are required to include in any basic health plan under the PPACA (Beronio et al., 2014).

Health access: This involves one's ability to afford and effectively use available healthcare resources for optimal functioning (Karikari-Martin, 2010; United States Department of Health & Human Services, Office of Disease Prevention and Health Promotion, n.d.).

Innovation: Novel or new ideas, skills, insight, and practices introduced to improve upon previous or current programs of an entity's interest (Rogers, 2004).

Mental health: Issues pertaining to psychological and psychiatric health. This could reflect the presence or absence of mental stability in an individual's functioning (CDC, 2011).

Obamacare: This is a derogatory moniker given to the PPACA by critics and opponents of the healthcare reform (Dunn, 2010; Kersh, 2011).

Parity: This refers to the level of importance and seriousness given to mental health and behavioral health disorders as given to physical healthcare (Smaldone & Cullen-Drill, 2010).

Patient Protection and Affordable Care Act (PPACA): A comprehensive healthcare reform signed into law by President Barack Obama in 2010 (Dubois, 2015; PPACA, 2010).

Substance use disorders: A combination of addictive use of alcohol and/or other illicit drugs (United States Department of Health & Human Services, 2014).

Assumptions

My goal was to explore the experiences of behavioral health service users before and since the implementation of the PPACA. The first assumption that I had before embarking on the fieldwork was that although behavior health service recipients may have experienced or had first-hand knowledge of the phenomenon of this study, their experiences would vary despite being selected from the same geographical location. I assumed that people with private health insurance may have a different perspective than those who have Medicaid or other public funded healthcare coverage. Despite the possible differences in the experiences of these services, participants would nonetheless offer their personal perception of how the PPACA has affected how they access treatment for their behavioral health needs.

Another assumption that I had was that behavioral health treatment providers would share the necessity for expanding treatment services with adequate means for meeting these treatment needs. For behavioral health treatment providers, it seems to be a common experience that people needing their services are hindered in many ways due to inadequate resources for this subgroup of healthcare users (Rowan et al., 2013). For these reasons, I assumed that behavioral health providers and service users would advocate for improved means for affording the essential healthcare benefits under the PPACA (Holahan & Blumberg, 2017).

Scope and Delimitations

In this phenomenological study, I focused on the effects of the PPACA on behavioral care access and treatment delivery in Anne Arundel County, Maryland. To keep this study manageable and concisely defined, it was limited to 10 participants. These participants were selected from Anne Arundel County and had personal experiences of receiving behavioral health services within the past 3 years. Selected individuals were direct recipients of behavioral health treatment services or family members who had first-hand knowledge of these experiences. To gather data specific to the topic of this study, I developed a personal interview guide central to the goal of this inquiry. This instrument was designed based on analysis of previous studies in the literature. Instrumentation was based on three characteristics of diffusion innovation, which are relative advantage, compatibility, and complexity.

Limitations

Since the enactment of the PPACA, the healthcare legislation has constantly faced threats of a possible repeal by its critics in the House and the Senate. Despite previous failed attempts at this effort, the election of President Trump and the Republican controlled House and Senate make the repeal of the PPACA a strong possibility. This makes the healthcare reform a moving target with a lesser prospect of being fully implemented or existing much longer (Holahan & Blumberg, 2017; Post, Raile, & Raile, 2010). The ongoing debates and potential vulnerabilities of the PPACA at the time of this study may have influenced the perceptions of participants.

Another limitation of this study was that it was limited to behavioral health service users in Anne Arundel County, Maryland. I intended to explore the experiences of Anne Arundel County residents in accessing behavioral health services following the PPACA implementation within the state. This study cannot be generalized to a larger population of other healthcare consumers within the state or other behavioral health service users in other states. Despite efforts to maintain neutrality while being reflexive in conducting this study, my background as a behavioral health professional in the state of Maryland may have influenced the worldview through which I approached this study. However, with the use of audit trails, any semblance of personal bias was examined and analyzed with evidence from the literature.

Significance of the Study

No matter what happens to the PPACA, there is no denying that the healthcare landscape has changed and will continue to do so, whether for the better or with more complexities for healthcare leaders (Rosenberg, 2012). Regardless of how much healthcare leaders, treatment providers, or policymakers tend to shift the responsibility of who should be held accountable for fixing the complex healthcare infrastructure in the United States, what is obvious is that no one is immune from the effects of inaction or intentional disregard for public demands for answers (Pacheco & Maltby, 2016). Individual states and municipalities that are invested in expanding Medicaid coverage for their constituents still have questions on how to effectively implement the PPACA across different segments of healthcare services (Sommers et al., 2014; Sonier, Boudreaux, & Blewett, 2013).

Some studies indicated that behavioral health recipients and treatment providers seem to share significant apprehension with the healthcare reform due to previous policies and funding challenges for behavioral healthcare (Golden & Vail, 2014; Hensley, 2012). People with mental health and substance use disorders, like the rest of the nation’s disadvantaged populations, want to live healthy lives, and they seek opportunities to pursue and attain vitality through effective access to healthcare services (Rosenberg, 2012). Determining the efficacy of the PPACA to expand behavioral health services and other areas of healthcare requires an objective consideration of stakeholders’ perspectives while advocating for collaborative implementation (Brandon & Carnes, 2014; Plough, 2015). The PPACA provides a health insurance market that offers the opportunity for almost anyone to afford healthcare coverage. However, the packaging of healthcare products to make this marketplace profitable to insurance companies without losing a substantial number of healthcare consumers or the behavioral health services users who are deemed a vulnerable subsector is another issue.

This research offers stakeholders opportunities to understand the benefits and challenges associated with behavioral health services under the PPACA in Anne Arundel County, Maryland. Having behavioral health service recipients and treatment providers share their opinions and experiences offers insight on how these stakeholders are interacting under the PPACA healthcare reform (Plough, 2015). Rather than categorically dismissing the healthcare reform as being ineffective, or simply harping on its superiority over previous healthcare reforms, it is crucially important to identify areas of the PPACA that possess relative advantage and compatibility to current healthcare infrastructure. This will allow for policymakers, healthcare provider communities, and service users to strategically innovate and curate these strengths in order to serve the overarching goals of the general public. This process will help stakeholders clarify what factors need to be improved upon for better coordination of services to improve access and promote wellness and disease prevention efforts.

Summary and Transition

The healthcare industry in the United States frequently finds itself on a rollercoaster of evolving uncertainties. Challenged by the demands to provide effective and efficient care to the general population, healthcare leaders and policymakers could accomplish much progress by finding common ground for developing the political capital and will, which could lead to attaining the mutual goals of concerned stakeholders (Post et al., 2010). To navigate the testy waters of varying ideologies and political persuasions, stakeholders in these efforts would be wise to pay careful attention to issues of greater importance for achieving all-inclusive goals. Behavioral healthcare and healthcare in general in the United States needs the infusion of innovation (Kwan et al., 2015), where the healthcare consumer is not just a vulnerable entity but a well-informed and active and stakeholder in the process (Brandon & Carnes, 2014).

Public opinion has the capacity to move the levers of public policies, including healthcare. Public opinion and dialogues help shape advocacy efforts when built upon available evidence. Framing such dialogues would greatly benefit from evidence-based innovations that have relative advantage to involved stakeholders and are compatible with existing infrastructure. Reducing complexities would also require making compromises where necessary in the interest of all parties involved.

The goal of this phenomenological study was to explore the effects of the PPACA on behavioral health. In this chapter, I offered a precursory overview to Chapters 2 and 3 of this research. The main sections addressed in this chapter included (a) the background of this study, (b) problem statement, and (c) nature and the significance of this study. In Chapter 2, I provide a detailed review of the literature, with careful attention to the historical context of what formed the basis of this study. In Chapter 3, I describe the methodology used for this study and how it was implemented.

Chapter 2: Literature Review

Introduction

Providing better healthcare access to more Americans and reducing escalating healthcare costs are the two main principles upon which the PPACA, also referred to as the ACA, was built (Linder et al., 2016). Some studies indicated that the opponents of the PPACA contend that the healthcare reform is driven more by liberal principles of governance (Caswell, Waidmann, & Blumberg, 2014; Greer & Méndez, 2015). These contentions have produced rising questions about the efficacy of the PPACA delivering on its promises of expanding healthcare access to more Americans or the possibility of increasing access to care without increasing the burden of healthcare costs.

In this literature review, my goal is to present findings from available literature on the PPACA and the expansion of Medicaid so far and how these factors affect access to behavioral health services, that is, treatment services for individuals with mental health and substance use disorders. The literature has minimal to inconclusive data on the implementation of the PPACA on access to behavioral health services (Han et al., 2015). Moreover, no study has addressed the perceptions and perspectives of individuals receiving treatment services for behavioral health and treatment providers of these services in Maryland regarding the effects of the PPACA on access to behavioral healthcare.

The following databases were used for this review: Academic Search Complete, Business Source Complete, CINAHL, Google Scholar, MEDLINE, ProQuest Central, and Thoreau Multi-Database Search. Government websites and private organizations reporting on the trends of behavioral health and healthcare reform were used to facilitate this research. Some of these organizations include the Urban Institute, CDC, and Healthy People 2020. Search terms used included *healthcare reform, Affordable Care Act, PPACA, Obamacare, health access, behavioral health care, mental health, substance use disorders (SUD), Maryland*, and *Anne Arundel County*.

In this literature review, I searched for peer-reviewed articles and grey papers from government and other nongovernmental websites that addressed the PPACA healthcare reform, its implementation, and some of its implications for behavioral health. Articles that provided reliable frameworks for study were further analyzed for their application to this review. I developed a Word document as a literature review matrix that I used to collate these articles for in-depth evaluation in order to determine their usefulness in my exploration. I examined the premise of each article, along with its conclusions and recommendations for future research. Selected articles for use were then catalogued into Zotero software as a means of further recall and data management protocols (see Willmes, Kürner, & Bareth, 2014).

In this chapter, I present the literature on Rogers's (2004) DIT as the theoretical framework for exploring the PPACA and healthcare initiatives that are promulgated under its implementation. I used the theory to elucidate how individuals within a society adopt changes over a period. Similarly, I examined society's views on behavioral health, including mental health and substance use disorders. The implications of these views and their influence on behavioral health policy formulation are addressed. I also explored the literature around the implementation of the PPACA in different states around the nation, including the preliminary outcomes with reference to the Medicaid expansion and access to behavioral health. Whereas I did not attempt to exhaust every piece of literature on the implementation of the PPACA and how it has influenced access to behavioral health services, I found a general consensus in the literature indicating that there were no available studies reporting the perception of behavioral health treatment users or the perception of treatment providers on expanded access to care in the literature.

Theoretical Foundation

The theoretical framework provides a general representation of relationships between concepts in an identified phenomenon, while the conceptual framework explains the researcher's idea on how the research problem will be explored (MacFarlane & Brún, 2012). This frame of reference provides others with an informed interaction with the study. On the other hand, theories are an organized and interconnected set of statements derived from the observed relationships between two or more variables (Green, 2014). These statements are formalized to develop a general understanding of a phenomenon or a combination of phenomena. Applying these concepts and theoretical frameworks are not without inherent challenges (Green, 2014), especially for any given theoretical framework, to exclusively own the lens through which a study can be approached. However, the goals of a study prescribe the type of framework that is suitable for a logical exploration with reliable and valid outcome.

Rogers's (2004) DIT was the theoretical framework used for this study. According to Rogers (2002), diffusion refers to the process wherein certain avenues are used to disseminate innovation to members of a social system. DIT offers a paradigm for examining the process of adopting new or novel ideas within a society over a period of time. It is based on the understanding that when such new ideas are introduced, not every member of that social system may be readily inclined to accept them at the initial stage. However, after the idea has been tested by a select few, those individuals become the ambassadors for promoting the ideas to the larger society, thereby leading to larger adoption at a subsequent time.

Diffusion of Innovation Theory

The DIT was originally advanced to understand how individuals within societies adopt changes to improve upon prevalent practices in a given domain (Ryan & Gross, 1943). In the early application of the diffusion model to the Iowa corn belt study, Ryan and Gross (1943) found that although there was the adoption of the new innovation in this study (hybrid corn seeds) by a few experts and neighbors who were early adopters, the majority of others needed personal experience to be convinced of this new idea. Years later, Rogers (2004) reflected that the possible rationale for how these farmers adopted this innovation was contingent upon the sources of the information, the influence from these sources, and their reliability for achieving the expected outcome. For this reason, Rogers emphasized that at the core of the diffusion process was information exchange in addition to the shared meaning that members of that social system attribute to their personal and subjective experiences of that innovation.

Structures of Diffusion of Innovation

While the diffusion model has gone through various modifications and refinement, Rogers's DIT continues to be a model that has been applied to numerous areas of social sciences including healthcare (Mirza et al., 2013; Rogers, 2004; Yuksel, 2015). In many ways, diffusion of innovation is a form of universal microprocess of social change that is applicable to numerous disciplines. Rogers (2002) noted four main factors that facilitate the diffusion of a new idea: (a) the innovation, (b) communication channels, (c) time, and (d) social system. It was further suggested that the characteristics of the innovation that influences the adoption of such ideas by members of a social system are (a) relative advantage, (b) compatibility, (c) complexity, (d) trialability, and (e) observability (Piña et al., 2015; Rogers, 2003; Sugarhood, Wherton, Procter, Hinder, & Greenhalgh, 2014). Relative advantage refers to the extent to which the new idea is believed to possess superior qualities to previous ones it is intended to replace. Compatibility refers to the degree to which the innovation is viewed as being compatible with existing structures and how it could address the concerns of the system. On the other hand, complexity is the degree of challenge that the application of the innovation could pose to members of the system. This refers to the usability and adaptability of the innovation to the system as a whole or individuals within the system. Trialability addresses the question of whether an innovation may be experimented within a smaller scope before a larger application. In addition, observability speaks to how the outcome(s) of the innovation are presented to others (Rogers, 2002; Sugarhood et al., 2014).

Rogers (2003) postulated that these characteristics determine the rate at which innovations are adopted. In other words, innovations are likely to be adopted at a faster rate when such innovations are perceived to be more advantageous, are more compatible with current practices, and have reliable means of being tested with outcomes reported to members of that system. Innovativeness in DIT is the space in time at which an individual or unit of adoption within a system accepts the idea relatively earlier than others within the system (Rogers, 2002). There are five groups of adopters in this category. These include (a) innovators, (b) early adopters, (c) early majority, (d) late majority, and (e) laggards (Hartzler & Rabun, 2013; Schleien & Miller, 2010).

Constructs for this study. Innovators are individuals who venture into unfamiliar terrain in search of answers and ideas that may not be readily available in their circle; early adopters are anchored within the local system and are in tune with activities taking place in their immediate environment. Early adopters usually include opinion leaders who have some responsibilities to their communities and are deliberate about their decision. While the early majority does not assume any leadership role per se, they represent an important link between early adopters and late adopters of an innovation. Also, the early majority invests a lengthy period into deliberations about the innovation. Ultimately, they share the prospects of willingness to give new innovations the opportunity for trial or exploration. The late majority is skeptical and would adopt an innovation only after being pressured by peers and others within the system. Finally, while laggards are suspicious and usually resistant to an innovation, they would hesitantly adopt innovation based on the confidence of like-minded peers. Rogers (2002) noted that the latter category of adopters would only adopt innovation on the merit of peers who have adopted the new idea and are satisfied with the outcome.

The DIT was chosen for this research because it offered applicable framework for evaluating the PPACA (the innovation) and the elements of the reform that could determine its adoption and implementation into the United States healthcare system. Furthermore, this conceptual framework highlights the characteristics of the reform and the innovative categories of those who could be impacted by the adoption of the reform. While consumers of behavioral health services and their families continue to anticipate what lies ahead in the implementation of the PPACA regarding their access to care, behavioral health providers and scholars-practitioners in healthcare continue to scramble for what to expect after the implementation of the PPACA (Makse & Volden, 2011). Using this framework in studying these dynamics would offer additional insight into the literature on the factors that drive stakeholders' engagement in the process of healthcare reform and policy adoption (Knudsen & Roman, 2014; Makse & Volden, 2011).

Makse and Volden (2011) identified that there are limited studies in the literature that have evaluated the attributes of policies using the DIT. However, they emphasized that the rate at which a policy is adopted lies on the attention given to such policy with the relative ease for understanding the various components of the policy to those whom it applies. Nevertheless, it is worth pointing out that the perception of those who are expected to implement an innovation is a major factor in facilitating the adoption and implementation process (Darney, Weaver, Vanderhei, Stevens, & Prager, 2013). If these individuals are disenfranchised or inadequately engaged in evaluating a new process, the resultant effect could be inconclusive, leading to ineffective programs or policies for executing such plans. Whereas the PPACA may entail the potentials for expanding healthcare access to the uninsured and promote better quality of care for the nation's healthcare structure while keeping the cost of care contained, each stakeholder in the healthcare community would experience the implementation of the reform at the different capacities with varying outcomes.

Evaluating the characteristics of the PPACA with regard to its impact on states which have implemented Medicaid expansion and those that plan to follow suit is key to assessing its effectiveness in the context of this study (Cabassa, Gomes, & Lewis-Fernández, 2015). Doing so offers insights to how stakeholders perceive the nature of the PPACA's relative advantage, compatibility, and complexity associated with the reform; these will also inform the literature on how they affect the rate of its adoption in the areas of behavioral health access.

Several studies that have examined the characteristics of innovations which contribute to their adoption and implementation suggest that relative advantage, compatibility, and complexity are frequently cited as the reasons for social systems and organizations embracing the introduction of a new program geared towards improving a previous one (Fajans et al., 2006; Tornatzky & Klein, 1982; Vedel et al., 2013). Tornatzky and Klein (1982) reported that findings from a comprehensive meta-analysis they conducted on innovation characteristics and innovation adoption showed that only three of ten innovation characteristics that they examined demonstrated strong consistency relating to adoption. They pointed out that these characteristics were compatibility, relative advantage, and complexity. In addition, it was reported from this study that while relative advantage and compatibility were favorable towards implementing an innovation, complexity as a characteristic had negative impact on implementation.

An innovation is deemed compatible when it is perceived to be in alignment with the norms, values, and roles that stakeholders anticipate to play in the adoption and implementation of the new idea (Vedel et al., 2013). Furthermore, Darney et al. (2013) noted that compatibility of an innovation is reinforced when it is better aligned to the values and goals of the members of a social system to whom the innovation is planned to benefit. Another characteristic of an innovation that promotes its acceptance and implementation is relative advantage.

According to Rogers (2002), this is the extent to which an innovation is perceived to be more advantageous than the previous or existing system. Despite how beneficial the new idea may appear, the perception of those adopting the innovation plays a crucial role in the adoption process. In addition, Sahin (2006) suggested that cost and social status motivations are at the core of what define this relative advantage. Furthermore, relative advantage is categorized into two dimensions - preventive and incremental innovations (Rogers, 2003; Sahin, 2006). The preventive aspect of innovation addresses the need to forestall an undesirable event in the future. On the other hand, the incremental innovations are implemented to start generating beneficial outcomes within a short period. In this way the benefits of an incremental innovation are anticipated to start yielding results shortly after its implementation.

Due to the anticipated increase to healthcare access that formed a significant foundation for the enactment of the PPACA (Plein, 2014), there is a need to identify how such proposed benefits affect individuals who have behavioral health needs, that is, people with mental illnesses and substance use disorders, and those who are expected to execute these specialty cares under the healthcare reform. It was pointed out in the literature (Mark, Wier, Malone, Penne, & Cowell, 2015) that there is a need to produce reliable data reflecting the nation's outlook on mental health and substance use disorders and those who are likely to become eligible for these services due to Medicaid expansion. This information should assist policymakers in implementing structures that would accommodate these needs. However, Mark et al. (2015) noted that from the most recent data available on the prevalence of mental illness and substance use disorders, about 14% of people who would qualify under Medicaid expansion have diagnosable substance use disorders. Of these numbers, just 2.3% of those with mental illness and 1.8% of those with substance use disorders may access treatment. Therefore, if the Medicaid expansion under the PPACA fails to address adequate access to care for these behavioral health needs, then its relative advantage in light of previous structures in place would be in question.

Another innovation characteristic that is worth considering in this study is complexity. Once again, Rogers (2003) described this concept as the perception that individuals have of an innovation regarding the degree of its difficulty to understand and use. Some studies have suggested that there is a negative relationship between complexity and the willingness to adopt or implement an innovation (Sahin 2006; Tornatzky & Klein, 1982). The United States healthcare system is riddled by complexities driven by heterogeneous systems of care delivery (Piña et al., 2015). Introducing the PPACA against this backdrop, therefore, invites a delicate negotiation among various stakeholders for developing frameworks that would promote the implementation of behavioral health services proposed in the PPACA (2010). Studies have shown that less ambiguous frameworks and interdependent accountability seem to reduce the perception of complexity while promoting continuous innovative processes (Piña et al., 2015).

Figure 1 below shows the innovation characteristics that promote or impede the adoption and implementation of an innovation, adapted from Rogers's (2004) DIT.

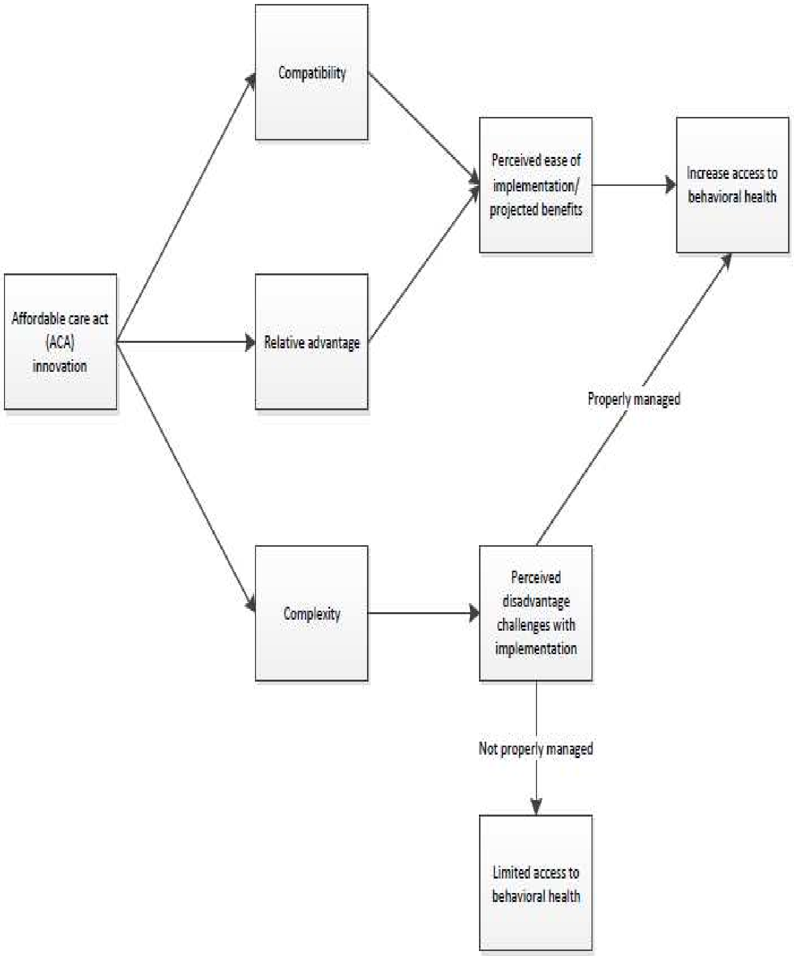

Figure 1. The innovation characteristics that promote or impede the adoption and implementation of an innovation, adapted from Rogers's (2004) DIT.

Diffusion of Innovation in Previous Research

In their study of adoption practices among treatment providers for substance use disorders (SUD), Knudsen and Roman (2014) examined factors that promoted the adoption of evidence-based practices using the characteristics of perceived relative advantage, compatibility, and adopter attributes. They interviewed 307 leaders in facilities that provided drug and alcohol treatment services. These organizations were reported to be entities that had recently adopted new forms of evidence-based treatment approaches or were in the process of doing so. The researchers reported that their participants were drawn from a nationally representative sample of substance use disorder treatment organizations in the United States. It was reported that about 30.7% of organizations reported recent adoption of evidence-based practices, 20.5% of organizations reported plans for adoption, and 48.8% of organizations had no plans to adopt any evidence-based practices. The researchers reported that the compatibility and the advantages that the evidence-based practices added to the majority of the organization resulted in a wider margin of adoption. They suggested that the consideration for an innovation might be driven by the evaluation of whether the new idea provides more value than the existing one with minimal complications. These insights are worth considering when evaluating the adoption of the PPACA and its implementation in states that have indicated their preparations to do.

Similarly, Walshe and Davies (2013) conducted a study in the United Kingdom using the DIT to examine factors that informed the framing of health policies and how such informed the health research leading to the adoption of health practices. They reported that they drew from the developments and health innovations from 1988 to 2013 in England using the DIT to understand the factors that facilitated or hindered the processes of implementing these innovations. The focus of the research was to identify the social and political context in addition to the language that informed the framing of such policies. Worthy of note is that they pointed out that during such discourse and implementation, some fundamental concerns were ignored or deliberately left out of the conversations simply to satisfy the demands of the opposition to the new ideas.

To this effect, Walshe and Davies (2013) identified that their study was developed with the understanding of multiple stakeholders involved in the adoption of healthcare reform or innovation and multidimensional negotiations involved in offering majority acceptance of these reforms. Walshe and Davies reported that there was an extensive use of ineffective practices in the delivery of care among healthcare provider organizations due to the perceived complexities of new evidence-based and more effective initiatives. The results from this study suggested that due to the changing demography of healthcare consumers and changing trends in service delivery, healthcare providers should see themselves as innovation adopters who would help diffuse innovation about care delivery to the communities that they serve.

The outcomes of the study also suggested that provider organizations could better drive innovation in service delivery if the needs of a community are locally defined while applying evidence-based approaches that have been shown to be effective. In the same vein, May (2013) reinforced this argument by emphasizing that the implementation of healthcare policies or healthcare interventions exceeds the borders of healthcare institutions or chambers of policy negotiations. Rather, these must involve an interdisciplinary team that involves policymakers, clinical teams, and the community they serve in order to establish a sustainable implementation process that eventually serves all parties involved.

Correspondingly, Harris, Weisberger, Silver, and Macinko (2015) conducted a qualitative study using diffusion of innovation to explore the perception of healthcare providers as adopters and implementers of a new healthcare innovation translated from one context to another. One of the premises of their inquiry was to examine if the preconceived assumption of the adopters impedes the reception of a new idea based on the origin of the idea. To carry out this study, they selected key informants from institutions and organizations with similar interests in understanding how to use reverse innovation to breach barriers that obstruct the adoption of innovations in healthcare. Informants were chosen from academia, nonprofit organizations, healthcare systems, and policy advocates. The 11 participants chosen for this study were reported to have a wide range of experiences, from executive leadership to community services, within the different domains they represented.

According to Harris et al. (2015), findings revealed that participants evaluated healthcare innovations poorly based on the innovation's origin and the prejudiced assumption that the innovations in question were inferior to the systems and processes that they were already used to. The researchers had anticipated that participants would offer technical and evidence-based reasons for discounting innovations. Rather, the findings indicated that innovations received push-back from those who they were supposed to benefit due to a “not invented here culture” (Harris et al., 2015), a perception that the researchers described as a biased and stereotypical perception of innovation simply based on difference in geographical context. With insight from this study, it is essential, therefore, that studies addressing the adoption and implementation of the PPACA should examine the possibility of bias or stereotypical assumptions among stakeholders involved in the process across individual states.

Patient Protection and Affordable Care Act

The PPACA (2010) has been referred to as one of the most polarized pieces of legislation in the history of modern politics of the United States (Plein, 2014; Rigby, Clark, & Pelika, 2014). The overarching aim of the PPACA is to improve healthcare for all Americans, promote greater healthcare access to more than 20 million uninsured and underinsure non-elderly individuals, and improve the quality of care while reducing the overall cost of care (Hardcastle, Record, Jacobson, & Gostin, 2011; Nordal, 2012; PPACA, 2010). Oberlander (2010) described the PPACA as the most important healthcare legislation that has been signed into law since the creation of Medicare and Medicaid in 1965. He further stated that the PPACA is a dramatic change to the United States healthcare policy, which has only managed to make incremental adjustments to healthcare policies in the past 40 years. Rigby et al. (2014) reported that the legislative processes leading to the passing of the PPACA were shrouded in conflicts of ideological positions and proposals from both the Republican and Democrat parties. It was also pointed out that the healthcare policy passed without any Republican votes.

Although the healthcare reform had included compromises made by both Republicans and Democrats leading to the final passage of the legislation, opponents of the healthcare reform from the Republican Party claimed that the legislative process was rigged by President Obama's Democrat associates involved in the process (Oberlander, 2010; Rigby et al., 2014). Some of these dissatisfactions have contributed to the legislation being given the moniker "Obamacare" (Dunn, 2010; Kersh, 2011). Whereas there is a conjecture from members of the Republican Party characterizing the PPACA as the invention of Democrats, that is not entirely the case (Rigby et al., 2014). Various authors have argued that the PPACA in many ways bears semblance to previous healthcare reforms spearheaded by members of the Republican Party. For example, Quadango (2014) stated that the PPACA shares close similarities with the Health Equity and Access Reform Today (HEART) Act, which was crafted by Republicans as an alternative to counteract President Bill Clinton's version of healthcare reform in 1993, the American Health Security Act (AHSA). The HEART Act included provisions for free market and individual and employer mandates which were healthcare policy positions long espoused by Republicans before the arrival of the PPACA.

The Massachusetts healthcare reform that was signed into law by Governor Mitt Romney in 2006 was another healthcare reform that had similar features of the PPACA (Brandon & Carnes, 2014; Jones, Bradley, & Oberlander, 2014). The Massachusetts healthcare reform was crafted in response to providing opportunities for the uninsured to become insured and the capacity for small firms to offer insurance coverage with the aid of purchasing pools (Jones et al., 2014); this framework was eventually named the Commonwealth Health Insurance Connector (Holahan & Blumberg, 2006).

Purchasing pools provided the health insurance exchange advantages that mitigated against the challenges of the inability to purchase healthcare coverage due to economic status or pre-existing health conditions (Jones et al., 2014). This also helped manage the administrative costs for purchasing health insurance services. Furthermore, Quadango (2014) emphasized that both the PPACA and HEART plan shared similarities, such as stipulating the individual mandate, the employer mandate, and a standard benefit package that ensured that treatment services are covered in all plans. Also included were state exchange provisions and subsidies for low-income individuals. In addition, both healthcare plans included tough regulations on insurance companies which prevented them from denying prospective customer insurance coverage on the grounds that these individuals have pre-existing health conditions; in the same manner, insurance companies were not allowed to discontinue customers' premiums due to health conditions.

While the PPACA shares almost identical provisions with the Massachusetts Commonwealth Health Insurance Connector (Brandon & Carnes, 2014) and the HEART plan (Quadango, 2014), the PPACA does contain some provisions that differ from the HEART plan. For instance, Quadango (2014) highlighted that the PPACA denies insurance companies the allowance to set lifetime limits on insurance premiums but the HEART plan did not. Another notable difference in the PPACA included the extension of coverage for dependents up to age 26 on commercial private plans, whereas the HEART plan did not (Quadango, 2014; Sommers, Buchmueller, Decker, Carey, & Kronick, 2013). Another difference, and perhaps one of the lightning rods of the PPACA which sets it apart from the others, is its near universal scope of healthcare coverage.

Brandon and Carnes (2014) suggested that the PPACA practically expanded the scope of Medicaid from a mere categorical program to that of universal entitlement, which placed it at the same level with Medicare. Given this status, the only qualifying barometers to become eligible for healthcare coverage under the PPACA provisions was to be at the income bracket below 138% of the federal poverty level and to lack another form of insurance coverage. Some of the beneficiaries in this category included children, parents, childless adults, and non-elderly individuals below age 65 (Quadango, 2014).

Compromises in the PPACA

Several authors agree that after much deliberation between Republicans and Democrats, including their nonpolitical allies, Democrats seem to have won the battle in ensuring that the PPACA was enacted (Beaussier, 2012; Kersh, 2011; Rigby et al., 2014). However, Republicans had some of their important conditions met on the final piece of the legislation, while Democrats lost some provisions they wanted to include. For example, Werner (2010) reported that House Democrats aggressively pushed for national insurance regulated by the federal government. Their reasoning for this was that such a plan offered more security to consumers and provided more uniformity than exchange models regulated by individual states. Although President Obama was highly in support of the national healthcare program, this was shut down by the Senate. This move ended up with the compromised version of state exchanges, which was considered more of a central option (Jones et al., 2014).

By the same token, Republicans and moderate Democrats, such as Bart Stupak (D-MI), were given concession in their opposition of using federal funds to cover abortion services (Beaussier, 2012; Rigby et al., 2014). This opposition gave states more flexibility to tighten or do away with any type of government provision which allows individuals to elect for abortion services using government funds. Another provision that Democrats seemed to have ceded in the PPACA negotiations was allowing extension for the Bush tax cut (Henchman & Stephens, 2014). Although President Obama had previously proposed excluding individuals earning $250,000 and above from benefiting from this cut, he and both chambers came to a compromise where the threshold was expanded to include individuals earning up $400,000 and for married couples who have a joint earning of up to $450,000 (Henchman & Stephens, 2014).

Opponents of the PPACA have vehemently criticized the PPACA as violating the tenets of American federalism, stating that President Obama's administration and its allies used the healthcare reform as another opportunity to meddle with the rights of citizens, businesses, and states around the country (Plein, 2014). For this reason, the reform was branded as another liberal ploy to peddle a socialist agenda and socialized medicine (Dunn, 2010; Grogan, 2011; Quadango, 2014). Nevertheless, Frakes (2012) described many of the issues surrounding the passage of the PPACA as ideological wrestling that were hashed out in a legislative process centered on an unprecedented law in modern politics. Despite these differences, Frakes (2012) pointed out that one of the bipartisan accomplishments of this piece of legislation was the agreement that there is the need for increasing the quality of healthcare while at the same pursuing cost containment initiatives.

Whether the PPACA is viewed as socialized healthcare reform (Dunn, 2010; Grogan, 2011; Quadango, 2014) or an attempt to usher in the much needed overhaul in the United States' healthcare (Whittington, Nolan, Lewis, & Torres, 2015), what is obvious is that healthcare reform has moved to its implementation stage. Drawing on almost a decade of research focusing on healthcare optimizations, the Institute of Healthcare Improvement (IHI) has posited a national strategy that could aid United States healthcare stakeholders in implementing the PPACA. These include, "improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations" - a framework also known as the "Triple Aim" (Whittington et al., 2015, p. 246).

PPACA Implications for Behavioral Health

In this study, I wanted to explore the effects of the PPACA on behavioral health. In light of some of the negotiations that went into Medicaid expansion clauses in the PPACA and the efforts that some states have already made towards expansion, there is a need to examine how this is affecting access to the delivery of behavioral health services. For this reason, it is only appropriate to discuss the evolving nature of behavioral health prior to the enactment of the PPACA.

Historical Trends in Behavioral Health

Behavioral health as used in this study is the combination of mental health and substance use disorders (SAMHSA, 2015). Each disorder may occur independently or jointly within an individual. However, more often than not, these disorders go hand-in-hand. When this is the case, the resultant effect becomes a situation where an individual is suffering from co-occurring disorders. Nonetheless, individuals who have suffered from psychiatric disorders and substance use disorders seem to have been dealt a double hand of misfortune as far back as history can recall (Hornstein, 2009). Hornstein indicated that from ancient history leading into the eighteenth century, healers, professionals, and members of society have tried to understand the perplexing nature of these disorders. As a result, there have been different views and perceptions - humane and inhumane - which have influenced the approaches for addressing the needs of sufferers.

Societal views on behavioral health issues seem to evolve as members of society, political leaders, and policymakers gain better appreciation of the impact of behavioral health disorders on not only the life of the individual and those who are closest to them, but the toll of these issues on society at large. Some have perceived individuals with these disorders as having character defects that are entrenched in moral weaknesses (Chamberlin, 2014). Multiple factors continue to shape and inform how society conceptualizes behavioral health issues. Grob (2008) identified some of the factors that have informed these views to include cultural beliefs, regional or national traditions, political tenor, and the dominant views on illness among others. Invariably, these have shaped how people with mental illness and other behavioral health issues were cared for and treated, whether these are in solitary confinement, hospital wards, or in less restrictive environments with more or less quality care.

Although there has been a progressive awareness of the numerous factors contributing to the development of these disorders, stakeholders in the domain of policy design and treatment service delivery have not adequately represented the interest of those for whom they are supposed to advocate.

Mohr (1998) provided a picture of some of the maneuverings that disrupted the opportunities of providing adequate behavioral health treatment to individuals suffering from mental illness and substance use disorders. Further, Mohr highlighted one of the case studies, which he suggested mirrors some of the grievous practices in the contemporary era of psychiatric care. It was reported that the case study reflected in the narrative occurred in a for-profit psychiatric institution between 1985 and 1991. Mohr (1998) pointed out that the unpalatable behaviors that were exhibited by these identified institutions could have been motivated by “the prevalence of market based ideologies, a concern with deregulation, and a disposition by insurance providers to cover inpatient psychiatric care in favor of outpatient care” (p. 302). Owing to some of these irregularities in providing care to individuals with psychiatric disorders, the movement towards community mental health and outpatient treatment services emerged in the 1960s (Shore, 2012). One of the main goals of this movement was to restructure the influence wielded by the establishment at the time, a structure that was opposed to regulation and effective public oversight.

Following these developments, the community mental health organizations grew tremendously between 1970 and 2000. One report indicated that these outpatient institutions grew from 3,005 to 4,546 within this period; these institutions included “general hospital psychiatric units, outpatient clinics, and mental health centers, halfway houses, day hospitals, and private practice” (Beinecke & Huxley, 2009, p. 215). With the proliferation of these provider organizations also came the need to secure adequate funding for the delivery of treatment services. According to Frank and Glied (2006), the expenditure on mental health treatment delivery has remained consistent since 1971. They indicated that in 1971 alone the total amount spent on mental health consisted of 0.84 of the GDP. While the number of individuals receiving behavioral health services has increased, policymakers have also bemoaned the crushing cost of delivering these services; this situation has been suggested as influencing the financial allocation to these services by policy makers (Frank & Glied, 2006).

In a similar trend, mental health issues absorbed a significant portion of states’ budgets, these along with several other factors invited the intervention of the federal government into mental health policy (Grob, 2008). It is generally believed that the modern health insurance system may have found its origin in the Kaiser system, introduced by Dr. Sidney Garfield in 1933, as a way of offering affordable prepaid health care (Wang, 2014). However, the Hospital Survey and Construction Act of 1946 (also referred to as the Hill-Burton Act) seems to have created the opportunity for the development of a wide range healthcare infrastructure and the expansion of medical care to the less-privileged (Almond, Currie, & Simeonova, 2011). Nevertheless, with the enactment of the National Mental Health Act of 1946, advocates of the Act, such as Dr. Robert H. Felix, were able to garner attention to mental health and behavioral health disorders, declaring them as public health concerns.

Prevalence of Behavioral Health Disorders in the United States

Mental Health Disorders

Mental illness refers to a combination of mental disorders which interfere with an individual's ability to demonstrate clear thinking, poor mood regulation, erratic behaviors resulting from distress, and psychological impairment in daily functioning (CDC, 2011). In the United States, over a quarter (26.2%) of adults and 13.1% of children have a diagnosable mental health disorder (Mendenhall, Jackson, & Hase, 2013). Furthermore, the CDC (2011) reported that nearly 50% of adults in the United States would experience no less than one mental health disorder in their lifetime.

Mental illness and SUDs are debilitating diseases that continue to plague American society at an alarming rate. Co-occurring disorders of mental illness and substance use disorders are among the leading causes of mortality in the United States each year (Starr, 2001). The National Institute of Mental Illness (NIMH) (n.d.) estimated that in 2008, more than half (58.7%) of adults suffered from serious mental illness in the United States. About 71% of adults who were diagnosed with depression received mental health and treatment services for their needs.

It is estimated that these disorders cost the nation's economy over $800 billion per year (NIMH, n.d.). Another report from the Center for Behavioral Health Statistics and Quality (Hedden et al., 2015) indicated that in 2014 alone, there were 46.3 million adults age 18 and older who met the diagnostic criteria for any mental illness in the United States. Otherwise stated, this figure reflected that about 18.1% of all adults in the United States fit this category. Merikangas et al. (2010) reported that one in four to five adolescents in the general population suffers from disorders that result in severe impairment leading to a staggering economic impact of about a quarter of one trillion dollars borne by families and American society.

Substance Use Disorders

In a similar development, substance use disorders have been identified by Healthy People 2020 as one of the leading health indicators which demands urgent attention by all stakeholders in disease prevention and wellness initiatives across communities in the United States (United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.). It was indicated by Healthy People 2020 that in 2005 about 22 million Americans struggled with a drug or alcohol problem. Of these numbers, about 95% are ignorant of the fact that they have an existing problem with substance use, while among those who recognized their struggles with substance use, about 273,000 have made unsuccessful attempts in either seeking or securing needed help for their disorder. Unfortunately, one of the most challenging aspects of SUDs is the incidents of death resulting from opioid overdose. The increasing numbers of opioid related deaths are resultant from illicit opiate substances such as heroin and prescribed analgesic opioids for medical reasons (Cropsey et al., 2013; Gwira Baumblatt et al., 2014).

Regarding incidence of drug overdose, the CDC (2012) estimated that approximately 27,000 unintentional drug overdose deaths occurred in the United States in 2007, with one death occurring every 19 minutes. Prescription drug abuse is the fastest growing drug problem in the United States. The majority of these deaths have resulted from the increasing use of prescription opioid analgesics. Furthermore, for every unintentional overdose death related to an opioid analgesic, nine persons are admitted for substance abuse treatment, 35 visit emergency departments, 161 report drug abuse or dependence, and 461 report nonmedical uses of opioid analgesics. The current data available from Healthy People 2020 (USDHH, 2014) estimated a baseline occurrence of 12.6 drug-induced deaths per 100,000 population occurring in 2007 (age adjusted to the year 2000 standard population).

The projected target is to reduce this occurrence to 11.3 deaths per 100,000 population. When put into perspective, this would lead to a 10% improvement in this area of healthcare prevention (USDHH, 2014). These estimates not only highlight the national dilemma on substance related fatalities in the United States, it also confirms the reality and magnitude of what states and local communities have to grapple with in keeping the dilemma contained. This problem necessitates building political will, creating platforms that facilitate expanded access to mental health and substance use disorders treatment, and developing a continuum of care that helps reduce hospital re-admission rates and prevents individual and family disruptions at home, school, and work (Lezine & Reed, 2007; Rosenberg, 2016).

Behavioral Health and Parity Laws

From a healthcare policy implementation and health insurance coverage standpoint, behavioral health treatment services have not always been accorded the same status as treatment for physical health. Historically, mental health policy in the United States has been one of ambivalence, complicated struggles, and the formulation of idealistic approaches on how to care for individuals suffering from mental health disorders (Hudson, 1993). Early on in the evolution of mental health policies in the United States, two major factors further complicated this process for legislators - fiscal constraints on federal and state governments due to the Cold War and the escalating cost of healthcare (Hudson, 1993). Owing to these concerns, managed behavioral health gradually emerged with hopes of helping keep cost of care contained. The limits placed on mental health services by insurance companies could be traced back to when managed care organizations came onto the scene (Barry, Huskamp, & Goldman, 2010).

The introduction of managed behavioral healthcare seemed to be a way to provide ongoing care for mental health disorders while attempting to keep costs contained. On the contrary, this had its disadvantages for private insurers as there was little to no advantage for them to provide coverage for services that were included in community-based mental healthcare (Barry et al., 2010). At the most, private insurance policies that offered mental health coverage were provided through a carved-out arrangement (Grob & Goldman, 2006). This is a situation where a managed care organization has the flexibility to separate service offerings by functions and illness classifications. Subsequently, the managed care organization is able to contract specific illness categories to other managed care organizations, which could offer coverage for such services at a lower cost to a customer. Because of the complexities of these arrangements, individuals with mental health and substance abuse disorders seem to be more at a disadvantage to become eligible for these plans.

In a study conducted by Rowan et al. (2013) to examine the effects of cost to receiving specialty care, individuals with behavioral health problems who had private insurance plans reported that financial burdens in their premiums were a deterrent to them receiving care for their behavioral health concerns. Managed behavioral care plans have been described generally as restrictive in terms of what types of services individual are eligible for during the course of a calendar year or in a lifetime. Sundararaman and Redhead (2008) reported that private health insurance plans have a reputation for offering limited coverage for behavioral health disorders in comparison to other physical ailments. For behavioral health disorders, private health plans have historically outlined lesser annual or lifetime dollar amounts on mental health and substance use disorder treatment services. These include restricted treatment options for mental health disorders, less than evidence based supported inpatient and outpatient treatment, and higher deductibles and copays (Chamberlin, 2014; Sundararaman & Redhead, 2008).

Opposition to behavioral health insurance expansion emanated from individuals who argued that mental health and substance use disorders were fictitious illnesses that lacked scientific evidence (Grob & Goldman, 2006). Others held that any attempt to treat these disorders were efforts in futility, as they pointed out difficulties with effective diagnoses and efficient management of these diseases (Sundararaman & Redhead, 2008). Following the undeniable necessity to provide behavioral and psychiatric healthcare to returning servicemen in the Second World War, there became a shift in nomenclature from “mental illness” to “mental health” (Johnston, 2004, p. 120). Subsequently, around this era, the National Mental Health Act was passed into law in 1946, creating avenues for funded mental health research endeavors and expansion of mental health programs. Nevertheless, efforts towards mental health parity did not fully emerge until President John F. Kennedy's administration. The first of these efforts was the enactment of the Mental Retardation Facilities and Community Mental Health Centers (CMHC) Construction Act of 1963 (Kemp, 2007). The other was his collaboration with the U.S. Civil Service Commission, which was the predecessor to the U.S. Office of Personnel Management, to push for equal insurance coverage for both medical and psychiatric illness (Barry et al., 2010).

Following was the Federal Mental Health Parity Act (MHPA) of 1996 which was enacted by President Bill Clinton (Buchmueller, Cooper, Jacobson, & Zuvekas, 2007). Although the intention of the MHPA was to eradicate mental health discrimination from health insurance and to promote equity of care for individuals and their families, this legislation seemed to come short of accomplishing its aims. Buchmueller et al. (2007) pointed out that the MHPA offered exemption for firms consisting of 50 or less employees from participation. Additionally, firms were given a pass when any claim of increase in expenditure beyond 1% was attributed to the insurance by these organizations. Also, there was no strong language mandating the inclusion of mental health benefits in healthcare plans, neither was there any mechanism put in place to deter the practice of restricted coverage. Because of these loopholes, there was an unregulated practice of insurance companies imposing limits on behavioral health service offerings.

Subsequently, there was a milestone attainment in the evolution of parity laws. In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into law and became effective in January 2010 (Smaldone & Cullen-Drill, 2010). As an advanced version of its predecessor, the MHPAEA was binding on firms that had 50 or more employees. Not only did the MHPAEA require concerned entities to offer mental health and substance abuse coverage as part of employee benefits, these requirements extended to self-insured plans as well (Smaldone & Cullen-Drill, 2010). It is worth noting that the MHPAEA was widely received by many representatives of the health insurance industry comprising America's Health Insurance Plans (AHIP), which represents 1,300 carriers including CIGNA (Dixon, 2009). Offering a sober assessment of what an effective and efficient parity ought to accomplish, Glied and Frank (2008) candidly remarked that parity requirements should not be an avenue for exploitation of care among service users or service providers. As a result, there must be well-defined criteria of what constitutes mental health and substance use disorders which qualify for parity coverage. These notwithstanding, the expectations in parity laws ensures that individuals with serious mental illnesses are not disenfranchised from needed care but offered services that would facilitate recovery and wellness (Glied & Frank, 2008).

PPACA Implications for Behavioral Health Access

The PPACA (PPACA, 2010; P.L. 111-148, 2010; P.L. 111-152, 2010) contains various provisions that are intended to promote access to behavioral health services. The law mandates that all healthcare plans must contain essential health benefits. Among the ten categories of healthcare services required to be covered as essential health benefits are, “mental health and substance use disorder services, including behavioral health treatment” (Sec. 1302 (b)). Concerning individual choices from market exchanges, the law establishes the Applicability of Mental Health Parity - Section 2726 of the Public Health Service Act, which is expected to apply to all “qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans” (Sec. 1311 (j)). Beginning in 2014, smaller groups (entities with less than 50 employees) that were not included in previous parity coverage such as the MHPAEA are now required to use standardized benchmarking in the marketplace to offer mental health and substance abuse services in their plans (Beronio et al., 2014; Brandon & Carnes, 2014).

While previous parity laws including the MHPAEA did not necessarily include coverage for mental health and substance use disorders except when they were included in the original plan, the PPACA goes a step further to mandate the inclusion of behavioral health services as essential healthcare benefits (Beronio et al., 2014). As the full implementation of the PPACA progresses, publicly financed behavioral health services may find opportunities for improving on their service offerings, thereby assisting in expanding access to specialized behavioral healthcare (Goldman & Karakus, 2014). In addition, due to the restructuring of service reimbursement for specialty services under the PPACA, there is likely going to be a shift towards community-based support program and recovery services (Levit et al., 2013; McCance-Katz, Rabiner, & Rivers, 2014). This, therefore, calls for strategic alliances between provider organizations to harness their resources in order to remain viable, as well as having the capacity to accommodate the needs of the evolving population that would need behavioral healthcare.

Whereas there is a growing consensus in the literature that the application of the essential benefits in the PPACA will promote expanded treatment access for behavioral health disorders, there remains the question of how to define various behavioral health disorders in order to be eligible for treatment coverage (Burns, 2015; Chamberlin, 2014). Garcia (2010) has argued against any attempt to expand on parity initiatives for behavioral health, stating that such a move does not show any effect on the reduction of behavioral health problems in society. Garcia (2010) further contended that including substance use disorder treatment covered in parity would increase cost for health insurance providers and for individuals who are independently purchasing premiums for themselves. Rather, what is recommended as an alternative to parity initiatives is a multi-tiered insurance coverage that allows individuals to be covered based on their need, thereby eliminating coverage for those who do not need it. Saloner and Le Cook (2014) investigated the effects of the PPACA on access to behavioral health treatment for individuals with dependent coverage. In that study, the authors reported that post implementation of the PPACA, they found a 12.4% decline in the amount of uninsured visits by patients who were treated for mental health and substance use disorders and a 12.9% increase with visits paid for with private insurance. These authors suggested that while expanded insurance options and increased awareness of treatment services may have contributed to these preliminary positive outlooks, increased demand could put strain on provider capacity, thereby indirectly limiting access to care.

Access to Behavioral Healthcare in Maryland

In an attempt to better define healthcare access, several models have been used to conceptualize what access to care entails and to what end such conceptualization serves (Karikari-Martin, 2010). One of the main objectives of healthcare policy is to promote adequate healthcare coverage and healthcare resources to meet healthcare demand (Votruba, Eaton, Prince, & Thornicroft, 2014). This goal has been resoundingly lauded in the enactment of the PPACA through its emphasis on Medicaid expansion and other provisions in the law intended to boost the availability of essential benefits such as behavioral health access. Two main factors that have been identified to collectively capture the true grasp of healthcare access are (a) having healthcare coverage and (b) efficiency and effectiveness of service offerings (Karikari-Martin, 2010). To this end, the claim of true expansion for behavioral health access and services can only be made if the needs of enrollees are being met along the continuum of care (Garfield, Lave, & Donohue, 2010).

One of the recent studies on the implementation of the PPACA was conducted by Somers et al. (2014). Participants in this study were state Medicaid directors or representatives from states planning on Medicaid expansion in 2014. These individuals were either directly involved or had first-hand knowledge of the ongoing implementation of the PPACA's Medicaid expansion. Despite the prospects of Medicaid expansion, the outcome of this study suggested potentials of enrollment challenges, cost-containment dilemma for states, and adequacy of service access to individuals. Before the Mental Health Parity Act (MHPA) of 1996 was signed into law, the state of Maryland was among the first five states to adopt mental health parity laws with the aim of expanding access to mental health treatment (Peck & Scheffler, 2002). Similarly, Olson (2015) suggested that Maryland is among other neighboring states which have started reaping the preliminary results of PPACA's Medicaid expansion.

In light of these preliminary reports on the benefits of the PPACA, there continues to be efforts to repeal some or all parts of the healthcare reform (Kersh, 2011). On the other hand, other studies have found significant operational challenges interfering with the delivery and access to behavioral health services (Han et al., 2015). Additionally, other studies have suggested potentials for moderate increase in the cost of insurance coverage and inadequate administrative capacity to meet service needs (Blumberg & Holahan, 2015; Dickson, 2015). Since no study has addressed these issues and how they affect access to behavioral healthcare in Maryland, this research focused on exploring stakeholders' experiences, perceptions, and perspectives on access to behavioral healthcare and treatment delivery post the 2014 Medicaid expansion (Dickson, 2015; Hefei et al., 2015).

Phenomenology

Phenomenology is the study of an issue or a concern of interest with the intention of understanding the attributes of that issue (McConnell-Henry, Chapman, & Francis, 2009). Furthermore, Creswell (2013) suggested that phenomenological studies are used to describe the common meaning that individuals attach to their lived experiences regarding a concept. For these reasons, investigators using the phenomenological paradigm attempt to reduce individuals' lived experiences in relation to a concept, trend, or phenomenon to a universal description of the issue at stake.

The use of the phenomenological method was more suitable for this study because my inquiry in this research explored the perceived effects of the PPACA on access to behavioral health services among services users in Anne Arundel County. It has been indicated that the fundamental premise of phenomenology is the quest to understand the lived experiences of individuals within the context of an issue while appreciating the meaning that these individuals attach to such experiences in the larger context of societal structures (McConnell-Henry et al., 2009).

Comparative to the focus of this research, Hossen and Westhues (2011) conducted a study with the intention of understanding health systems related barriers confronting older women living in rural areas of Bangladesh, India. It was pointed out that the government of Bangladesh had introduced health programs to promote expanded access to care among its citizens. The researchers noted that using a phenomenological design would enable them to better understand the perception and perspectives of the population for whom these programs were designed, thereby having a better view of how these programs are meeting their expected designs. There is a consensus in the literature among studies where the collective experience of stakeholders has been examined in relation to the implementation of policies, with wide ranging effects among members of society (Freeman et al., 2015; Henriques, 2014; Hossen & Westhues, 2011; Petersen, Borg, Hounsgaard, & Vinther Nielsen, 2012). A common theme that has been observed in the literature is that user involvement, service user input, and the subjective views of stakeholders play crucial roles in promoting a better understanding of issues of societal interest. These have prompted an increased need to use phenomenological methods in qualitative studies to better understand individual perception of subsectors of society with hopes of having better appreciation of the phenomenon under study.

The PPACA has been enacted as a healthcare law that will facilitate individual state adoption of policies (Sommers et al., 2014). The implementation of the reform could lead to varying outcomes for individuals who are seeking behavioral health services as a result of the new attendant guidelines that are included in the healthcare reform (Han et al., 2015; Hefei, Druss, & Cummings, 2015; Hensley, 2012). The essence of the phenomenological method to this research was that it aided the understanding of the macro and the micro dynamics of stakeholders (see Heniques, 2014) and the shared perception and perspectives of these stakeholders in understanding the true worth of the PPACA in improving access to behavioral healthcare.

Summary

There is no doubt at this point that due to the escalating cost of healthcare in the United States, all stakeholders - the government, private payers, providers, and even consumers - are seeking means of keeping the cost of care under control in order to provide more access to healthcare when needed (Hackbarth, 2009). The PPACA is a piece of complex healthcare legislation that has caused passionate argument from both the proponents and opponents of the legislation. Proponents of the healthcare reform argue that the legislation would increase healthcare coverage for the uninsured and underinsured, as well as expand access to specialty care to beneficiaries who otherwise would not be eligible for these types of care. Opponents describe the legislation as mere socialized medicine that would inflate the burden of healthcare cost on the nation's economy.

Mental health and SUDs and behavioral health problems are essential specialties in healthcare which have been recognized as such in the PPACA. Despite the debilitating nature of these disorders, ill-informed perceptions and conflicting priorities in healthcare policies have consistently disenfranchised individuals with these problems from experiencing adequate and effective care for their needs. As the implementation of the PPACA unfolds, following its enactment in 2010 by President Barack Obama, questions remain if the healthcare reform can live up its hype with expanding much needed access to behavioral health services. Although the PPACA is a new healthcare reform with limited literature on its implementation, stakeholders are frequently confronted with the expectations of coming to terms with how to define healthcare access in the United States (Karikari-Martin, 2011) and better processes for designing viable cost-containment approaches (Geyman, 2012). Consequently, exploring the effects of the PPACA needs to be treated as a trend that is yet defining itself in the United States healthcare environment.

While policymakers, healthcare practitioners, and consumers of healthcare services anticipate what lies ahead in the post enactment of the PPACA, studying these healthcare trends among consumers and other stakeholders through the framework that was used in this study provides additional insight into stakeholders' engagement in the process. More importantly, this research contributes to the knowledge base in this area by further providing stakeholders with informed insight on the trends leading to this reform and perhaps elicit more opportunities of improving the process of delivering behavioral healthcare in the Anne Arundel County, and perhaps the state of Maryland at large.

The PPACA is changing who has access to care, how care is paid for and delivered, and how patients and providers interact. Coordinated efforts to promote wellness and prevent diseases are proliferating among a diverse set of stakeholders, including organizations that are traditionally not focused on health issues (Plough, 2015).

In chapter 3, I will focus on the methodologies used to explore the experiences, perceptions, and perspectives of behavioral health treatment recipients and treatment providers post PPACA implementation. Chapter 3 comprises of the research design, the process for selecting research participants, and the rationale for this selection process. Following will be my role as the researcher in this process and the steps I took to insure quality and adherence to ethical guidelines.

Chapter 3: Research Method

Introduction

Behavioral health policies in the United States have faced significant ambivalence and complicated struggles for a long time (Mechanic, 2014). For this reason, developing a collaborative system of healthcare that expands access to behavioral healthcare continues to be a public health concern. Achieving such collaboration requires increased attention, not only for individuals suffering from mental health and substance use disorders, but also for treatment providers who are entrusted to provide these services, along with other stakeholders in this pursuit (Dinan, 2014; Mechanic, 2012). Inherent in the PPACA (P.L. 111-148, 2010; P.L. 111-152, 2010) are provisions that are intended to promote access to behavioral health services.

Research Design and Rationale

Despite some of the proposed benefits of the PPACA (Kersh, 2011), some researchers have suggested that there are significant operational challenges interfering with the delivery and access to behavioral health services in the healthcare reform (Han et al., 2015). Additionally, other researchers have suggested potential for a moderate increase in the cost of insurance coverage and inadequate administrative capacity to meet service needs (Blumberg & Holahan, 2015; Dickson, 2015).

Since no study has addressed these issues and how they affect access to behavioral healthcare in Maryland, my goal in this phenomenological qualitative research study was to explore stakeholders’ experiences, perceptions, and perspectives on access to behavioral healthcare and treatment delivery post 2014 Medicaid expansion (see

Dickson, 2015; Hefei et al., 2015). The PPACA was a relatively new healthcare reform at the time of this study, which was still evolving in its implementation stages. This study, therefore, adds to the literature by providing a first-hand account on how behavioral health service users, treatment providers, and other stakeholders in Maryland are navigating the process, service access, implementation, and affordability of behavior health services.

The literature does indicate the existence of some studies that have attempted to address preliminary findings in the ongoing implementation of the PPACA. Some of these studies were done using quantitative methods (Han et al., 2015; Sommers et al., 2014). Nevertheless, due to the scant data on the early stages of the PPACA's implementation, available findings were more descriptive and may not necessarily represent a true sample of the population (Han et al., 2015; Sommers et al., 2014). This study was developed with the worldview that health service users, including consumers of behavioral healthcare, are key stakeholders in the evolution of healthcare reform and policies. Their voices through their perceptions and experiences ought to be considered in the formulation and adoption of healthcare reforms and policies (Beidas et al., 2013; Hare et al., 2013).

Since scientific rigor starts with exploring an issue of concern by asking questions relevant to the problem under examination (Wakefield, 2014), this qualitative study was carried out using a phenomenological approach. This approach was chosen for this study because its fundamental aim was to understand the lived experiences of individuals within the context of an issue while paying careful attention to participants' perception and the meaning they attach to their experiences in relationship to the subject of study (McDonnell-Henry et al., 2009). As of the time of this writing, there has not been any study on the effects of the PPACA on the behavioral health landscape in Maryland. As a result, my goal of this study was to explore the perceived effects of the PPACA on access to behavioral health services among service users and treatment providers in Maryland, particularly in Anne Arundel County.

Research Questions

In this study, I used the interpretive phenomenological method (see Matua & Van Der Wal, 2015) to explore the experiences of behavioral health services users in the County. Following are the research questions used for the exploration of this research:

1. What are the perceptions of behavioral health service recipients on access to needed care in Anne Arundel County?

2. How do behavioral health service recipients in Anne Arundel County describe their access to care since the implementation of the PPACA healthcare reform?

3. How do treatment recipients perceive the quality of behavioral healthcare since the implementation of the PPACA?

4a. What perceived challenges are treatment recipients reporting with their behavioral health plans since the PPACA went into effect?

4b. What are perceived advantages have they observed?

Role of the Researcher

I bore the responsibility of ensuring that all the quality, credibility, and ethical measures were met. Heidegger’s (1962) interpretive phenomenology was used to facilitate the inquiry of this study. Heidegger posited that every inquiry is an attempt to understand a phenomenon, and that such understanding did not exist in a vacuum but is an interplay between what is known about the subject of study beforehand and the meaning derived as a result of additional facts uncovered. As a result, Heidegger asserted that every attempt to understand an interest of inquiry is guided by what is known beforehand.

With this interpretive approach to qualitative study, the researcher is also tasked with the role of interpretation (Humble & Cross, 2010). In other words, uncovering the perception and meaning that participants attach to their experiences will involve the researcher's interpretation of data gathered, thereby leading to an expanded or deeper understanding of the issue at stake. Furthermore, this nature of evolving insight occurs within the context of participants' experiences relative to the subject under examination (Lopez & Willis, 2004). With this in mind, I acknowledged deep involvement in the collection, analysis, and interpretation of data emerging from this process. Reflexivity and thoughtful engagement with participants are skills that offered more depth to information gathering and analysis during this process (Råheim et al., 2016). This further established the awareness that I was jointly constructing new insight and data with participants who offered their experience in relation to the subject of this research endeavor. Being a behavioral health clinician partially triggered my interest in this topic.

Nevertheless, it was the review of the literature that showed the lack of literature addressing the experiences and perceptions of behavioral health service users in Maryland, thereby establishing the need for this study. Among other responsibilities for maintaining strict adherence to quality and the validity in this research (Mays & Pope, 2000), I developed the data gathering instrumentation, facilitated recruitment, interviewed participants, and stored data collected to ensure privacy and confidentiality. In addition, I carried out the data analysis, interpretation of study findings, and conducted respondent validation to minimize errors and misconception to the best possible degree.

To meet the requirements of the Institutional Review Board (IRB), a detailed description was provided of how participants' rights and welfare would be protected while at the same time ensuring the integrity of this study. In addition, a sample of informed consent forms designed for the study's participants and the compensation determined to be appropriate for research purposes was provided (see Cook, Hoas, & Joyner, 2013). The informed consent form was modified following the IRB's recommendation to reflect a sixth-grade reading and comprehension level. The informed consent form was approved after all necessary adjustments were made.

Methodology

In-depth and semistructured interviews have been identified among qualitative researchers as one of the widely used methods for data collection in qualitative studies (Rubin & Rubin, 2012; Tong, Sainsbury, & Craig, 2007). This method allows the researcher to explore participants' experiences and perceptions of an issue by inviting them to share freely their perspectives on the phenomenon of study using open-ended questions (Tong et al., 2007). According the Patton (2002), there are three primary methods of qualitative interviewing: (a) informal conversational interview, (b) general interview guide approach, and (c) standardized open-ended interview.

The informal conversation interview is mainly carried out through a natural flow of interaction, which sometimes involves the researcher being a participant observer. On the other hand, the general interview guide entails the exploration of a set of themes using a preplanned guideline to steer the conversation in the interviewer's direction to elicit information from participants. While an open-ended style of questioning is used in this approach, the checklist serves the purpose of ensuring that all of the relevant areas are covered in the interviewing process (Patton, 2002). The standardized open-ended interview consists of a predetermined set of questions that are worded and arranged sequentially to structure the dialogue between the interviewer and the interviewee (Rubin & Rubin, 2012).

Among several other advantages for using in-depth qualitative interviews, Rubin and Rubin (2012) pointed out that this method gives researchers the opportunity to recreate events the researcher has or has not experienced with less bias. In-depth interviews can also provide opportunities for challenging dated assumptions, and in so doing open new avenues to promoting relevant dialogues, which in turn could improve public policies. It must be noted, however, that the semistructured in-depth interview does have some disadvantages. One disadvantage is that the preplanned structured interview may steer the interview process in the direction of the researcher's interest of study (Doody & Noonan, 2013). This may prevent the free flow of unanticipated data or themes from unfolding naturally. Nevertheless, the in-depth nature of the semistructured interview creates opportunities for exchange of dialogue that could expand the scope of exploration during the interviewing process.

In this study, I used a structured interview guide (Appendix A) to facilitate face-to-face in-depth interviews with each selected participant. This structured interview guide was developed from the research questions chosen for the exploration of this research topic. The guide provided a list of key points explored during the interviewing process. Furthermore, the semistructured interview guide offered avenues to explore uncovered themes related to this study with sensitivity to each interviewee's comfort level. Similarly, this instrument helped keep my bias in focus in order to avoid compromising the quality of the data (Devers & Frankel, 2000; Wise & Phillips, 2013).

Participant Selection

Upon the approval from the IRB, the process of recruiting participants for this research commenced. There is a consensus among qualitative researchers indicating purposive sampling as a major method for selecting participants for qualitative studies (Cleary et al., 2014; Creswell, 2013; Devers & Frankel, 2000; Patton, 2002; Topkaya, 2015; Zakrison et al., 2015). With this sampling approach, the researcher is intentionally seeking participants who have experiential knowledge and information to share regarding the subject of study. The rationale for this sampling method is that it provides researchers with a pool of suitable participants from a population akin to the phenomenon of study. In other words, participants have a firsthand experience or are currently experiencing issues related the researcher's subject of exploration. As a result of the phenomenon of study, criterion sampling (Rudestam & Newton, 2015; Zakrison et al., 2015) was used to focus recruitment efforts on a homogenous group of participants who share related experiences or affiliation with the inquiry of this study.

Participants for this study were selected from Anne Arundel County, Maryland. Eligible participants were individuals receiving behavioral health services or family members who have personal experiences or direct knowledge of these experiences. Their engagement with treatment could be concurrent with the time of this study or within the past 18 months.

For a phenomenological study such as this, the purpose and focus of the research determines the appropriateness of participant size used (Patton, 2002; Trotter, 2012). Nevertheless, other researchers (Creswell, 2013; Rudestam & Newton, 2015) have stated that having 10 or fewer participants is adequate for conducting phenomenological studies, especially with the understanding that these participants are intentionally selected because of their understanding or experience of the phenomenon of study. Additionally, in the search of peer-reviewed literature, a number of phenomenological qualitative studies were found (Topkaya, 2015; Zakrison et al., 2015) which used comparable numbers of participants for executing similar credible research endeavors. To this effect, 10 participants were recruited from Anne Arundel County. I distributed flyers for this study at treatment facilities, healthcare centers, the Anne Arundel Department of Health, and other community centers in the area.

The reason for recruiting participants from different facilities is to generate an expanded pool of participants with relatively diverse backgrounds and personal experiences related to the phenomenon of study (Bloomberg & Volpe, 2015). This method of triangulation was further used to check against possible misinterpretation of meaning attached to participants' experiences. This was accomplished by monitoring for possible discrepancies in the experiences of chosen participants. To this end, my task was to attain in-depth meaning through the lens of participants with different backgrounds and personal experiences.

To facilitate the recruitment process, I contacted facilities that provided behavioral health services in Anne Arundel County through phone calls and emails. These were followed up with face-to-face meetings at some of the agencies that responded to the request for recruiting from their facilities. I explained the goal and scope of the research. Furthermore, meeting the requirements of the IRB required that a detailed description be provided of how participants' rights and welfare were to be protected while at the same time ensuring the integrity of this study. In addition, copies of informed consent forms approved by Walden University's IRB were included. After receiving approval from contacted facilities, recruitments flyers were distributed to invite willing participants. I personally screened and selected all participants for this study. During this process, I explained the rights and risks involved in this study to all participants. This study did not involve any risks that would compromise the wellness of participants.

Instrumentation

Since the main avenue for data collection was through face-to-face interviews (Devers & Frankel, 2000; Doody & Noonan, 2013; Wise & Phillips, 2013), a semi-structured interview guide was used (Appendix A) which was developed following the review of the literature. Three of the broad factors identified in the literature which contributed to the development of the interview protocol were (a) availability of treatment resources for behavioral health, (b) ease of access, and (c) affordability of treatment services. These were based on the findings in the literature on healthcare access (Karikari-Martin, 2010), expanded behavioral healthcare (Votruba et al., 2014), and implementation of Medicaid expansion (Sommers et al., 2014). Based on these insights from the literature, the following interview protocol for conducting the in-depth face-to-face interview was developed:

1. Have you or any member of your immediate family received any type of behavioral health services in the past 18 months?
2. Describe some of the behavioral health services (mental health or substance use disorders) that you have received in the past 18 months.
3. Do you have a previous history of receiving behavioral health services before 2014?
4. How did you afford behavioral health services before 2014?
5. How are you currently affording these services?
6. How has your access to behavioral health services been affected or improved in the past 18 months?
7. In searching for treatment providers, how quickly are you able to secure treatment in the past 18 months?
8. How satisfied have you been with the amount of care you have received since the new healthcare law was passed?
9. Without the new healthcare law (Obamacare), what could have been your options of receiving behavioral health services?

10. If you could make any suggestions, what would you tell treatment providers and state policymakers to improve in order to meet your behavioral health needs?

Data Collection

During the face-to-face interview with participants, I used high quality audio recording devices to capture this process while I concurrently took field notes and memos to record impressions and personal reflections of the exchange with those involved. The literature offers several instances on the use of audio recording for capturing interviews for qualitative research (see Topkaya, 2015; Zakrison et al., 2015). Rudestam and Newton (2015) highly recommended the use of tape recorders to document interview sessions while suggesting that field notes should be used as a secondary documentation method for augmenting the researcher's audit trail and for noting other reflexive activities taking place within the context of the evolving research.

Nonetheless, Rubin and Rubin (2012) pointed out that interviewees may respond differently to the idea of being recorded during the interview. They pointed out that while some may easily welcome this idea, others may be shy or even reluctant to be recorded. Therefore, participants for this study were informed beforehand that the interview would be audio recorded. They were offered the IRB approved informed consent documents, which specified to them that they had the right to decline participation in the study at any time without any obligation to me or anyone else.

The interview took place at a facility conveniently located within the community with easy commute capabilities for participants. Interviews were between 30 to 60 minutes for each participant. There were no follow-up interviews. Avoiding follow-up interviews averted placing an extra burden on participants or organizations that volunteered for this study. Moreover, there were no follow-up phone calls to participants. Audio recordings of the interviews were stored in a password protected hard drive which could only be assessed by me. In addition, I personally transcribed and conducted analysis of all gathered materials.

Data Analysis Plan

Merriam and Tisdell (2015) suggested that data collection and analysis ought to go together from the beginning. Prior to data analysis, I developed pre-codes to guide my analytic process. According to Merriam and Tisdell (2015), failure to initiate data analysis alongside data gathering activities at the onset may lead to needless repetitions of information and an overwhelming amount data that could derail the efforts of the research. To manage the dataset from the beginning, some pre-codes were created that were used to facilitate the simultaneous efforts of data collection and analysis. These pre-codes were drawn from the broad themes identified in the literature which were central to the phenomenon of this research (Miles et al., 2013). The reason for the pre-codes was to have a broad set of codes used for extracting and organizing potential relevant information into categories. Furthermore, the pre-codes guided the process of ongoing analysis for further refinement and better alignment with emerging themes (see Attride-Stirling, 2001; Merriam & Tisdell, 2015).

Based on the 10 questions that I developed for the interview tool, 10 broad categories were initially identified. However, during data analysis, some themes were merged, others were eliminated, while some new ones emerges as the process evolved. Here were some of the categories that initially emerged from the literature and the reflections from the interview questions (a) behavioral health usage, (b) types of services used, (c) length of service used, (d) ease of service used, (e) health insurance, (f) administrative process, (g) access and varieties of services, (h) PPACA, (i) capacity to treat, and (j) treatment adequacy.

I used NVivo software to facilitate data analysis. Transcripts of the interviews were uploaded into the software. While NVivo software was used to organize, sort, and analyze the data, the process was aided by the use of field notes and memos. I coded and categorized data as their collection was taking place. Data was later re-evaluated before they were embedded in this study to attain comprehensive data analysis and emergent findings. With the NVivo software, preliminary findings could be shared with others. This could be done without other secondary users owning the software (Gibbs, Frieze & Manga Beira, 2002; QSR International, 2014). This feature was especially important because it could further promote inter-rater capability, which in turn further established the credibility and reliability of this data collection and analysis.

Trustworthiness

Similar to quantitative methods of research, qualitative studies have checks and balances to ensure that the outcome of a study is credible and reliable. This means that a researcher needs to demonstrate thoroughness, authenticity, and integrity when reporting the process and findings of his study (Creswell, 2013). Not only is the methodology used in conducting quality research crucial to establishing its trustworthiness, the credibility of the researcher in interacting with these methods is as important as the methods used (Merriam & Tisdell, 2015). To this end, it was emphasized that the trustworthiness of the data is as good as those who collect, analyze, and interpret the data outcome.

Credibility

During the recruitment of participants, initial pre-screenings were conducted using the prescreening questionnaire (Appendix B) to ensure that those who were selected for this study have experiential knowledge of the subject of this study (Topkaya, 2015; Zakrison et al., 2015), that is, the use of behavioral health services or involvement in decision-making regarding a family member's use of these services. These participants could describe their experiences in reference to behavioral health, especially after the implementation of the PPACA. Member checks (Guba 1981) were used during face-to-face interviews to clarify with participants the researcher's understanding and interpretation of the information they have provided during interviews.

Such informed participants provided the richness of data that was sought in this study. Nevertheless, being reflexive allowed awareness of internal dialogues and how these dialogues contributed to judgements and decision-making in data gathering and analysis (Clancy, 2013). Being reflexive allowed me to develop more awareness of personal biases related to issues that were confronted during interactions with participants and the outcomes that were obtained from the combination of data that was generated.

Confirmability

Keeping an audit trail is one way of demonstrating steps taken during the research process to arrive at a proposed conclusion (White, Oelke, & Friesen, 2012). Such audit trails were used to show how the data collected was translated into the findings of this study. To accomplish this, field notes, memos, and journaling in the different phases and processes of data collection and analysis were used (Clancy, 2013; Rubin & Rubin, 2012). Moreover, I used NVivo qualitative software for data coding and analyses. NVivo software is a multifaceted tool that can assist the researcher in collecting data on almost every form of mobile device including iPhone, iPad, Android phone, or tablet using Evernote (QSR International, 2014).

Ethical Concerns

The Code of Federal Regulations pertaining to the protection of human subjects in research stipulates that any credible research conducted within the domain of health and human services using human subjects must be evaluated by an IRB (Protection of Human Subjects, 45 C.F.R, 2009). Walden University upholds this protocol and makes this a compulsory part of completing the dissertation process (Walden University, n.d.). Securing adequate informed consent from research participants and ensuring their privacy and safety have been predominantly identified in the literature as the two major ethical issues that must be established in the process of a study (Bloomberg & Volpe, 2015; Phelan & Kinsella, 2013; Rudestam & Newton, 2015).

Therefore, in order to meet the requirements of the IRB, I provided a detailed description of informed consent, ensuring that participants were provided with a clear explanation of what this research entailed and their right to accept or decline solicitation to participate in this study. Steps towards protecting participants' rights and welfare were defined while at the same time ensuring the integrity of this study (see Swauger, 2011).

Additionally, the risks and rewards involved with study participation were communicated to participants. Further, a copy of the informed consent form approved by Walden was included. This document indicated that each participant would be offered a $15 gift card as appreciation of their time. Gift cards were offered at the conclusion of each individual's participation.

I explained privacy and confidentiality concerns to participants (Cook et al., 2013). To maintain privacy, face-to face interviews took place in a secure office space, which prevented others from hearing the conversations taking place during the interview. Pseudonyms were used as identifiers for each participant to keep their identity confidential. In addition, recorded audio files and interview manuscripts were secured in a locked safe and will be destroyed after no less than five years.

Summary

Judging from the political climate that preceded the enactment of the PPACA and thereafter (Rich, Cheung & Leurvey, 2013), one cannot discount the reality of conflict that the healthcare reform was introduced into and continues to wade through to see the light of day. I chose the phenomenological qualitative method to elicit the experiences of individuals who had different degrees of interaction with the implementation of the PPACA in Anne Arundel County, Maryland. Without a doubt, the implementation of the PPACA introduced a new era of healthcare in the United States (Rich et al., 2013). This new frontier begs the need to offer in-depth, accountable, and evidence-based approaches to provide insight to the state of the nation's healthcare; there is a need to understand how it is being influenced to yield its current and potential future results.

In this chapter, I provided the factors that formed the development of the interview protocol (Appendix A) that was used for this research. The population and selection of participants were described with the rationale leading to such determination. Following that was how quality measures and IRB requirements were addressed to ensure credibility and trustworthiness in this study. Chapter 4 entails data collection, analysis, and findings of this study.

Chapter 4: Results

Introduction

The goal of this phenomenological study was to explore the effects of the PPACA on access to behavioral healthcare. I sought to examine the perception and perspectives of behavioral health service users on how healthcare reform has influenced their demand and usage of behavioral health treatment services. In-depth face-to-face interviews were conducted with 10 participants who were purposefully recruited from Anne Arundel County in Maryland. These individuals had first-hand experiences using these services within the County. Each participant was interviewed using a 10 question semistructured interview guide (Appendix A).

Upon receiving IRB approval, I contacted four behavioral health treatment agencies in Anne Arundel County to allow distribution of participant recruitment flyers (Appendix C) at their organizations. All four of these organizations granted the request to distribute recruitment flyers at their facilities. Two of these organizations provided letters of cooperation (Appendix D) to conduct face-to-face interviews at their sites. The nature of this study and eligibility criteria (Appendix E) were discussed with these organizations. These organizations were also provided a sample of the updated informed consent form with IRB approval #06-16-17-0399323. Interested participants contacted me following the distribution of the recruitment flyers. I begin this chapter with the research questions that were addressed in this study. Next, a detailed description of the research setting, participant demographics, data collection, and data analysis is explained. Procedures that I followed to demonstrate evidence of trustworthiness and key findings of the study will conclude the chapter. Interpretation and discussion of findings are presented in Chapter 5.

Research Questions

The RQs that were addressed in this study are as follows:

RQ1: What are the perceptions of behavioral health service recipients on access to needed care in Anne Arundel County?

RQ2**:** How do behavioral health service recipients in Anne Arundel County describe their access to care since the implementation of the PPACA healthcare reform?

RQ3: How do treatment recipients perceive the quality of behavioral health care since the implementation of the PPACA?

RQ4a. What perceived challenges are treatment recipients reporting with their behavioral health plans since the PPACA went into effect?

RQ4b. What perceived advantages have they observed?

These research questions provided the outline that guided dialogues with participants in this study. Using the interview protocol, I was able gather valuable insights on the perspectives of behavioral service consumers in Anne Arundel County on the effects of the PPACA and their access to treatment services.

Research Setting

This study took place in the Glen Burnie and Annapolis areas of Anne Arundel County. Like several other neighboring communities in the state of Maryland, Anne Arundel County has experienced a growing population of individuals who need treatment services for mental health and substance use disorders with limited resources to meet these needs (Anne Arundel County Department of Health, 2015). Despite the increase in demand for co-occurring treatment services for mental health and SUDs, insufficient treatment facilities and access to affordable care had been identified as some challenges confronting residents of the county with attaining needed care.

Flyers for this study were distributed at various health and behavioral health clinics and agencies within Anne Arundel County. These organizations provided treatment or rehabilitation services for mental health, SUDs, or both. Lived experience with any aspect of behavioral health treatment services within the county was used as criteria for selecting eligible participants. Eligible individuals who responded to the distributed flyers for this study willingly offered their consent to participate in the study without any personal or organization constraints. Each participant was given a $15 Walmart gift card as appreciation for their time at the end of the interview session.

Demographics

In addition to the informed consent document, participants also provided basic demographic information about themselves that were relevant to the study. There was a total of 10 participants for this study. All participants voluntarily offered basic demographic information, which included gender, age, race, type of insurance, and identified patient or family member of someone with firsthand knowledge of treatment history. This information was obtained using a template (Appendix F) designed for this study. Participants were assigned a pseudonym to mask their identity but to help in correctly identifying them during the coding and data analysis. The pseudonyms were randomly selected from gender specific names from alphabet letters A to C. To further secure the identity of participants, signed paper forms were locked in a secured cabinet in my home office, while the research designated computers were password encrypted with access only known to me.

Participants consisted of nine females and one male. Their ages ranged from 18 to 48. Two participants were between ages of 18 and 23, five ranged between the ages 26 and 35, and three were between the ages 44 and 48. While all participants identified that they had received behavioral healthcare services, three reported that they also had children or other family members who received treatment services for behavioral health in the past 18 to 24 months or more. Participant demographics are shown in Table 1.

Table 1

Participant Demographics (N =10)

Participant pseudonym	Age (years)	Gender	Identified patient	Family member	Type of insurance
Anthony	48	Male	Yes	Yes	Medicaid/Medicare
Barbara	44	Female	Yes	Yes	Medicaid/Medicare
Beverly	29	Female	Yes	No	Medicaid
Briana	48	Female	Yes	No	Private Insurance
Bridget	35	Female	Yes	Yes	Medicaid
Britaney	29	Female	Yes	Yes	Medicaid/Medicare
Brook	26	Female	Yes	No	Medicaid
Catherine	34	Female	Yes	No	Medicaid
Chelsea	23	Female	Yes	No	Medicaid
Claire	18	Female	Yes	No	Medicaid

Data Collection

In-depth face-to-face interviews were conducted with participants in a designated private office at WorkLife Urgent Care Center and at Serenity Sistas Inc. The interviews took place between July 10 and July 28, 2017. Three weeks prior to the interviews at WorkLife Urgent Care, the CEOs and director of the agency showed me around the facility to become acquainted with the environment. The office used for interviews was one of the spaces that was used for therapy and counseling sessions. These offices were designed to avoid any outside interference or breach of privacy and confidentiality. Participants arranged for dates and times that were convenient for them to present at the venue of interview. Once each participant arrived for the interview, I went over the purpose and nature of the study with them as had previously been done over the phone upon their first indication of interest. Following the participant's signing of the informed consent, as well as providing basic demographic information, the interview session commenced.

Interview sessions lasted between 25 to 45 minutes. Two digital audio devices were used to record interviews. The second recording device was a back up to ensure that nothing was left to chance during the interview sessions. The face-to-face interview afforded me the opportunity to both record and observe participants' verbal and nonverbal responses to the interview questions. While using the semistructured interview guide, adopting a conversational style (Tong et al., 2007) with participants fostered an atmosphere that allowed them to freely share their lived experiences and perspectives with the focus of this study. At the end of each interview, I thanked participants for their time and involvement in the study. They were asked if they had any questions and informed that summaries of the study could be forwarded to them at their request upon completion. Only one participant requested to receive a study summary upon completion. Audio interviews were transcribed and uploaded into NVivo 11 software for further analysis.

Brief Participant Profile (Pseudonyms)

Below are brief profiles of participants which were provided in the demographic information collected and the narratives that emerged from the interviews.

Participant 1

Anthony identified as a 48-year-old Caucasian male living in Anne Arundel County. Anthony reported that he has been receiving mental health treatment on and off since 1998. He indicated a previous history of substance use disorders, but is currently in remission. Anthony, at the time of the interview, had dual insurance (Medicare/Medicaid) due to his age and chronic disabilities. Anthony reported that he was receiving treatment services in the county for his chronic psychiatric conditions at an outpatient treatment facility.

Participant 2.

Barbara identified as a 44-year-old Caucasian female living in Anne Arundel County. Barbara indicated that the she has been receiving treatment on and off for mental health issues since the 1990s. During this interview, Barbara reported that she has dual insurance (Medicare/Medicaid), and she disclosed that she was receiving treatment services in the county for mental health issues at an outpatient treatment facility.

Participant 3.

Beverly was a 29-year-old Caucasian female, who identified that she was living in a recovery house in Anne Arundel County. Beverly had been in treatment on and off for over seven years for mental health and substance use disorders. At the time of the interview, Beverly had recently completed another episode of inpatient treatment for her substance use disorder. She was receiving outpatient rehabilitation and aftercare services while she was working towards fully reintegrating back into the community and the workforce. Beverly had Medical Assistance through Medicaid with which she could afford treatment.

Participant 4.

Briana identified as a 48-year-old Caucasian female who had private insurance. Although she appeared to be high functioning, she reported a long history of receiving mental health treatment for ongoing psychological and life change concerns. She was a resident and receiving treatment services in the county.

Participant 5.

Bridget was a 35-year-old African American female who is a resident in the county and was receiving treatment services for mental health challenges at the time of the interview. She has a young daughter who was being treated for ADHD at the same facility where she was receiving outpatient treatment services. Both have been receiving care for over one year and were obtaining treatment with the Medical Assistance program.

Participant 6.

Britaney identified as a 29-year-old African American female and resident in the county. She indicated that she had severe and chronic health problems in addition to her chronic mental health challenges. Britaney also has a younger sister who had a chronic history of mental health challenges. Britaney had both Medicaid and Medicare due to her disabilities. She reported that she previously had just Medicaid prior to be being transitioned to dual insurance status. Britaney was receiving outpatient treatment for her mental health concerns at the time of her interview. She stated that she had been with her current provider for about one year.

Participant 7.

Brook is a 26-year-old Caucasian female living in a recovery house in the county. She had just completed a 22-day inpatient treatment program for substance use disorder. She was receiving outpatient rehabilitation and aftercare services while she was working towards fully reintegrating back into the community and the workforce. Brook reported that she had been in treatment on and off for more than two years for both mental health issues and substance use disorders. Her previous treatments were under her mother's private health insurance before she turned 26, at which point she was able to secure her health insurance through the health exchange. Brook's treatment in the past two years had been covered through Medicaid.

Participant 8.

Catherine identified as a 34-year-old Caucasian female resident in the county. She has had two episodes of 21-day inpatient treatment for substance use disorders within 2017 alone. Her last inpatient treatment was completed in April 2017. She was living in a recovery house in the county at the time of the interview. Catherine stated that she was working towards fully reintegrating back into the community and the workforce. Catherine reported battling with a chronic history of co-occurring disorders of depression and anxiety with substance use disorders. She had lost her job, her apartment, and important relationships because of her disorders. Catherine reported that she "got

Obamacare through the Marylandhealthcare.gov a little over two years ago." This is how she has been affording her treatment services for her behavioral health needs.

Participant 9.

Chelsea was a 23-year-old Caucasian female resident in Anne Arundel County. She reported that she has been receiving treatment for comorbid conditions of mood disorders and substance use disorders for more than 10 years. At the time of this interview, she was being treated for these disorders at an outpatient clinic within the community. She was previously under her family's private insurance, but now has her own through Medical Assistance (Obamacare).

Participant 10.

Claire is an 18-year-old Caucasian female living with her both of her parents in Anne Arundel County. She reported having moderate to severe mental health challenges. Claire was admitted into the psychiatric ward around April 2017. She was receiving treatment at an outpatient clinic at the time of the interview. Her treatment for the psychiatric inpatient hospitalization and ongoing outpatient was funded through Medicaid.

Data Analysis

The data analysis process was started after completing the first interview. After each interview session, I documented a summary of perceptions of each interview in my field notes. This process was repeated with all 10 participants in this study. This practice was in alignment with Merriam and Tisdell's (2015) suggestion that data collection and analysis ought to go together from the beginning. NVivo 11 Pro for Windows software was used for data management, organization, and analysis. During the transcription of recorded interviews, I paid close attention to ensure that information shared by each interviewee was adequately captured. This process also helped me reflect on the field notes that were documented during each interview. Transcripts of interviews were formatted to enhance efficient analysis and were subsequently uploaded into NVivo software. Case nodes for each participant were created in NVivo with all the demographic characteristics, such as name (pseudonym), gender, age, type of insurance, and identified patient or family member attached. Next, case nodes were created for the pre-codes which were developed from the 10 interview questions (Appendix A).

These pre-codes were informed from the themes that were gathered from the literature review prior to data collection. The purpose for these pre-codes was to have a broad set of codes used for extracting and organizing potential relevant information into categories (see Miles et al., 2013). Also, these pre-codes were designed to guide the process of ongoing analysis for further refinement and better alignment with emerging themes (Attride-Stirling, 2001; Merriam & Tisdell, 2015). Through running word frequencies, word cloud, and word tree through NVivo, consistent patterns emerged from coded contents. Additionally, I use hand coding to further clarify emerging themes. During the iterative content analysis of interview transcripts, some pre-codes were eliminated and similar ones were combined, while some new ones were developed with more reflections and analysis.

Table 2 illustrates how gathered data from interviews and field notes were condensed, organized, and analyzed to present the main findings of this study. Categories were initially developed from peer reviewed literature as pre-codes for potential information that might be discovered during the study. These categories served as filtering tools during the first and second cycles of the coding process. Codes were thereafter combined or eliminated to form emergent themes.

Table 2

Codes, Themes, and Key Findings from Data

Codes	Themes	Key findings
Get help Treatment sooner and quicker Life or death situation	Getting needed help	All participants have used behavioral health treatment. All participants considered behavioral health treatment as important part of daily survival
Insurance Treatment adequacy Type(s) of behavioral health service	Affordability of treatment services	70% of the participants would not be able to afford care without the PPACA Some (20%) may rely on fate or use nonprofessional help
Quality of care Scope of care Length of treatment received Administrative challenges	Ease of getting needed treatment	Behavioral health providers as mini hub for health services 90% of participants report feeling adequately cared for through providers' collaboration. Do not feel falling through the cracks in the era of Obamacare
Take away Obamacare Repeal sentiments Concern about family Only source of care No insurance dilemma	Fear of losing health coverage	Some participants expressed ambivalence with lasting effects of the reform May become unable to attain current behavioral health services
Healthier community People on the street Less death Less crime	Lifeline	Less than half (40%) believe improvement to PPACA is a welcome idea About 20% suggested monitoring service by consumers and providers behaviors to avoid waste.

Although one of the participants (Claire) had spent a lesser period using behavioral health treatment services (mental health) than the rest of the participants, there were no divergent ideas or deviance indicated in her experience from the other participants. Similarly, despite the variation in the nature of behavioral health services (mental health or substance use disorders) used by participants, there were no variance in the themes extracted from their reported experiences.

Evidence of Trustworthiness

Credibility

To attain credibility, participants were recruited who have lived experiences of using behavioral health treatment services. Recruitment was done using clearly defined criteria in the recruitment flyer (Appendix C). Participants who responded to the flyers were further screened using a prescreening protocol (Appendix B) to ensure they met criteria for the study. These approaches were used to ensure that selected participants had experiential knowledge of the subject of this study (Topkaya, 2015; Zakrison et al., 2015), that is, the use of behavioral health treatment services. To avoid placing an unnecessary burden on participants, a follow-up interview was not conducted. However, one of the participants requested a transcript of her interview which was sent to her following the interview. In addition to using audio recording devices for face-to-face interviews, a field journal was used to document highlights of each interview session. Having these multiple documents helped clarify my understanding and interpretation of the information provided during interviews.

Transferability

Whereas the goal of this study was not intended to promote generalizability, I endeavored to provide sufficient detail describing the issues and context of this study's inquiry. The population, setting, methods of recruitment, and engagement with participants were described. With the methods used in this study, findings similar to this one may be attained under similar circumstances elsewhere.

Dependability

Accomplishing dependability for this study required strict adherence to the processes that were described in the IRB application with Walden University. These were collaboratively reviewed with members of the doctoral committee to ensure that potential inconsistencies were addressed before embarking on the study. White et al. (2012) have suggested using an audit trail to document the integrity of steps taken to ensure quality with one's evolving study. I kept an audit trail with a field journal and memos as a way to demonstrate steps taken during each stage of the study to arrive at emergent findings. During data analysis, multiple versions of analyses were run to eliminate inconsistent assessment and interpretation of data.

Confirmability

Throughout this study, bracketing strategies were adopted such as reflexivity and mental and self-awareness (Chan, Fung, & Chien, 2013) to guard against the potential occurrence of personal bias influencing interactions with participants or analysis and interpretation of collected data. Being reflexive allowed me to be aware of internal dialogues and how these dialogues may be contributing to judgements and decision-making in data gathering and analysis (Clancy, 2013). With the aid of audit trails and personal memos, I was able to keep perspective of subjective deductions and the development of findings from generated data.

Study Results

Findings from this study were organized into themes which became manifest from participants' responses to interview questions. Five main research questions were used to develop the 10 question semi-structured interview guide (Appendix A) that was used to facilitate dialogues with participants. Following are the themes and sub-themes originating from these research questions.

RQ 1: What are the perceptions of behavioral health service recipients on access to needed care in Anne Arundel County? More open-ended questions were used to engage participants in exploring this research question (see Appendix G: Questions 3, 4, and 6).

Theme 1: Getting Needed Help

An overwhelming majority of participants (9 of 10) described getting needed help as a significant benefit they have enjoyed using the health exchange under the PPACA to attain behavioral treatment services. There was strong emphasis on getting connected to treatment services on time, being able to use available treatment services without accumulating more debt, and getting needed treatment. Reporting their previous experiences with getting treatment for either mental health issues or substance use disorders prior the PPACA, participants described hesitation to seek care due to difficulties with getting needed care, inability to pay out of pocket, or copays.

Briana stated, “Before they didn’t take my insurance; it was out of pocket. So, I paid $20-$25 a visit maybe. I think that’s what it was. It was just out of pocket but… It was through a Christian service.”

Chelsea, who had struggled with co-occurring disorders of mental health and substance use, was previously on her stepfather’s Tricare plan. She reported previous limited options for treatment while experiencing psychiatric or substance use crises. She described her experiences as follows: “From 2007 up until 2012 or 2013 it was through my step-father's insurance which was Tricare. Through the military. So, it was that and a little bit out of pocket.”

Some participants who had some types of care from other types of provider organizations reported selective services that they were entitled to. For example, Barbara stated that her previous health plan “was basically like a card that allowed you go to the doctors, OB-GYN, and mammogram and they paid for it. But if you needed dental care or prescription, you have to pay for that out of pocket.” Barbara further expressed that the plan was very limited for her other needs, especially behavioral health treatment before receiving the dual insurance through the Maryland Health Exchange. She stated,

> Because it was what was in the insurance that I had at that time. Because I had it through the hospital, I didn’t have regular insurance until I got into disability and got to be Medicare and Medical assistance…but it only allowed me to go these three places. So, since I needed to talk with somebody, it was just like a regular doctor with the benefits that I had.

Nevertheless, through the PPACA they reported receiving improved access to care. Anthony reported that

> All I got to do is pick…I got the after hour emergency number for all the different doctors. All I got to do is dial that number, say, ‘I need to talk to Dr. such and such.’ They ask me who I am, I tell them. They are like, ‘Ok, Mr. Anthony, I’ll get you right on the phone.’

Barbara echoed this sentiment stating that “Now I got more of the advantage to have all the people helping me, and that’s what is good about it.” In addition, Brook stated that, “It’s definitely taken a weight off my shoulders. It's making it - it's made it possible for me to receive necessary services. Yeah, because previously I wasn't able to afford it.”

Others who had previously resorted to using nonprofessionals, such as family members and friends, to help them address their psychological problems or more complex psychiatric concerns now enjoy going outside of these circles to seek professional help. Briana noted that, “Just having to talk to someone that's not involved in the certain situations I've been in. So, having an outsider to talk with me and help me figure out my feelings.”

Research Question 2: How do behavioral healthcare recipients in Anne Arundel County describe their access to care since the implementation of the PPACA healthcare reform?

In addition to the selected interview guide questions, more open-ended questions were used to engage participants in exploring this research question (see Appendix A: Questions 5 and 8).

Theme 2: Affordability of Treatment Services

Similar to the previous theme, the majority of participants (eight of 10) identified this as a core issue addressed by the PPACA regarding their behavioral health care needs. These participants described either challenges they previously had affording adequate treatment for their specific behavioral health needs or how they are now able to use services that they could not have otherwise afforded.

Before the PPACA, Beverly noted, “Yeah, my insurance was not accepted at many treatment centers. I remember that. I called… and I couldn't get in.” She further stated, “I wouldn't have been able to self-pay. I didn't even have a job. I wouldn't have been able to get help.”

Bridget, who was a low-income earner before the enactment of the PPACA, described her experience as follows:

> It was private insurance through my job. I was getting over $300 bi-weekly so a total of $700 and some change taken out of my check monthly. It was very expensive. It was not affordable. And the co-pays were extremely high. So, with my daughter we had to pay out of pocket. And I wasn’t interested in the services that I’m getting now because of the cost and expenses.

Similarly, Chelsea pointed out that

> I had a few stays in psychiatric hospitals and insurance only covers so much and then you had to be kicked out basically. And even so they covered so much, you still have to pay like \$500-\$600. Now since I've been on state insurance it's not like that.

Participants reported that with the help of the PPACA they have been able get some crucial behavioral health treatment services which had been previously difficult for them to attain. Catherine stated

> Before treatment [this time], I guess for the last two years, I've gone with the state insurance with Obamacare and Medicaid. I went online to Marylandhealthconnection.gov, and filled out all the necessary information, and was approved. And I used Medicaid for both of my treatments.

Anthony reported that

> Well, with me being on the disability that I get the Medicare and the Medical Assistance, ok right there, that's easy for me. It's easy for me to get the help and that stuff. But if I didn't have that insurance and that stuff, I'd be struggling just like other people are. With me being on disability, there's no way I'd be able to afford medical insurance on my own, without the help.

Putting it into perspective, Chelsea described her previous and present experiences as follows:

> I honestly don't know. I don't know. All I can say is that you can call your insurance and tell them what you need, and they will guide you to what your options are and where to get the help that you need. I don't know. I just remember

> it wasn't like that with Tricare. And I know if I wasn't covered at all, then these services are thousands of dollars. There's no way I could afford that. No way.

Others described the privilege of having equal access to appropriate levels of care despite the nature of behavioral health issues that required treatment at the time they presented for care. This, they suggested, minimized perceived feelings of discrimination between substance use and mental health disorders while receiving fairly adequate care. For instance, Beverly stated that, "I was able to get into a nicer, more qualified treatment center." Catherine added

> Yeah, yeah. If I did, you know, I'd probably won't have to go to drug and rehab treatment center, because I won't be spending my money on my addiction. So, it made it… with the payment plan, so that I can get the help that I needed.

Further, Catherine noted that

> So, it's been my experience that this kind of generosity is given if someone is familiar with the disease of addiction. And either empathizes or knows the challenges that we face and the adversities that we face because there is a huge stigma on people with addiction.

Research Question 3**:** How do treatment recipients perceive the quality of behavioral health care since the implementation of the PPACA? Added to interview questions 6 and 9 (Appendix G), all participants were asked the question, "Describe any changes you have observed with the service you receive, since the ACA went into effect."

Theme 3: Ease of Getting Treatment

Participants viewed how they were connected to treatment providers, the amount of time they spent within a level of care, and whether it is outpatient or inpatient as factors which have improved with implementation of the PPACA. Nine of the 10 (90%) participants indicated that they noticed a difference with how they are now getting treatment since the implementation of the PPACA. They reported that they neither feel dismissed when they are seeking care nor rushed out of treatment after barely receiving adequate care due to the type of insurance that they have.

Participants discussed improved processes with getting outpatient mental health appointments during a psychiatric crisis or inpatient admission when experiencing a drug and alcohol related crisis. Beverly reported that

> To get my therapy it was less than an hour. Yes. I went in to do an outpatient program and therapy. They called the insurance company, within 15-20 minute conversation it was approved and it went through. I was able to get therapy.

Corroborating the notion of being connected to care quickly, Britaney related that "Okay, it was pretty…they did pretty good when I signed up. I was able to start right away, no copays and things like that. So, they did pretty good on that part." Britaney also described some other essential benefits she enjoyed, especially given some other chronic medical conditions she was dealing with. She stated that, "With Obamacare, you know I had my dental, I had my vision. I am dealing with a diagnosis of lupus. Systemic lupus, so I always needed insurance anyway."

Anthony commented that “Well, with me being on the disability that I get the Medicare and the Medical Assistance, ok right there, that’s easy for me. It’s easy for me to get the help and that stuff.” Brooke, describing how she got into an inpatient facility for an episode of inpatient treatment for substance use disorders, stated that, “No problem at all. They took me right away.”

Claire had a psychiatric crisis about four months before the interview. Although she stated that she was new to treatment processes for mental health concerns, she described confusion with what to do next after her inpatient psychiatric treatment. She reported that

> I guess I want to say luck that I met that girl there, because it wasn't certain that I was actually going to outpatient. But she actually lives in Annapolis, so I think that's why they recommended her to go there.

Claire reported that through that facility and another peer whom she met in treatment, she was connected to appropriate outpatient care. Catherine, on the other hand, had much to say on this issue as she provided a narrative of how quickly she was able to get inpatient treatment during a time of crisis:

> But without it [ACA/health exchange], the places I was calling to try to get treatment and get help, it was upwards from anywhere from $20,000 to $30,000 for a 28-day of inpatient program. And if you know anything about addicts, and this disease, we don’t have that kind of money typically. Surprisingly so, to me I just expected it to be a lot of hoops that I have to jump through. When you are in the throes of addiction, I mean any hiccups is a huge deterrent. You just give up!

> Like, forget it, I am not going to do this. This isn't worth it. I don't want to do it. Because you are already weary about doing it to begin with. You know it's an entire lifestyle change. So, now once I was pointed in the right direction, it really wasn't difficult. The one thing that was very scary for me was when I did call the treatment center that I went to, they told me that they probably wouldn't be able to get me in for at least a week. And being an addict, I know that if something isn't going to happen right away, and you tell me to come back in five days, I'm probably not going to do it. They said we would see what we can do, which was again little kind of discouraging, but because I have been through the process once, I had a little more faith. They called me the next morning at 8:00 a.m. and said if you're here by noon, we will get you in. But I don't know if that would be the case had I not already been there.

A common thread that connected aspects of this theme was that participants felt like there was better collaboration between providers to facilitate continuity of care. With this at play, they felt like they became engaged with treatment sooner than they anticipated based on previous experiences.

Research Question 4: What perceived challenges are treatment recipients reporting with their behavioral health plans since the PPACA went into effect? Interview Questions 9 and 10 (Appendix A) in addition to open-ended dialogues were used to further explore this research question.

Theme 4: Fear of Losing Health Coverage

In response to their perceived challenges since the PPACA went into effect, a significant number of participants (seven of 10) expressed sentiments of fear and frustration over the potential of repeal or rollback of the law. Although the repeal of the PPACA has not taken place yet, participants noted that it appears the law would not last for long or provide adequate care for them for long. Barbara commented that

> But if you didn’t have any insurance, who’s going to take you with no insurance? They are going to want the money up front. If you don’t have that money up front, you can’t talk to anybody. You got to talk to someone that would be a family member that wouldn’t charge you, and your stuff wouldn’t be kept private. Because they would tell everybody else. So, this is the benefits that you have. They keep to themselves. They keep your dirt... [pauses], they keep your business to themselves.

At the time of the interview, Barbara stated that she felt like the Trump administration and proponents of the repeal efforts “cared little” about the benefits that the PPACA offered “those of us low-income people.” As if these individuals were in the room during the interview, Barbara expressed in a feisty tone her displeasure and anger towards anyone trying to “toy” with the healthcare law. Bridget stated that

> Yes, I would have had to work part time just to provide the other half of the healthcare for myself and my family or lack in services. And a lot of, you know, clients that need services lack services a couple years ago due to the issue. So, I believe that's why a lot of crime rate has increased, people at the time a couple of

> years ago, couldn’t afford the treatment and now it's, you know, if I would have lacked those services I would have had to work extra hours. Adjust my insurance. Skip the co-pays and accumulate bills. It would have had a major impact on my credit from doctor bills, owing.

Britaney stated that the daily commentary made her worry for herself and her family all the time because she felt they would be left vulnerable if the repeal went into effect. She stated that “So, I was hurt, because I was like oh man what’s going to happen to my life now. But I was grateful because that could have been my downfall in life.”

Chelsea, on the other hand, stated that she feels because of new enrollees into Medicaid, some services would be scarce in some areas creating a longer wait time to get into treatment. Based on her experience with using treatment services since the PPACA, she stated

> Well, that actually, it's kind of hit or miss because sometimes there is bed availability. And I've gotten, there's been no issues, like you know, when it comes to me getting in when I think I need to go in. But sometimes I was waiting to get placed into a program for treatment and that took a couple of months…But it was simply because of bed availability but they did keep you in the same building. You were just on a different floor more transitional housing, waiting to go to the actual program.

Although Catherine had expressed enjoying full benefits under the PPACA, she nonetheless shared a sense of perplexity of how all these benefits could end for her abruptly were the PPACA repealed. She noted

> I don’t know that I would have had any options honestly. I mean for somebody to voluntarily admit themselves into treatment, you really do have to hit an all-time level with your bottom. I no longer had a job. I no longer had an apartment of my own. I no longer had any money in my bank account. I mean just to get the $350.00; I had to borrow it from my family. Unfortunately, I had people I could borrow it from. And that was even a struggle even. To go say, ‘I’ve let you down for the last 10 years, but I want $350.00 [nervous laughter…then pauses for 2 seconds then continues with train of thought]’. I really don’t know. It’s a scary thought. It’s a scary, scary thought!

Research Question 4b: What are perceived advantages that they have observed?

Subtheme 4b. The PPACA is a Lifeline

All 10 participants stated that their health outlook has improved beyond just behavioral health treatment services. Briana had a private health insurance plan at the time of the interview. When asked how her access to behavioral health services has been affected or improved in the past 18 to 24 months, she responded, “I would say definitely improved.” She added that she was “very satisfied” with her premiums. Her reasoning was that although she is not on “Obamacare,” members of the community benefited from the same type of healthcare and behavioral healthcare that she was receiving. She noted that even if her premium increased, it was for the benefit of the wellness of her community. To this end, she suggested that

> Work it out where maybe your premium will be a tad bit higher but not have to pay any co-pay at all every time you went. Yes. I know it has to come out

> somewhere so maybe not increase it a great deal but maybe a tad where you're not paying a co-pay every time.

Brook stated that she turned 26 in 2017, the year the interview was conducted. She stated that she was previously under her mother's insurance and did not bother about having health insurance until she became painfully aware of the consequences of not having insurance. She commented that

> When I first found out about it I didn't have medical assistance. So, I didn't fully understand and I kind of supported it at the time because of what I heard. But now that I've seen how helpful it is to myself as well as many others, I just hope they don't modify it too much to where it would take it away completely because I think a lot of people are going to suffer because if it.

Beverly offered an emotionally charged account of how the PPACA became a lifeline for her when she was on the streets. She stated that "Yeah. I was dying out there. So, without it I wouldn't have been able to get treatment." She further commented that

> Wait. Go out and see who it effects because it effects a lot of people. Not everybody's rich and stuff or has good jobs. People's lives depend on it. They really do. I'm not just talking about like addiction. People with other medical problems, diabetes even, it helps a lot more people than they probably think. And I don't know if it has to do with money - a lot of stuff does. But it helps. It helps a lot… I didn't think I was going to cry.

Others described the PPACA as offering them better mental health and a healthier community with less death and a lower crime rate. They suggested that if taken away, life experiences for a lot of people in this regard would take a dire turn. Chelsea stated that

> I mean, me and thousands of other people would be stranded and screwed. I mean, there's no back up system in place I don't think and people need help, you know. And I really - I get overwhelmed thinking about that because I don't know what I would do if I didn't have this available.

Referring to an apartment complex where he lives, Anthony reported that "They've found a total of seven people dead in that building because of drugs and all. It could be because of the drugs or other things." He suggested that "I think they should improve it! Improve it and that stuff. Like I said, push issues on that more and more. Get it out there so people understand what is going on."

Summary

This study was designed to explore the experiences of individuals and families receiving behavioral health services since the implementation of the PPACA. The goal of the study was to examine the perception and perspectives of these individuals with navigating behavioral health treatment services since the healthcare law went into effect. In-depth face-to-face interviews were conducted with 10 participants who were purposefully recruited from Anne Arundel County in Maryland. These individuals had first-hand experiences using these services within the county. Each participant was interviewed using a 10 question semi-structured interview guide.

Responses from in-depth interviews revealed four main themes and one subtheme. These themes were (a) getting needed help, (b) affordability of treatment services, (c) ease of getting needed treatment, (d) fear of losing health coverage, and (e) the subtheme of being a life line.

Key findings from this study suggest that participants attributed the PPACA to their getting needed help with their mental health, substance use, and other psychological disorders. Most of the participants viewed that getting needed help involved having access to specific treatment for their behavioral health needs. While all participants considered behavioral health treatment as an important part of their daily survival, over half of the participants viewed their treatment or service agencies as a mini health hub for their health services.

This perception was especially prevalent among participants with chronic substance use disorders who would normally not see the need to pursue health maintenance when they are in the throes of their addiction. When these individuals eventually sought inpatient or residential treatment services, these opportunities became avenues for them to receive a basic medical checkup and possible medication management for their substance use, psychiatric disorders, and physical health needs.

In this chapter, I provided a description of participants and their demographic information, research setting, data collection, data analysis, and a narrative of findings. In chapter 5, I will discuss the findings, limitations of the study, in addition, I will provide implications for social change, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The aim of this phenomenological study was to investigate the effects of the PPACA on access to behavioral health treatment services in Anne Arundel County, Maryland. I sought to explore how the healthcare reform has influenced the availability of behavioral health services to individuals seeking these types of care. In addition, I aimed to identify the perception and perspectives of behavioral health service users on how the essential benefits of the healthcare reform have impacted their demand and usage of behavioral health care. Behavioral health problems are comprised of mental health issues, substance use, and psychological disorders.

Despite the prevalence of behavioral health disorders (SAMHSA, 2015) and vulnerabilities (Hedden et al., 2015; Wittchen et al., 2014) associated with these disorders, a significant number of those impacted are likely to be underinsured or uninsured (Rowan et al., 2013). As a result, these individuals lack access to treatment and necessary services. Having health insurance coverage is one of the most important determining factors of whether individuals with behavioral health disorders seek or refrain from treatment services (Pearson et al., 2009). More so, individuals with severe behavioral health disorders are more likely to be within the lower income bracket, dependent on public health insurance programs, and with poorer physical health than the general population (Garfield et al., 2011; Han et al., 2015).

Considering these challenges that further complicate existing dilemmas confronting families dealing with behavioral health disorders, there is a need to (a) promote access to care, (b) reduce the burden of affordability, and (c) promote quality of care. Further, there is a collective responsibility among stakeholders to be mindful of the efficient use of limited resources while attempting to manage the cost of care across all sectors of healthcare.

This study was based on the following research questions:

RQ1: What are the perceptions of behavioral health service recipients on access to needed care in Anne Arundel County?

RQ2**:** How do behavioral health service recipients in Anne Arundel County describe their access to care since the implementation of the PPACA healthcare reform?

RQ3: How do treatment recipients perceive the quality of behavioral health care since the implementation of the PPACA?

RQ4a. What perceived challenges are treatment recipients reporting with their behavioral health plans since the PPACA went into effect?

RQ4b. What perceived advantages have they observed?

To address these questions, in-depth face-to-face interviews were conducted with 10 participants who were purposefully recruited from Anne Arundel County in Maryland. These individuals had first-hand experiences using these services within the county. Each participant was interviewed using a 10 question semistructured interview guide (Appendix A). These processes were guided using the conceptual framework of Rogers's (2004) diffusion of innovation framework as presented in Chapter 2. Phenomenological studies provide rich data from participants because they provide opportunities that allow them to give voice to their experiences of the phenomena under study and the meanings they attach to their lived experiences regarding such situations (Hensley, 2012; Moerer-Urdahl & Creswell, 2008; Wise & Phillips, 2013). Additionally, through the phenomenological framework, participants and investigators become partners in curating narratives that promote better understanding of issues at stake, and subsequently active engagement (Freeman et al., 2015; Henriques, 2014; Hossen & Westhues, 2011).

In this chapter, I further discuss the themes and findings discussed in Chapter 4. This discussion includes the interpretation of the findings, limitations of the study, recommendations, implications for social change, and concluding thoughts resulting from the experiences of the study.

Key Findings

One of the findings of this study was that all participants perceived behavioral health care as crucial to their functioning. Individuals considered receiving professional care for their behavioral health disorders as an important aspect of their daily survival. For this reason, there appeared to be a sense of urgency with getting needed help to these participants. Hence, the first theme was named getting needed help.

The second finding indicated that 70% (7 of 10) of participants would not be able to afford treatment for their disorders without the PPACA. Two of the participants reported that in the event they lacked access to professional care, they would rely on nonprofessionals, such as family members and other means to address crisis situations when such occurred.

Third, participants appeared to view their behavioral health providers as a mini hub for providing their healthcare services. Even when some of their identified providers were not equipped to treat their physical health concerns, participants shared a sense of collaboration among treatment providers. These collaborations among treatment providers seemed to make participants feel cared for and not letting them fall through the cracks in the process of navigating treatment services.

Fourth, while participants regarded the PPACA as presenting them with better opportunities to attain better care at the time of this study, half of the participants (5 of 10) welcomed the idea of improving the healthcare reform even if it comes at a small cost but providing access to more people. Nonetheless, 70% (7 of 10) of the participants expressed despair and pessimism towards the possibility of a repeal of the healthcare reform at the time of this study. They expressed that if the repeal or any major changes took place, they could become unable to attain current behavioral health services.

Interpretation of Findings

Findings and interpretations presented in this section have been inductively gathered from research questions, supported by information shared by participants, and further review of insight presented in the body of literature presented in Chapter 2.

Research Question 1: What are the perceptions of behavioral health service recipients on access to needed care in Anne Arundel County?

Getting Needed Help

The first research question was intended to address the lived experiences of participants with access to behavioral health services since the implementation of the PPACA. All participants reported that they had used behavioral health treatment services between 2014 and 2017. Others indicated that they had used these types of treatment services “off and on” within the past 10 years. Participants expressed a deep sense of value with the services that they were receiving at the time of this study. Participants made frequent reference to “getting help,” “being in treatment sooner,” and a sense of hope in “life or death” situations. There appeared to be a shared belief among participants that the PPACA improved their chances of attaining needed behavioral healthcare on time and that the treatment they were offered was adequate for their presenting problems at the time of service. During the face-to-face interviews, Participant 3 (Beverly) provided an emotional account of her experiences on the street and how hopeless life would have been without the PPACA healthcare coverage. She also provided examples of her friends and peers who have lost their lives due to the double dynamics of mental health issues and substance use disorders. In the same manner, Participant 6 (Britaney) reported that she had “better mental health treatment coverage with Obamacare.”

These findings support previous studies, which have suggested that people with behavioral health disorders tend to avoid treatment due to lack of insurance or inadequate insurance (Pearson et al., 2009; Rowan et al., 2013). The National Center on Addiction and Substance Abuse (2012) reported that in 2010, about 40.3 million people met the diagnostic criteria for substance use disorder in the United States. Of these individuals, only 1 in 10 was able to receive specialized and professional treatment for their disorders. This trend appears to contrast with the perceived experiences of participants in this study.

Given this finding from this study, there is the possibility that the essential health benefits clause under the PPACA may have played some role in relaxing restrictive or exclusionary practices with delivering behavioral health services (Beronio et al., 2014).

Participants expressed having the confidence to seek treatment services knowing they have better chances of attaining professional care despite the type of insurance they had at the point of care.

Research Question 2: How do behavioral health service recipients in Anne Arundel County describe their access to care since the implementation of the PPACA healthcare reform?

Affordability of Treatment Services

The capacity to afford care was a feature theme that emerged under Research Question 2. A significant number of participants (70%) reported that they would not be able to afford care without the PPACA. They pointed out that not having insurance would have prevented them from seeking professional care, especially if the type of behavioral health challenge they were dealing with at the time was not considered a crisis. Eight out of the 10 participants reported that they were unemployed at the time of the study and as such would not be eligible for employer-sponsored insurance. One of the participants (Bridget), who had previously used an employer-sponsored insurance while she held a minimum wage job, stated that she could not afford the biweekly deductions from her paycheck or the copays that were due her at the time of services. She reported,

> I was getting over $300 biweekly so a total of $700 and some change taken out of my check monthly. It was very expensive. It was not affordable. And the copays were extremely high. So, with my daughter, we had to pay out of pocket.

In the same vein, 18-year-old Claire noted that were if not for the Medicaid that she was using for her treatment services, her family would be in a compromised position about securing treatment services for her psychiatric disorders. She reported that without the PPACA supported Medical Assistance,

> It would probably be extremely hard, and my mom would probably be crying every single day because our financial situation is very bad. It's not at all what it used to be so I'm very grateful that we have insurance. For sure.

Insurance was one was among the most frequently occurring words during the various cycles of coding and data analysis. Participants significantly shared the sentiments that tied their ability to afford specialized behavioral health treatment among other health services to the PPACA. The PPACA was tied to the possibility of attaining treatment services and determined what type of treatment services individuals could afford. It has been reported that Medicaid funds one-third of opioid use disorder treatments (Slavitt, 2017). These findings are consistent with previous studies, which suggested that if the implementation of the PPACA were properly managed and restructured, publicly financed behavioral health services might find opportunities for improving on their service offerings, thereby assisting in expanding access to specialized behavioral healthcare (Goldman & Karakus, 2014). They also suggest that the PPACA may be contributing to the eradication of loopholes which have previously stifled access to behavioral health treatment services (National Center on Addiction and Substance Abuse, 2012).

On the contrary, this finding disconfirms the study by Garcia (2010), which suggested that including substance use disorder treatment covered in parity would increase costs for health insurance providers and for individuals who are independently purchasing premiums for themselves. Participant 4 (Briana), who had private insurance at the time of this study, noted that she had not noticed any increase in her premiums or any unusual charges.

Research Question 3: How do treatment recipients perceive the quality of behavioral health care since the implementation of the PPACA?

Ease of Getting Treatment

Nine of the 10 (90%) participants indicated that they noticed a difference in how they are now getting treatment since the implementation of the PPACA. They reported that they neither feel dismissed when they are seeking care nor rushed out of treatment after barely receiving adequate care due to the type of insurance that they have. The experiences of being connected to treatment on time at various levels of care and collaboration among treatment providers in the process may have informed the perception of less complexity of entering treatment.

In a bipartisan effort by 29 U.S. Senators making arguments for expanded coverage for substance use disorders treatment, there were acknowledgments of progress made to improve processes of securing behavioral health treatment (Feinstein, 2016). In those acknowledgments, they pointed out the rise in the level of coordination and integrated treatment framework of behavioral healthcare in Medicaid programs. There appear to be improved treatment outcomes and possible cost reduction through the emphasis on maintaining effective continuum of care since 2015. Feinstein’s (2016) press release also demonstrated a recognition that the Innovator Accelerator Program (IAP) initiatives, as emphasized by the Centers for Medicare and Medicaid Services (CMS, n.d.), is stimulating efforts by providers to increase value in the treatment services they offer.

Behavioral health providers in this study were perceived as a mini hub for general healthcare services by most participants (seven of 10). The perception seemed to be shared among individuals with chronic substance use disorders, who would normally not see the need to pursue health maintenance when they are in the throes of their addiction. When these individuals eventually sought inpatient treatment services, these opportunities became avenues for them to receive simple medical checkups and possible medication management for their substance use, psychiatric disorders, and physical health needs. This sentiment was captured in Catherine's report of her experiences

> …And that includes your detox and medications for your withdrawal symptoms, maintenance medication when you meet the psychiatrist to kind of see if you are on prescribed medication. And if you are, if that's the right medication you should be currently on. So, I was actually prescribed new medication for my depression and anxiety. I was given Vistaril and Lexapro, and that was given to me. It was included in the $350. It included food, room and board, laundry, and everything like that.

Also, Anthony described the way his care was coordinated as such

> All I got to do is pick…I got the after hour emergency number for all the different doctors. All I got to do is dial that number, say, 'I need to talk to Dr. such and such.' They ask me who I am, I tell them. They are like, 'Ok, Mr. Anthony, I'll get you right on the phone.'

Participants viewed their mental health therapists, psychiatrists, and other clinicians as their advocate to receive more comprehensive care in the appropriate care settings for their healthcare needs. They described instances where these clinicians and care providers helped them make calls to schedule them for referrals. These are initiatives that they otherwise would not have made themselves. They also attributed these collaborations to the reasons why they were easily connected at a faster rate to other providers.

The experiences of these participants regarding the ease of getting into treatment seem to reflect a possible benefit of the PPACA in promoting better access to care based on a widely held position on true tests of healthcare access (Karikari-Martin, 2010). That is, any true claim of promoting better access to care must include (a) having healthcare coverage and (b) efficiency and effectiveness of service offerings. This view was also supported by other studies emphasizing that better access to behavioral healthcare should demonstrate that individuals' treatment needs are being met along the continuum of care (Garfield et al., 2010).

Research Question 4a: What perceived challenges are treatment recipients reporting with their behavioral health plans since the PPACA went into effect?

Fear of Losing Health Coverage

The majority of participants (seven of 10) expressed sentiments of despair, frustration, and pessimism over the potential of repeal or rollback of the law. Although the repeal of the PPACA had not taken place at the time of this study, participants noted that it was looking more likely that the healthcare law would be repealed or left to collapse by the sitting president and members of his political party. Participants expressed that if the repeal or any major changes took place, they could become unable to attain current behavioral health services.

Britaney, who reported that she had severe and chronic health problems in addition to her chronic mental health challenges, asked what the repeal would mean to her pre-existing conditions, including that of her parents and her younger sister. Britaney emphasized during our face-to-face interviews that “there is a life behind those numbers.” Her statement seemed to reference the human cost of actual repeal beyond administrative burdens. Similarly, Chelsea shared a related concern of what would become her reality in the absence her health insurance. She stated that she would “feel like a cornered animal without the help I need.” Chelsea also suggested the likelihood that “crimes will go up if healthcare is taken away.”

Before this study, there were feverish efforts geared towards the repeal of the PPACA despite some of the benefits attained by the first phase of its implementation (Kersh, 2011). At the time of this study, the presidency and legislative chambers of the United States government were controlled by the Republican party, which has incessantly drummed the beats to repeal the healthcare reform. Correspondingly, supporters of the PPACA and Medicaid expansion have not been without their fair share of doubts and concerns as well. Some have indicated inadequate arrangements between states and the federal government on how to fund fiscal and administrative responsibilities under the healthcare exchange or Medicaid expansion (Dinan, 2014; Sommers et al., 2014).

As a result, there was always a sense of uncertainty about how healthcare reform will affect the availability of behavioral healthcare and wellness resources. There is also the concern of how long the benefits ushered in will last, especially those that seem to alleviate the burden of care for individuals and families who would not be able to afford the cost of professional care on their own. Whereas the repeal of the PPACA had not taken effect at the time of this study, there seemed to be a pernicious effect from repeal crusades on consumers' trust in the system, a system that comprises the ecosystem of healthcare providers. These issues were confirmed by participants as weighing heavily on their minds as indicated in previous studies.

Research Question 4b**:** What perceived advantages have they observed?

Lifeline

All participants indicated they have been "very satisfied" with the amount and quality of care that they have had since the implementation of the PPACA. One out of 10 participants had private health insurance with which she had funded her treatment in the past two years. The reason for stating that she was satisfied was twofold. First, her premium had not increased within the period as some studies had previously projected (Blumberg & Holahan, 2015; Dickson, 2015). Second, she indicated that if members of her community were benefiting from the healthcare reform, then it was positively impacting her community at large.

Community impact of behavioral health disorders should not be taken for granted or considered lightly. The United States is facing an opioid epidemic crisis, which has resulted in an unprecedented number of fatal overdoses in recent years (United States

Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2014). About three out of 10 people who suffer from opioid addiction receive treatment through Medicaid funding (Young & Zur, 2017).

These reports were confirmed in this study as four participants reported a history of current substance use disorders. Three of the participants had recently completed inpatient treatment and were living in a recovery home waiting to re-integrate into the community. Participants reported that their treatments were funded through their Medicaid insurance. However, their recovery home stays were under different payment arrangements because insurance does not cover the cost of service for most of the recovery homes.

Another issue that impacts communities from behavioral health disorders is the problem of unemployment. According to Krueger (2017), opioid-related disorders and mental health concerns have become intertwined with the rate of unemployment for prime-age young people in the United States. This situation has been particularly true for young men who are not in the labor force. Krueger (2017) further indicated that these individuals tend to be unhappy and want to get better. Krueger (2017) also noted that effective treatment strategies are the best approaches for dealing with this dilemma. With unemployment, there is a critical economic impact of less productivity, resulting in less economic enterprises and more reliance on welfare programs.

About half of the participants in this study expressed interest in getting back into the workforce. They reported that treatment was the lifeline they needed to get back on their feet and to become productive members of society. These findings are consistent with previous studies which highlighted the community impact of behavioral health disorders (Boyd et al., 2010; Krueger, 2017). With effective coordination of treatment and community resources, there are possibilities that these efforts could foster healthier communities by reducing preventable disease burdens and other potential societal challenges associated with these diseases.

Integration of Conceptual Framework

Rogers's (2004) DIT was used to conceptualize the approach to this study. Originally introduced by Ryan and Gross (1943), the DIT was used to examine social and cultural factors that influence the adoption of innovative phenomenon. They suggested that various aspects of social interaction with people within a community play a vital role in the dissemination of new ideas. Rogers (2004) later advanced the DIT by highlighting the importance of sources of the information, the influence from these sources, and their reliability for achieving the expected outcome. From this perspective, the driving mechanisms of diffusion process are information exchange and working in conjunction with the shared meaning that members of that social system attribute to their personal and subjective experiences.

In the context of this study, the DIT was used to explore the adoption of the PPACA as it relates to the advancement of behavioral health services. With the healthcare law being a new frontier in healthcare delivery at the time of this study, there were indications that not every member of the healthcare or legislative orbit readily accepted the healthcare law. However, I proposed in this study proposed that if the effects of the PPACA on behavioral health were explored and tested by early adopters, those individuals could become the ambassadors for promoting the new findings and ideas to the larger society, thereby leading to increased adoption at a subsequent time. This study used three characteristics of DIT which had been identified in previous studies as key features which could promote or impede the adoption of innovations. These were (a) relative advantage, (b) compatibility, and (c) complexity (Fajans et al., 2006; Vedel et al., 2013).

Participants in this study perceived that they had enjoyed relative advantage from the implementation of the PPACA. They shared their perspectives of gaining needed behavioral health, being able to afford these services, and indicating that it is a lifeline that could jump start them back into living more productive lifestyles. Maryland is one of the early states which embraced the healthcare exchange and Medicaid expansion; there appear to be fewer disruptions in how behavioral health services were offered to service users following the phases of implementation. Rather, participants perceived that they had experienced easier access to comprehensive treatment despite previous inability to afford some of these services.

In terms of exploring opportunities for their treatment needs, participants shared few concerns with the availability of treatment resources for psychiatric crisis. Two of the participants reported long waiting periods to be admitted into the psychiatric unit during their crisis episodes. One of the participants who seemed to be familiar with the process of being placed into these units in the past suggested that the challenge was possibly due to many people attempting to get help based on their ability to now attain professional care. More so, some participants referenced inadequate behavioral healthcare providers in the county, which created a notion of sparse facilities in some areas of the county. Also, there were concerns with having transportation to attend treatment appointments.

Limitations of the Study

Despite concerted efforts made to adhere to defined protocols for conducting qualitative research, this study had some limitations. First, the study was conducted at a time when the repeal of the PPACA seemed almost certain. The imminent possibility of repeal made the healthcare reform a moving target with lesser prospect of being fully implemented or existing much longer (Holahan & Blumberg, 2017). The ongoing debates and potential vulnerabilities of the PPACA at the time of this study may have influenced the perceptions of participants in this study.

The second limitation was the small sample of 10 participants who were purposefully selected from Anne Arundel County. The limited number of these participants may not be a true representation of the entire county. As such, the perceived experiences of these participants may not truly reflect the sentiments shared by other members of the county. Consequently, this study cannot be generalized to a wider population of other healthcare consumers within the state or other behavioral health service users in other states.

Third, despite my efforts to maintain neutrality while being reflexive in conducting this study, my background as a behavioral health professional in the state of Maryland may have influenced the worldview through which I approached this study. Nonetheless, through reflexivity and the use of audit trails, I was able to curtail any semblance of personal bias. I thoroughly reviewed and examined my analysis of gathered data against evidence from the literature.

Recommendations

As debates continue by various interest groups for the heart and soul of healthcare in the United States, there is a sense of agreement among these interest groups that a viable healthcare system is essential for the wellbeing the nation (LaVito, 2017). Healthcare in the United States comprises about one-sixth of the nation's economy (Case, 2016); the nation is in a phase of healthcare consumption that demands an all hands on deck approach to attain modest progress. The PPACA may be a controversial piece of legislature depending on the lens through which it is evaluated. It also has potential benefits or consequences for the nation in general as it is intertwined with various fabrics of society. What is yet evolving with the PPACA are (a) concrete evidence supporting its benefits on sub-groups, such as behavioral health service users and providers, and (b) concrete evidence supporting the hardship it has created for individuals and entities because of its implementation.

If there is growing evidence that it has been beneficial to a significant number of individuals in the general population, this could foster its widespread acceptance and thereby adoption of its major provisions. However, when there is significant evidence to the contrary suggesting that the healthcare law has been more of a complex burden to the general population than it was initially presented, this could spur a widespread rejection altogether.

This study was designed to explore the perspectives of interest groups in the domain of behavioral health treatment usage and service delivery in the burgeoning implementation phases of the PPACA. Originally, I planned to include behavioral health treatment providers as participants in the study. These individuals could have represented the perspectives of provider organizations in Anne Arundel County. The eligibility criteria for these treatment provider participants could have been individuals who are clinicians or administrators, who had firsthand knowledge of the patient or client population that were admitted into their facility, admission criteria, and the facility's capacity to provide needed services. The inclusion of provider participants was discouraged by my dissertation committee members due to the phenomenological scope and time limitation for completing research of that nature. To this end, it is recommended that future research considering the effects of PPACA on behavioral health should include treatment providers of these services as stakeholders in the venture. These participants could have meaningful information to share pertaining their roles, experiences, and perception of the implementation process.

Although the findings of this phenomenological qualitative study do not endorse broad generalizations about the effectiveness of the PPACA in advancing behavioral health treatment services in Maryland, the outcome nonetheless underscores crucial benefits of the healthcare law for those in need of these services. Therefore, it is recommended that similar research should be carried out in other regions of the state and beyond; such efforts would further inform the possible worth of the law within diverse sociocultural and sociopolitical regions. Furthermore, in agreement with Han et al.

(2015), it is recommended that complementary quantitative studies be conducted to ascertain the trends of behavioral health service use among individuals with private insurance and other groups who are ineligible to participate in Medicaid or health exchange programs.

Implications for Social Change

Policy Application

Findings from this study could offer insights to issues of common interest to healthcare stakeholders. Knowledge gained from this study could provide reasonable platforms for objectively addressing complex challenges which tend to undermine potential policies that could yield positive dividends for all parties involved. Insights derived may offer stakeholders additional understanding of the benefits and challenges associated with behavioral health services under the PPACA in Maryland.

This study has contributed to the body of knowledge in that it has identified some of the perceptions that behavioral health treatment users have of their providers. That is, considering treatment providers as a mini hub for their healthcare services. This inference creates an opening for further research inquiry. One previous study (Clemans-Cope et al., 2017) examined the PPACA's optional Medicaid health home model (OHH), which was implemented in Maryland, Rhode Island, and Vermont. The opioid health home is a system of care that incorporated medical and behavioral health care and other adjunct services, some of which include approaches designed to cater to social determinants of health. The investigators in that study found that there was a low compliance rate among service users in Maryland due to insufficient reinforcements from program coordinators.

Similarly, Case (2016) postulated that lack of coordination and actionable data are some of the challenges confronting a weak healthcare system filled with trials and errors.

Programs like the OHH and other innovative channels for delivering healthcare services can be reinforced by further exploring other community intermediaries that could play adjunct roles of providing stabilization for people with behavioral health disorders when experiencing episodes of crisis. These types of provisional resources could offset the cost of emergency room usage when individuals are faced with critical challenges resulting from chronic health conditions.

System Level Application

The idea that individuals who receive benefit from healthcare reform are mainly interested in what they can get from the system could be misleading. Participants in this study shared their observations of possible abuse of the healthcare system by treatment consumers and some providers alike. Particularly, they pointed out doctor shopping behaviors among treatment recipients and practitioners who prescribed medications with less caution or monitoring practices. As stakeholders, participants demanded accountability on both sides. Participants were open to discussing behaviors and characteristics of potential culprits, this possibly suggests that healthcare service users are invested in healthcare improvements as well.

While treatment providers may not be directly responsible for crafting healthcare policies, they play critical roles in informing policymakers with the trends of service delivery. They could also make helpful recommendations to stakeholders in healthcare debates that could inform the adoption and implementation of better and more comprehensive healthcare policies. As was demonstrated by most participants in this study, treatment providers and facilities tend to have the trust of their service users. Such seemed to be the case if service users felt that their treatment needs have been met; moreover, in such cases, they perceived that their providers have their best interest at heart. Nurturing these important provider-user or clinician-client alliances would require providers to have some awareness of social issues that are important to their clientele. Having such insight equips providers to objectively frame messages of hope and resilience in times of economic or social uncertainty. This study may contribute to facilitate social, civic, and positive health behaviors in self monitoring with the use of healthcare services.

Since this study has potential implications that are beneficial to multiple stakeholders ranging from policymakers to individual service users, I intend to share the findings of this study across any accessible platform. I plan to share findings of the study with facilities that were involved in the process as well as at professional conferences, local health fairs, town hall style meetings, and faith-based events. Also, I plan to publish this research in peer reviewed journals.

I have begun discussing some of the findings of this study with behavioral health clinics and their patients while emphasizing the dividends of treatment collaboration. The Anne Arundel County Health Department, which helped with the distribution of study flyers, has requested an in-house presentation regarding the findings at the completion of the study. These dissemination efforts will further pave the way for promoting the application of research to practice.

Theoretical Implication

Rogers's (2004) DIT was used for this study. The three constructs of this theory that were adopted to explore the interplay between the PPACA and behavioral health access among participants were relative advantage, compatibility, and complexity. The conceptualization of the study was that while relative advantage and compatibility are usually favorable towards the acceptance and implementation of innovation, complexities from the phenomenon tends to negatively impact the implementation of the new opportunity that is presented.

In this study, some indicators confirmed this premise. Participants viewed the PPACA as a piece of legislation that may have enhanced their ability to access and afford behavioral health services. It was suggested that the PPACA was of relative advantage to them. There appeared to be program compatibility between PPACA and existing behavioral health framework in the county, which led to little or no significant disruptions during the implementation phases. Participants shared that they experienced more ease with attaining treatment following the PPACA's enactment. Although service users reported fewer complexities in the process, the views of treatment providers could not be ascertained because they were not included in the study. For this reason, it is recommended that future study designs should include participants from both spectrums to evaluate the perception of complexity.

Conclusions

In this phenomenological study, I explored the experiences of individuals and families receiving behavioral health services since the implementation of the PPACA. In-depth face-to-face interviews were conducted with 10 participants who were purposefully recruited from Anne Arundel County in Maryland. These individuals had firsthand experiences using these services within the county. Rogers's (2004) DIT was used as the conceptual framework of this study. Relative advantage, compatibility, and complexity were the characteristics of the DIT, which guided the explorative and interpretive activities of the study.

Findings from this study suggested that behavioral health services were vital aspects of participants' daily functioning. Most participants indicated that without the PPACA, they would not be able to afford behavioral health treatments and most of their healthcare needs. Also, participants considered their behavioral health treatment providers as a mini hub of care, where their other healthcare services were met when they were in dire need. Furthermore, whereas participants embraced the idea of improving the PPACA in the interest of all stakeholders, they also expressed deep despair and pessimism towards the possibility of a repeal of the healthcare reform at the time of this study. They expressed that if the repeal or any major changes took place, they could become unable to attain current behavioral health services.

This study has demonstrated that involving the public or end users of public goods and services in the deliberation of new initiatives promotes a better understanding of issues at stake, and subsequently active engagement. Leaders in healthcare and other industries that share similar interests agree that the new frontier in healthcare is innovation that is making things simpler and not complex for providers, patients, and educators. Behavioral healthcare should not be an exception to the rule. It is hoped that the findings of this study can further stimulate the ongoing momentum in Anne Arundel County around behavioral health issues. Also, it is recommended that leaders and policymakers at the local, state, and national levels give behavioral healthcare an equal level of urgency that other health services assume in healthcare policymaking deliberations.

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Appendix A: Interview Questions/Guide

1. Have you or any member of your immediate family received any type of behavioral health services in the past 18 months?

2. Describe some of the behavioral health services (mental health or substance use disorders) that you have received in the past 18 months.

3. Do you have a previous history of receiving behavioral health services before 2014?

4. How did you afford behavioral health services before 2014?

5. How are you currently affording these services?

6. How has your access to behavioral health services been affected or improved in the past 18 months?

7. In searching for treatment providers, how quickly are you able to secure treatment in the past 18 months?

8. How satisfied have you been with the amount of care you have received since the new healthcare law was passed?

9. Without the new healthcare law (Obamacare), what could have been your options of receiving behavioral health services?

10. If you could make any suggestions, what would you tell treatment providers and state policymakers to improve in order to meet your behavioral health needs?

Appendix B: Prescreening Questionnaire

(1) Are you 18 years or older?

(2) Do you live in Anne Arundel County?

(3) Have you received any mental health or substance use disorders treatment in the past 18 months?

(4) Have you cared for or been directly responsible for someone accessing treatment for mental health or substance use concerns?

Appendix C: Research Flyer

Research Volunteers Needed!

Effects of Patient Protection and Affordable Care Act on behavioral Health Access
You are invited to take part in a research study about the effects of Affordable Care Act, also known as "Obamacare" on behavioral health in Anne Arundel County. The goal of this study is to identify how the Affordable Care Act has affected behavioral health treatment services within Anne Arundel County.

To be eligible for this study, you have to be:

- ✓ 18 and older
- ✓ Have received behavioral health services in the past 18 months
- ✓ Someone directly responsible for a loved one with behavioral health needs.

- ⇨ Dates and times for participation are flexible.
- ⇨ Participants will receive a token of appreciation for their time.

To learn more about this study, and how you could participate, please contact Mr. Godwin Oshegbo at Ph# or email provided

Appendix D: Letters of Cooperation

President/CEO

May 8, 2017

Dear Godwin Oshegbo,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Effects of Patient Protection and Affordable Care Act on Behavioral Health Access within our facility. As part of this study, I authorize you to distribute your flyers and conduct interviews at our clinic. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include use of rooms for interviews. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the student will not be naming our organization in the doctoral project report that is published in Proquest.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix E: Participants' Demographic Form

Participant's Code	Pseudonym	Identified Pt or Family	Type of Insurance	Gender	Age

Appendix F: Phone Contact and Introduction of Study Sample

Hello,

My name is Godwin Oshegbo. I am a doctoral student at Walden University, College of Health Sciences. Thank you for volunteering to participate in this study on the effects of Patient Protection and Affordable Care Act on behavioral health in Anne Arundel County, Maryland. I would like to discuss the following items with you:

Research focus:

Procedures of study:

Informed consent:

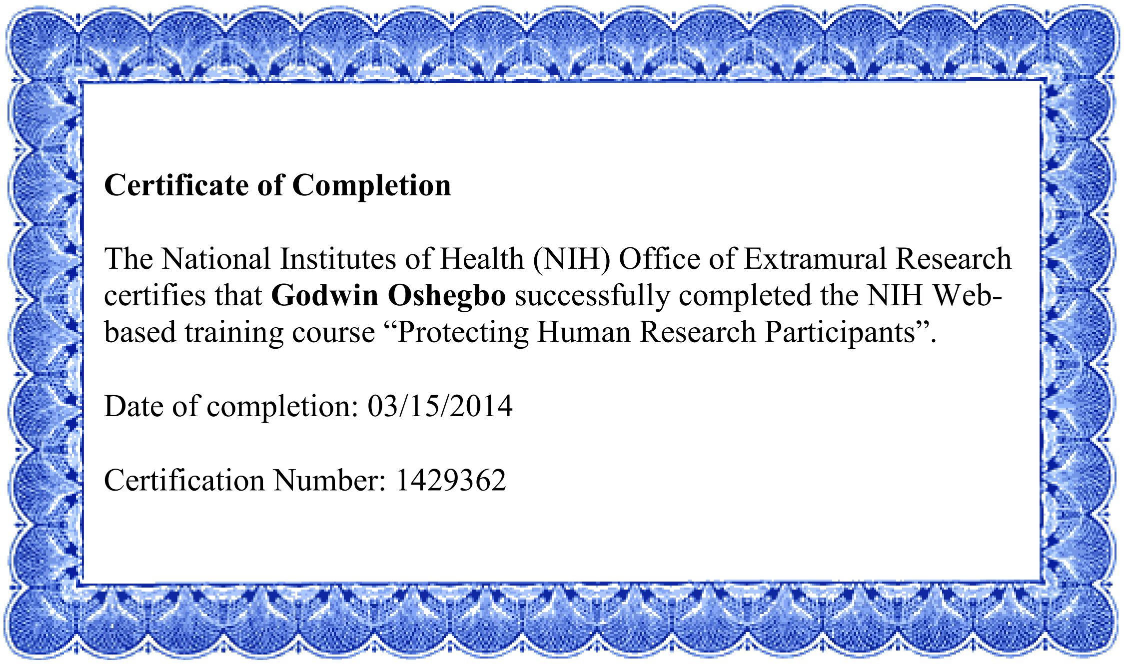
Agreement on interview venue, date, and time:

Follow-up data review:

Again, thank you very much for your help.

Godwin Oshegbo

Appendix G: National Institutes of Health (NIH) Office of Extramural Research



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Godwin Oshegbo** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 03/15/2014

Certification Number: 1429362

Appendix H: Referral Resources

Free and low-cost Health and Behavioral Services in Anne Arundel County