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Perceptions of Recovery While Delivering Medicaid Covered Rehabilitation Services

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Perceptions of Recovery While Delivering Medicaid Covered Rehabilitation Services

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Abstract

Many states have shifted to Medicaid reimbursement methods to cover behavioral health services. In doing so, state mental health authorities have incorporated the concept of recovery into mental health policy. Thus, gaining a better understanding of practitioners' perceptions of recovery in a new fiscal environment is warranted. This qualitative study explores how New Jersey practitioners transitioning to a new state-wide Medicaid payment structure perceive recovery from mental illness. Four themes emerged following a thematic analysis. Future studies that explore perspectives of individuals receiving services could provide useful information for policymakers, agencies, and community stakeholders.

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Perceptions of Recovery While Delivering Medicaid

Covered Rehabilitation Services

Many states have shifted to Medicaid reimbursement methods to cover behavioral health services. In doing so, state mental health authorities have incorporated the concept of recovery into mental health policy. Integrating recovery into mental health policies provides a framework that, if applied, can lead to both cost benefits and valuable behavioral health outcomes (Jacobson & Curtis, 2000). Not surprisingly, practitioners play a critical role in the implementation of recovery policies and practice approaches. Emerging best practices in supporting recovery stress the importance of the individual practitioner viewing recovery as central to practice rather than an additional responsibility (Slade et al., 2012). Thus, gaining a better understanding of practitioners' perceptions of recovery in a new fiscal environment is warranted and can have implications for future practice.

In 2011, the Centers for Medicare and Medicaid approved a State Plan Amendment for New Jersey to provide Medicaid covered mental health Community Support Services (CSS; State Plan Amendment, 2011). CSS consists of mental health rehabilitation services and supports that help individuals achieve identified recovery goals, community integration, and remaining independent in the community (State Plan Amendment, 2011). Additionally, CSS is grounded in psychiatric rehabilitation goals and values such as self-determination, the promotion of valued social roles, recovery, and quality of life (Pratt et al., 2014). Many CSS programs in the state welcomed the clear focus on recovery and would argue that their policies and practices emphasized recovery approaches. Nevertheless, the state mental health authority contracted with an east coast University to facilitate a statewide training and consultation initiative in New Jersey

to ensure that the workforce delivering CSS acquired the knowledge and skills necessary to deliver recovery-oriented services.

This qualitative study will explore the concept of recovery and practitioners' perceptions of recovery while delivering Medicaid-covered mental health rehabilitation services. Data from current practitioners delivering Medicaid covered CSS was collected via focus groups. A thematic analysis will be presented along with recommendations for future investigation.

Recovery in Mental Health

The recovery movement began in the 1970s, placing focus primarily on individual experiences of people living with a mental illness (Davidson, 2016). Following this movement, recovery was defined in many different ways, with overlapping themes focusing on recovery as person and choice focused, a fluid process, strengths-based, and individualized (Slade et al., 2014). Although there is an agreement that recovery is multidimensional and rooted in choice and hope, there are competing views of recovery from service recipients and service providers (Frost et al., 2017). Frost et al. (2017) points out that many mental health services are medically focused, and in fee for service environments, billable services may be geared towards what Medicaid constitutes as billable services, shifting focus away from individual need and individual definitions of recovery, towards fulfilling service criteria requirements (Slade & Longden, 2015).

With the deinstitutionalization movement in the 1970s, definitions of recovery began to shift, as individuals with a mental health diagnosis desired more than a reduction in their symptoms, as they sought education, vocational, and social opportunities (Anthony, 1993). By the end of the next decade, long term research altered previous ideas of quality of life for individuals with a mental illness, as it showed that, regardless of psychiatric diagnosis, people

were able to fully participate in their lives through recovering from symptoms or adapting to their illness (Davidson, 2016). With the passing of the Americans with Disabilities Act in 1990, the language adopted characterized individuals diagnosed with a mental illness as those with disabilities, in turn granting them the same rights as individuals with physical disabilities, conveying inclusivity for people, regardless of physical disability or mental health diagnosis (Davidson, 2016). By the end of the century, Surgeon general David Satcher outlined the need for services driven by the individual, focusing on recovery (Davidson, 2016). By 2010, the US Substance Abuse and Mental Health Services Administration further focused on recovery by introducing its Recovery Support Strategic Initiative, which focused on recovery topics like hope, community, and strengths (Pincus et al., 2016).

Over the last five decades, the overall definition of recovery has deviated from concentrating on medically oriented definitions of recovery, focused on individual diagnosis, towards the notion that a person is more than their diagnosis and should be treated as a person, as opposed to a person with a mental illness (Anthony & Mizock, 2014). Psychiatric rehabilitation philosophy further disputes more traditional ideas and perceptions of individuals with a mental illness, as it focuses on respect, choice, strengths, and the thought that recovery is achievable and individualized (Frost et al., 2017). With this change in the definition of recovery, service models of recovery are shying away from focusing on concepts within the medical model, instead of acknowledging a person's individual goals, life roles, and wellness (Ahmed et al., 2016). Ahmed et al. (2016) further state that recovery-oriented models can focus on various interventions, including services provided by peers, illness self-management strategies, a focus on individual strengths, and a focus on employment.

Recovery focused service models may also support providers in shifting their focus toward more person-centered thinking as opposed to focusing on medical aspects, altering provider's definition of recovery away from one rooted in the medical model (Dalum et al., 2015). In the past, professionals have emphasized recovery through their viewpoint and have not focused as much on individual definitions of recovery (Slade et al., 2014). Certain professionals, like nurses, may have medically oriented definitions of recovery due to their education, training, and work experience or define recovery as a process dictated by service provision to individuals as opposed to a process that individuals experience (Aston & Coffey, 2012). Along with the competing views of recovery from professionals and individuals receiving services, there is also competition between service recipient's ideas of recovery and types of services that will help promote their recovery, with provider's desire to provide individualized recovery-oriented services while staying within Medicaid's definition of billable services (Spitzmueller, 2014).

Spitzmueller (2014) acknowledges that since the 2000s, community mental health providers have transitioned from funding services through state grants to funding services through Medicaid fee-for-service contracts, as a result of Medicaid expansion and reform. Some fee-for-service models are conceived to reduce government spending, opening up funds that can then be repurposed in other ways within the mental health system (Clay et al., 2016). Medicaid funded programs must follow Medicaid definitions of recovery and what constitutes a billable service, which can differ from how service recipients define recovery and limit their choice in the services that may help further their recovery (Spitzmueller, 2014). Medicaid funded fee-for-service programs follow a structured format, whereas service recipients have found that unstructured services are comfortable to engage in, as they are individually driven and emphasize choice (Spitzmueller, 2014).

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Methods

Overview

The researchers utilized a qualitative research method to explore the concept of recovery in behavioral health. Additionally, the researchers grounded their study using a phenomenological framework. Phenomenology and other qualitative research inquiries seek to understand the lived experience of participants (Adams & Van Manen, 2017). Moreover, a phenomenological framework allows a researcher to gain in-depth information about the experiences and perceptions of participants (Adams & Van Manen, 2017; Heinämaa et al., 2014). In the context of this study, the phenomenon studied was the perceptions of practitioners who deliver Medicaid covered rehabilitation services. The researchers used focus groups as a tool to better understand these experiences due, in large measure, to its ability to illuminate contextual nuances that may otherwise remain salient. The University Institutional Review Board of the authors approved the study (Approval Number 201800671).

Reflexivity

Reflexivity consists of self-scrutiny and a heightened consciousness on the part of the researcher (Bourke, 2012). Continuous self-awareness is important because each individual brings their positionality to the research process. In this regard, each researcher involved in this study explored their intersectionality and assumptions that may have impacted the focus groups and/or the data analysis process. Each researcher worked as faculty at a north-east university and knew some of the focus group participants from previous training and/or professional settings (e.g., conferences, boards). Additionally, each researcher had some previous work experience in

a community mental health setting. One of the researchers previously received mental health services, which, in turn, informed how they defined recovery. It is also important to note that one of the authors had specific training in qualitative research methods.

Participants

The researchers held the focus groups during an annual psychiatric rehabilitation conference. Two focus groups were conducted; each included 13 practitioners, which resulted in a total of 26 participants in the study. In phenomenological research, the exact number of participants is not the focus; however, the depth of information received is integral for the fidelity of the study (O'Reilly & Parker, 2012). Specifically, when collecting data using focus groups, 13 participants comport with the integrity of focus group data collection methods (Onwuegbuzie et al., 2009).

Sampling

The researchers used a purposeful sampling method, with a criterion sampling strategy (Creswell & Poth, 2018). Purposeful sampling is important in qualitative research to ensure participants all share the experience of the specific phenomenon (Patton, 2014). The specific criteria for participation in this study are attending the specific conference, being employed at a CSS program, and either a supervisor or direct care staff member. Those eligible for participation signed up to participate in one of the two focus groups facilitated during the conference. This purposeful criterion for sampling contributed to a homogenous group of participants, all of which were experiencing the identified phenomenon (Creswell & Poth, 2018).

Data Collection

The researchers used focus groups to collect the data. Focus groups afford opportunities for direct observation of group discussion, which can provide richer opportunities than that of

one-on-one interviews (Lamb & Cogan, 2016). Two of the four researchers were present at the time of both focus groups. One researcher acted as the facilitator while the other one kept track of time, took notes, and ensured the recorder was working properly. To ensure consistency between each focus group, the researchers used an interview protocol that was developed to guide data collection. An interview protocol strengthens the credibility of the data collection process (Jacob & Furgerson, 2012). At the onset of each focus group, an introductory statement was read aloud, which explicitly informed participants that the discussion would be recorded. Also, the introductory statement reviewed confidentiality and reminded participants that their attendance was voluntary. Afterward, the researchers used a semi-structured interview process to guide the discussion and posed open-ended questions deliberately crafted to elicit discussion about perceptions of recovery while delivering Medicaid covered rehabilitation services (McIntosh & Morse, 2015). Semi-structured interviews have become a best practice approach when conducting interviews for qualitative, educational research (Brown & Danaher, 2019). The interview protocol and open-ended questions were identical in both focus groups (See Appendix A).

Data Analysis

The researchers completed a verbatim transcription of the focus group audio recordings. Next, three of the four researchers used a hand-coding process using a three-step process, grounded in basic thematic analysis, to analyze the focus group data (Creswell & Poth, 2018). The three-step process the researchers followed consisted of 1) reading the transcription multiple times to become immersed in the text, 2) creating meaning units from the content of the transcription by completing line by line coding process, and 3) conducting a review of all the meaning units from both focus groups to develop emerging themes to answer the research

question (Saldana, 2016). This systematic process is inductive, involving the conceptualization of themes from empirical data (Creswell & Poth, 2018).

Trustworthiness

To increase the trustworthiness of the data, the researchers triangulated the data. Triangulation can also deepen the conceptual understanding of the variable of interest (Kern, 2018). For this study, the researchers utilized investigator triangulation to confirm the findings and add breadth to the phenomenon of interest (Kern, 2018). The researchers held an initial meeting to discuss meaning units and to ensure consistency in the data analysis process. Subsequent meetings followed to discuss the emerging themes, clarify, and condense the themes, and ensure developing themes were consistent with research questions.

Results

Following the structured and intentional data analysis, the researchers identified four different themes regarding practitioners' perception of recovery while delivering Medicaid covered services. The four emerging themes included: (1) increased hope and independence, (2) collaboration leads to comprehensive and holistic goals, (3) lack of flexibility, (4) lack of clarity. All themes are discussed and supported with direct quotes from participants from the focus groups. Participant names were omitted to increase participant anonymity and maintain confidentiality.

Theme 1: Increased Hope and Independence

Hope is a cornerstone value of psychiatric rehabilitation, whereas staff must have the optimism that consumers can learn, grow, and recover (Pratt et al., 2014). Further emphasizing this aspect was their discussion of hope being an important aspect of the recovery movement. The participants in this study highlighted the concept of hope to support one's recovery. One

participant reflected, “Some consumers who believe that they couldn’t do certain things, now do realize they are capable and have hope that they are capable of achieving their goals.” Hope continued to be a construct very important to an individual’s recovery in this Medicaid reimbursement model, recognizing that one can learn skills and become more independent. One participant commented:

> So, it’s like we’re not here just for rides. We know the people we serve have strengths and we’re here to teach them how to be able to utilize services and the point is they become independent and it gives them hope to see others make changes.

Building on one’s strengths to promote independence supports the work of Frost et al. (2017). Promoting skill development and supporting independence improves the relationship between a service provider and a service recipient. One participant in this study discussed:

> At this point, we’re decreasing a co-dependency or an enabling type of relationship. I don’t want to say enabling, I want to say I’m not going to do grocery shopping for you, I will teach you how to budget and how are you going to get on the bus and how are you going to get there.

In this fiscal environment, hope and independence are paramount in defining recovery. Practitioners continue to perpetuate the key aspects of recovery, leading to the ever-evolving, complex dynamic.

Theme 2: Collaboration Leads to Comprehensive and Holistic Goals

To support independence and add to the definition of recovery, practitioners illuminated the importance of collaboration and the holistic nature of services. Swarbrick (2006) highlighted the connection between a holistic approach and its improvement to one’s quality of life, one of the three goals of psychiatric rehabilitation (Pratt et al., 2014). In Medicaid service models,

emphasizing a more comprehensive, holistic approach to recovery is in stark contrast to the medical model approach of the past (Dalum et al., 2015). One participant responded, "We are learning more about all the different dimensions rather than mental health symptoms and medications, moving more toward wellness." A perspective shift in the definition of recovery is in line with the current trends of mental health services (Slade et al., 2014; Spitzmueller 2014).

To implement this approach in the current fiscal environment, practitioners ground their work in specific documentation practices. For CSS, and many other Medicaid covered services, practitioners collaborate with consumers to complete a comprehensive rehabilitation needs assessment identifying areas of needs and highlighting specific goals to work on. The CSS assessment covers 13 distinct areas of a person's life, supporting a holistic approach to recovery. The documentation lays the groundwork for a collaborative and more comprehensive approach. One participant reflected, "The documentation captures a lot more information that allows [the staff] to provide more comprehensive services." As practitioners begin the service delivery emphasizing collaboration and a holistic approach, they continue to support the current trend and emphasis in the definition of recovery.

Theme 3: Lack of Flexibility

Though the Medicaid covered CSS services lean toward a more holistic approach, practitioners perceive less flexibility in providing services. Flexibility concerns continue to be raised by service providers, as the shift to billing Medicaid penetrates the mental health field. Slade and Longden (2015) reinforced the notion of service provider perceiving the need to fulfill service criteria requirements as well as a structured format (Spitzmueller, 2014). For example, billable services need to be pre-authorized and indicated on a person's individualized

rehabilitation plan (IRP). Therefore, service providers are limited to only providing services based on the plan if they want to be reimbursed. One participant in this study discussed:

> We've booked our schedule so tight because of the budgetary necessity of what we're doing now, that there's not a lot of extra time. Or like, if there is a cancellation and we have to reschedule, when we get there, we may not have a certain amount of time and may have to leave earlier to get to the next one.

From a practitioner's perspective, the lack of flexibility limits what can be done to support recovery, ultimately influencing the recovery movement. For example, one participant commented, "Sometimes [individuals served] don't want to only focus on what is on the plan, decreasing engagement in community events."

While practitioners focus on the services outlined on the IRP, they tend to shift the narrative and definition of recovery to one that is tethered to the plan. Participants in this study continued to emphasize the struggle, as it relates to one's recovery, because of the emphasis on billing, related to the number of units of service. There was a resounding commentary on the "focus on the numbers" by participants, enhancing the theme of less flexibility and shaping the perspective of recovery.

Theme 4: Lack of Clarity

As with any transition, until the process is fully implemented, uncertainty may shape the process. In this case, uncertainty has shifted the definition of recovery. With services closely connected to the plan and flexibility diminished, conflict may arise between service providers and service recipients (Spitzmueller, 2014). The conflict as the participants in the study referred to as "inherent resistance to change," alter the rapport and create a barrier to recovery. One participant commented:

> Because of the changes impacting the rapport that staff have built and because of the things we can't do anymore or are unsure if we can do that, [individuals receiving services] are not meeting with us.

With participants refusing to meet, services may not be rendered, and individuals may not be able to fully actualize their unique definition of recovery. Instead, service providers are working on creative and effective strategies to engage consumers. For example, one participant discussed, "... [the staff] have to push themselves to a higher level to keep individuals engaged, and that's been a struggle and we lost some people." When services are impacted, due to the new payment structure, the notion and definition of recovery is altered, leading to more uncertainty of what recovery is and how individuals define recovery.

Discussion

The practitioners in this study shed light on the complexities of delivering Medicaid covered rehabilitation services that aim to promote recovery. Although reimbursement requirements dictated the types of services delivered, practitioners saw a positive impact. Providing recovery services that focus on skill development proved to empower some service recipients to be more self-reliant. Additionally, approaching recovery from a holistic perspective proved beneficial. Particularly, it broadened how both practitioners and service recipients viewed recovery. Rather than solely focusing on mental health and related symptoms, recovery was seen as part of all aspects of a person's life. Practitioners could more readily collaborate with service recipients on setting goals to achieve recovery as they defined it. Deegan (1993) reminds us that stigma around mental health can be debilitating and result in service recipients internalizing the role of a patient. Therefore, conceptualizing recovery as addressing all aspects of a person's life makes it more universal and applicable to any individual regardless of ability.

Integrating recovery approaches into behavioral health policies can play a pivotal role in practice. More specifically, if mental health authorities make recovery a priority, then it sets an expectation for programs and practitioners to make it a part of service delivery. However, simply including recovery principles into policy is not enough. While the practitioners in this study shared positive experiences when using recovery approaches there were also some unintended consequences given the fiscal climate. Due to agencies focus on billing Medicaid, practitioners felt pressured to deliver services that would generate reimbursement. The emphasis on agency revenue can diminish service quality and the individual nature of the recovery process. Individual needs fluctuate, so practitioners need to have flexibility in the recovery approaches they use.

Study Limitations

Although this study provides insight into practitioners' perceptions of recovery in a fiscally driven environment, the views of service recipients are absent. The voices of the individuals receiving services are important and should shape how practitioners work. Relying solely on a practitioner's view of recovery can minimize the value of the life experiences and aspirations of service recipients. Another drawback was the lack of demographic information collected from the focus group participants. For example, it may have been helpful to examine whether there were certain ideologies about recovery based on a practitioner's discipline (e.g., social worker, counselor, nurse), tenure in the field, and/or personal mental health history. An additional study limitation was the method of data collection. A focus group may increase the idea of groupthink, leading to less individualized perceptions (Woodyatt et al., 2016).

Future Research

Future studies that explore perspectives of individuals receiving services could provide useful information for policymakers, agencies, and other community stakeholders as it relates to recovery approaches. It is critical to examine whether service recipients have shifted their view on recovery, given behavioral health evolution. Further, it would be helpful to better understand their view on the services they receive and how they may have changed. Collecting data directly from service recipients would enable agencies and policymakers to understand both the strengths and areas for enhancement related to recovery that still need to be addressed.

Conclusion

Recovery is not monolithic. Yet, billing structures like Medicaid look to outcome measures to assess progress. In this case, identifying ways of measuring recovery may be challenging. The recovery process is unique and requiring practitioners to view it primarily in terms of outcomes could diminish the humanity and individualization that is so important to rehabilitation services. As such, the collaboration between policymakers, service recipients, and practitioners to determine practice implications is key. While fiscal constraints cannot be ignored, helping individuals reclaim their sense of self and see themselves as more than just a diagnosis should be prioritized.

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Appendix A

Introductory Statement

Good morning/afternoon. Thank you for agreeing to be a part of this focus group for the research study that will explore the experiences of supported housing agencies transition to a fee-for-service model. I appreciate your willingness to voluntarily participate in this study. Before we begin, I want to remind you of the topic we will be discussing. I will ask you questions about your experiences during the transition to Community Support Services. This focus group should last approximately 90 minutes. As a reminder, I will be recording this focus group and taking minimal notes so that I can transcribe the interview for data analysis later. The recording will be safely stored with passwords for confidentiality. Your information will be kept confidential upon publishing. If there are questions you do not want to answer, please let me know. If at any time and for any reason, you would like to end the interview, please let me know. Just a reminder, participation in this research study is voluntary and you can remove yourself at any time and for any reason. Do you have any questions for me before we get started?

Introductory Question

- Can you please tell us your name, position, and agency that you work for?

Interview Questions

- Questions related to consumers:
  - Tell me some of the positive benefits for consumers regarding the transition to Community Support Services.
  - Tell me some of the barriers for consumers regarding the transition to Community Support Services
  - Tell me some of the solutions for consumers regarding the transition to Community Support Services
- Questions related to direct care staff:
  - Tell me some of the positive benefits for direct care staff regarding the transition to Community Support Services.
  - Tell me some of the barriers for direct care staff regarding the transition to Community Support Services
  - Tell me some of the solutions for direct care staff regarding the transition to Community Support Services
- Questions related to agencies:
  - Tell me some of the positive benefits for agencies regarding the transition to Community Support Services
  - Tell me some of the barriers for agencies regarding the transition to Community Support Services
  - Tell me some of the solutions for agencies regarding the transition to Community Support Services

Concluding and Closing Statement

Thank you for again for your time today. I really enjoyed learning more about your experiences. Do you have any questions for me as we wrap up? Please feel free to contact me following this focus group with any additional questions or other possible participants for the study. Thank you.