CHAPTER 9 TABLE OF CONTENTS

CHAPTER 9: SYSTEM OF CARE: THE ROLE OF ADAMHS BOARD AND PARTICIPANTS’ RECOMMENDATIONS TO IMPROVE THE SYSTEM OF CARE...387

9.1 Introduction ...........................................................................................................................................................387
9.2 Role or function of the ADAMHS Board .............................................................................................................387
    Table 9.2.1 Role/Function of ADAMHS Board ....................................................................................................387
9.3 Recommendations to address needs for substance use and mental health services .................................................................388
    9.3.1 Individual needs ............................................................................................................................................389
    9.3.2 What individuals need from agencies and service providers ....................................................................389
9.4 Community, system of care .....................................................................................................................................390
    9.4.1 Funding reimbursement, and staffing .........................................................................................................390
    9.4.2 Prevention .....................................................................................................................................................391
    9.4.3 Accessibility ..................................................................................................................................................392
    9.4.4 Coordination and integrated care ..................................................................................................................393
    9.4.5 Social determinants of health ......................................................................................................................394
9.5 Conclusion ..............................................................................................................................................................394
CHAPTER 9: SYSTEM OF CARE: THE ROLE OF ADAMHS BOARD AND PARTICIPANTS’ RECOMMENDATIONS TO IMPROVE THE SYSTEM OF CARE

9.1 Introduction

This section provides a narrative summary of the open-ended responses of both the Executive Directors and providers. To begin the table below shows the frequency a role or function was mentioned in respondents’ comments. Here, it is important to note that this table reflects the number of times a role or function was mentioned as respondents may have mentioned more than one in their response. Additionally, it is not possible to discern whether respondents were thinking of the Board’s actual role, or the role(s) they thought the ADAMHS Board should fulfill. Regardless, responses can provide insight into how respondents view the Board.

9.2 Role or function of the ADAMHS Board

Table 9.2.1 Role/Function of ADAMHS Board

<table>
<thead>
<tr>
<th>Role or Function of the ADAMHS Board</th>
<th>ED N=34 (%)</th>
<th>Providers N=52 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding/Resources Fill the Medicaid Gap; funder of last resort, grant funding</td>
<td>18 (53%)</td>
<td>30 (58%)</td>
</tr>
<tr>
<td>Oversight/Accountability, Audits, quality Improvement, licensing</td>
<td>5 (15%)</td>
<td>11 (21%)</td>
</tr>
<tr>
<td>Advocacy</td>
<td>5 (15%)</td>
<td>7 (13%)</td>
</tr>
<tr>
<td>Planning</td>
<td>4 (12%)</td>
<td>6 (12%)</td>
</tr>
<tr>
<td>Coordinate services for agencies and “hub” for clients</td>
<td>3 (9%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Support/Support Innovation/Guidance, assist in delivery, help agencies</td>
<td>5 (15%)</td>
<td>15 (29%)</td>
</tr>
<tr>
<td>Evaluation, collecting data, Epidemiology; assess community need, monitoring</td>
<td>5 (15%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Training, Guidance</td>
<td>4 (12%)</td>
<td>11 (21%)</td>
</tr>
<tr>
<td>Access/Assure services available for all, treatment</td>
<td>4 (12%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Leadership in times of crisis/Provide Direction/Lessen impact on Economy</td>
<td>1 (3%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Provide Referrals</td>
<td>1 (3%)</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>Integrate services. Enhance system operations (system of care), efficiency, system support</td>
<td>2 (4%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Ethical Services/Investigate allegations of client abuse/client rights</td>
<td>0 (0%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Dispenses funds from federal, state and county to county agencies</td>
<td>1 (3%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Both the Executive Directors and providers found that providing funding and resources was the primary purpose of the ADAMHS Board. Several respondents indicated that the ADAMHS Board’s purpose was to fill the Medicaid gap, for example, by serving as the funder of last resort. Oversight, accountability, and advocacy, especially with the state,

http://www.adamhscc.org/
was each mentioned by 5 respondents. Planning, coordinating services and providing
support and guidance were mentioned by three. Evaluation, training, assessing
community needs for services and monitoring was mentioned by 5 respondents.
Increasing access were each identified by two respondents. One respondent indicated
that the role of the ADAMHS Board was to dispense funds from various levels of
government (federal, state, and county) to county agencies.

Some of the feedback from executive director surveys were less than positive. For
example, one respondent suggested that there was a healthy dose of animosity that
existed between the ADAMHS Board and the agencies. Another suggested that
perhaps the Board was less relevant, following Medicaid Redesign, since most of the
agency’s funding came from Medicaid, that was managed by the state and the MCOs,
with the ADAMHS Board having less control over funding.

While providers’ comments also reflected the role of the ADAMHS Board in funding,
there seemed to be more of an emphasis on the role of the ADAMHS Board in
supporting agencies, quality improvement, training and enhancing and integrating
services. Three providers suggested that it was the ADAMHS Board’s role to make
services as ethical as possible, to support client rights, and to investigation allegations
of abuse of clients’ rights. One respondent suggested that the ADAMHS Board could
think about being more of a “cheerleader” for agencies, to inspire and motivate them.
Generally, when hearing from the ADAMHS Board, they brace themselves for criticism.
According to one respondent agencies are doing the best they can with what they have,
and the Board is often expressing disappointment with the outcomes.

In a more aspirational tone, one respondent indicated that the ADAMHS Board’s role
was to assure services were available to all, while another simply used the word,
“treatment.” Here, it wasn’t clear whether the respondent meant assure that treatment
was provided, or that the ADAMHS Board was a treatment provider. To close, one
provider clearly saw the ADAMHS Board as playing a crucial role, by stating that the
ADAMHS Board was “…the voice of reason and the hope for the community of mentally
ill persons and those who suffer from chemical dependency.”

9.3 Recommendations to address needs for substance use and mental health
services

Following is a summary of recommendations to improve Cuyahoga County’s response
and capacity to address mental health and substance use. These summary
recommendations are gleaned from focus groups, provider and executive director
surveys, and executive director interviews. They are grouped into three broad areas,
individual needs, agency and provider needs and recommendations, and system-wide needs and recommendations.

9.3.1 Individual needs

Several participants in focus groups and interviews discussed attitudes and support, that may contribute to a sense of self-efficacy. These include hope and or spirituality, and acceptance. In terms of hope, individuals need to believe and know that the help they are being offered will actually help them; that the help being offered will be worth the time and effort and make a difference.

In terms of support and treatment, individuals need to know where to go, a better understanding of treatment, and an open ear, or someone who will listen to them. Individuals could benefit from stability, or continuity in how short and long-term services are provided and a road map to success. Others mentioned skills, such as learning how to be productive, life skills, finance skills, work training and employment skills, and how to keep a job. Individuals also need to learn how to manage their own impulsivity.

9.3.2 What individuals need from agencies and service providers

Several respondents mentioned concrete services such as providing basic hygiene products and other amenities (clothing, food). They need stable, sober housing before they can move on. Once they are finished with treatment, they need more long-term services, such as services SNAP benefits, housing assistance and Medicaid. Supportive literature such as AA/NA and other associated readings are needed. Several respondents indicated individuals needed a Universal Basic Income; they need resources, childcare, help around the house and having basic needs met.

Adolescents may also need academic help. Providers may try to make recommendations for their academic needs, but the advocacy doesn't always come through or result in getting adolescents the academic help they need.

Families need education on the treatment process. For example, families need help understanding how to cope with their emotions when their loved one is receiving services, and the next steps in treatment. Families of young children need support groups, and education on how to find programs. Overall, families need more support services.

Providers of MAT need to comfortable in their role as they prescribe medications. When providers are anxious, or appear anxious, patients may sense their anxiety and may
themselves become anxious. Providers of MAT could use a graphic presentation of what they can do, to assist them in conveying confidence to their patients. Providers may not be as well-versed on Vivitrol (naltrexone) when compared to Suboxone (buprenorphine-naltrexone). Overall, providers of MAT may need more education. One respondent indicated that MAT could have a force magnifier effect. There are probably a lot of providers who could provide MAT, but who don’t.

It was noted that we, as providers have lots of rules and we are working with individuals who are not necessarily rule-bound. We need to focus more on meeting the client/patient within the parameters of what they are willing to do. For example, the rule may be that clients must be in IOP in order to receive MAT, but what if they are not willing to do IOP at this point? There is a lot of rigidity in providing MAT but this is the population that doesn’t need rigidity. For example, they still need Suboxone but what if they are still using other substances?

In addition, many clients first express their mental health and substance use concerns with their primary care provider (PCP). The PCP might feel uncomfortable, may not know what to do, and may have own attitudes, biases. Many individuals trust their PCP the most and struggle when this person is not supportive. This can also happen in the ER room, where the health care provider may “punt” and look for the social worker. There is little ownership of this aspect of health.

9.4 Community, system of care

There were three major themes that came through, from surveys, focus groups, and interviews: funding and reimbursement, more emphasis on prevention, and a greater need for coordination, collaboration, and integrated behavioral health care. Harm reduction approaches also emerged as a theme, as illustrated in the comments above, regarding balancing clients’ needs with system requirements.

When reviewing these comments, it is important to note that information provided here reflect participants’ comments. Thus, they reflect their perceptions and their reflections on their own experiences and may or may not reflect actual circumstances or policy.

9.4.1 Funding reimbursement, and staffing

In terms of reimbursement and funding, some of the comments were: the importance of paying providers and professionals more, and consideration of a third-party payer system which may deny services. Raising the salary of providers could contribute to workforce stability and overall quality of care. There was concern expressed by several
respondents regarding the role of MCOs in determining the level and type of services that were authorized for reimbursement. As an example, providers were recommending residential treatment for an adolescent, and the residential service was denied because the adolescent was “only using weed.” Providers believed they were justified in recommending residential treatment and did not agree with the rationale for service denial.

While there were several suggestions for specific increases in funding, there was a general sentiment that all could benefit from more services. Specifically, it was suggested that there be increased funding for 1) CDCAs and counselors to obtain higher education and licensure to provide accessible and higher quality service, 2) funding for more holistic services like art and music therapy and entire continuum of care; and 3) an increase in rate of reimbursement for OP services; 4) supportive housing options for OP clients to provide a safe sober stable place to live while attending treatment 5) more funding support to bridge the gap between actual cost of MAT and current Medicare reimbursement, 6) Per diem increases, 7) more detox beds and diversion of jails to detox, 8) more funded positions in schools to allow multidisciplinary teams to treat families, 9) need a respite center as some shelters are not safe for vulnerable homeless, 10) more crisis stabilization beds, 11) increase funding for IOP. Reimbursement for IOP has not gone up since 1997); 12) an increase in services for pregnant women and women who have children; 13) Increased discretionary resources to agencies to allow agencies to better pay staff.

In terms of the workforce, at least one respondent suggested that the shortage of professionals in this area is due to the lack of attractiveness (and money) of the field. There is also a shortage of bi-lingual professionals, and there may be more need for a bi-lingual psychiatrist. It was recommended that the county recruit a provider from another country to meet this need.

In terms of funding agencies and programs, one respondent noted that there still seems to be a “good ol boy” network in the county. Agencies who are favored by funders or who employ friends/family of those in power receive an inordinate number of referrals and or funding from county courts and agencies.

9.4.2 Prevention

For prevention, it was suggested that providers be more flexible with individuals. Different things may work for different individuals. For example, maybe a TV show or a book might be helpful. The system needs to be more flexible with individuals who might never step foot into a psychiatrist’s office.
Prevention should start with children and young adults. Teach children in school what to do with those “big feelings”. This may also reduce the stigma around mental health, and people making jokes about it. Why not have mental health check-up or as part of a physical check-up. The earlier we’re able to pursue issues developmentally the more able we are to teach people how to manage feelings going forward. Overall, prevention seems to have been abandoned, according to the point of view of one respondent.

9.4.3 Accessibility

Regarding accessibility, just getting into the door can be problematic, especially when needing MAT. The buildings themselves can be intimidating. They can be loud, big, chaotic, and with a lot of people in waiting areas. Systemic racism and neighborhood blight also make it hard to access services. We need to get people in right when they want it and have the ability to capitalize when they ask for help and get them right in. First people have to overcome the limitation to seek help, and then are told to wait. When the window of perceived crisis ends, they are less likely to follow through with seeking services.

Lots of people who need services aren’t able to come in due to family and work commitments and other possible constraints. There needs to be more outreach to those who are not able to make it into the office, as well as some way to identify people and provide services, even if they aren’t able to come in during prescribed times.

To increase accessibility, we could create a booth at homeless shelters. Patients can access care there and are able to call and get telehealth at the moment. Physicians could be reimbursed and talk with a psychiatrist and clients could have their needs met. There are places in the country who have this model. But it is harder to implement strategies such as this when sticking with fee for service as a model for reimbursement. There are ways to leverage Medicaid to allow for such innovations. “Tell Scott this is a good idea.” We need to move away from fee for service and focus more on population-based services.

It was noted that there are not many psychiatrists available after 5, outside of ER. The ER is more expensive. But clients may find it difficult, as they have to take time off from work, which may not be allowed by their supervisor; plus they may not get paid when taking time off and could fear losing their job. Later in the day would be very helpful and often not available. This is where telehealth could also benefit. This is magnified when providing services to children, youth and adolescents, who have to come out of school, and parents must come out of work. A Saturday clinic could help.
9.4.4 Coordination and integrated care

Regarding coordination, there were several recommendations. To start, one respondent suggested that all providers should become dually certified so that issues are not treated in silos. There should be more collection and sharing of data associated with treatment and better medical record sharing.

Several comments suggested the need for increased care coordination, the development of a more systematic continuum of care, and the development of additional integrated behavioral health care approaches. By keeping mental health and substance use in silos, we emphasize the stigma. Clients with co-occurring disorders may be better served in an integrated system of care. Overall, there needs to be more substance use treatment centers that can treat individuals with mental illness. Many locations will not accept patients who are on antidepressants or mood stabilizers. Persons with co-occurring disorders continue to fall through the cracks.

The system is set up so that providers deal with person in front of them; the person who is able to come in, and reimbursement is consistent with this approach. As we move into a more population health direction, this will change.

One respondent asked whether services would be more beneficial if they were more centralized and we had fewer providers? Do we need to restructure the system?

Consider implementing a Center of Excellence for Evidence-based interventions. Evidence-based therapies are incredibly expensive and there is a high turnover among staff. (Researcher’s Note: information on the model for such centers can be found at the website for the Agency for Healthcare Research and Quality. (https://www.ahrq.gov/research/findings/evidence-based-reports/overview/index.html). One of the key functions of such a service is to provide technical assistance to professional organizations, employers, providers, policymakers, and to translate research reports on evidence-based interventions into quality improvement tools, evidence-based curricula, and reimbursement policies.

Rather than fee for service, we need a value-based payment system, that is similar to what is happening in physical health care. Mental health and substance use need to get on board.
9.4.5 Social determinants of health

In terms of society and the community, there is a lack of serious representation of substance use in the media; and denial of the issues associated with substance use.

More attention needs to be paid to the social determinants of health, such as childcare for mothers and parents. There should be more of a recognition that clients are also responsible for other people; they themselves are caregivers of children, and others.

9.5 Conclusion

This chapter began with a discussion of respondents’ perceptions of the role of the ADAMHS Board. It is apparent that executive directors and providers largely viewed the Board as fulfilling a myriad of roles. The next section summarizes participants’ perspectives on how services could be improved. Many participants recognized a need to support individuals, agencies, and providers and that all have a role in recovery and providing individuals what they need to get better. Major themes that emerged were the need for an increased emphasis on prevention, care coordination and developing integrated behavioral health or service delivery models, and consideration of the social determinants of health, especially for at risk and vulnerable populations.