Nassau County Stakeholder Forums

Key Themes and Take-Aways

1. Communication – between physical health provider and behavioral health provider, even within a single institution; between inpatient service and community-based health provider; between inpatient service and community agencies; between County and the health care provider system; between behavioral health providers and the criminal justice system; between mental health and chemical dependence providers; between providers and health home.
    - Very few have electronic linkages; agencies use different EHRs, and only a limited number have interfaces.
    - People are afraid to share information because of confidentiality concerns.
    - Systemic barriers remain a problem – health home consents, HIPAA consents, and concerns about liability issues.
    - No centralized source of information about community resources exists, so it is hard to provide one-stop support for a family with multiple needs.
    - Everything is siloed. The history of communication between siloes isn't great, and largely relies on personal relationships. Informal relationships sometimes exist between hospitals and agencies/community-based providers, but no formal protocols are in place to alert others when an individual is hospitalized.
    - Getting medical feedback about an individual receiving chemical dependence services is very difficult, regardless of where they're receiving primary care (hospital clinic vs. FQHC vs. private physician – "They're all bad.")
    - Poor communication between hospital and SNF contributes to hospitalizations and readmissions for concerns that could be resolved with a phone call.

2. High quality clinical assessment/triage needs to be available 24/7
    - If a home care patient needs clinical advice after hours, frequently the person answering the phone at the agency is not a clinician.
    - When someone in a residential I/DD setting needs care after hours, the only option is to go to the ED. The availability of urgent care specifically for this population in one center 24/7 would reduce both ED visits and admissions. Medical back-up to assist RNs in triage decisions would support decisions not to hospitalize.
    - Many admissions from SNFs occur on the weekends because no physician is available to assess them in the facility.
    - Co-location of psychiatric social workers in an urgent care setting.

3. Care coordination needs to be strengthened

- Care coordination is increasingly shifting to a telephonic interface, which is not typically sufficient to support the management of chronic conditions.
- A disconnect exists between different siloes; regular communication between MLTC, health home, and CBOs involved in an individual's care is necessary.
- Linkages between behavioral health and physical health services are not working well. Behavioral health providers need information about the physical health needs of their patients, but do not find receptivity, from either the hospital or the primary care setting.
- Health homes are an incomplete solution. Health homes were meant to expand case management, but lack of shared EHRs and inadequate resources has limited their impact. Health homes have not developed consistent connections with hospitals and other providers. The HIV community is particularly unhappy with health homes, as it has led to a significant reduction in case management (by increasing case load size.)
- Connections between care management and social service supports are largely informal, and follow-up is not consistent.

4. Patient education and self-management support need to be enhanced
    - Patients with chronic conditions do not know what to do when they experience signs and symptoms of a worsening condition, so they call 911.
    - Family members need to be included in treatment planning for people with I/DD, making sure they can explain back the information and instructions given. This extends to care-givers as well, who frequently have a low level of education and for whom English may not be their first language.
    - Patient education needs to reflect language/culture/ literacy of the communities.
    - Additional patient/family education is needed on the capabilities and limitations of a SNF, with better communication about advance directives.
    - There is a need to raise awareness about I/DD, especially within the Latino and Haitian communities, to improve early diagnosis and intervention. Language access, especially for families of origin and for care-givers, is a challenge for those managing complex chronic conditions.
    - Targeted educational interventions are needed to reduce unnecessary ED visits, e.g., not necessary to send everyone who has had a seizure to the ED.

5. Medication adherence can be a problem
    - Cost can be a barrier, especially for uninsured. But even for Medicaid patients, co-pays can be onerous for those taking multiple medications.
    - Physicians are not aware of what drugs are on the formulary. Unless a pharmacist intervenes with the provider, patients facing prior authorization requirements will fail to fill a prescription.
    - Literacy and health literacy, especially for individuals where English is not their first language, presents communication challenges in managing complex chronic conditions.
    - Remote medication management would be a big help in addressing chronic conditions.

- Many immigrant communities are afraid of medication and resistant to on-going reliance on medication.

6. Housing – the lack of stable, affordable housing was mentioned in every session.
   - The ability to manage chronic illness and avoid hospital care is much more difficult when housing is sub-standard.
   - For homeless, challenge of maintaining connections to providers as a result of transience.
   - Housing vouchers are inadequate to meet the cost of housing, and all emergency housing programs have wait lists.
   - Home environmental triggers exacerbate certain conditions.
   - Being able to maintain care coordination is difficult when population is transient. Patients change address and phone frequently, contributing to high no-show rates.
   - The number of people seeking shelter through the emergency shelter system with substance use and mental health complications is up sharply in recent years.
   - In order for ambulatory detox to work, you need to have a stable home to go back to.

7. Transportation
   - The size of the county, the limits of the public transportation system, and the limitations of the available transportation programs (Access-a-Ride, Able-Ride, Medicaid transportation) restrict access to care, make treatment adherence more difficult, and lead to reliance on 911.
   - Transportation for services that are not medical/treatment-related do not exist, and so valuable programs are unavailable for many people.

8. Language/Cultural Issues
   - Lack of services in languages other than English is a problem across the board. It contributes to disparities in outcomes, as well as to compliance with treatment.
   - Language barriers are a particular problem in behavioral health services.