HMA

HEALTH MANAGEMENT ASSOCIATES

Nassau County Stakeholder Forums

PREPARED FOR
THE NASSAU COUNTY COLLABORATIVE
DSRIP QUALITATIVE DATA REVIEW

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Immigrants and the Uninsured
September 17

Barriers to Access

- Lack of insurance is a major factor.
- Knowledge – not knowing what services are available, what services are accessible re: language and cultural competence.
- Nassau has limited sliding scale programs, and it takes a long time to get a first-time visit, or even a follow-up post-ER visit. When doing community outreach, it will sometimes take over a month to get them connected to services. People are encouraged to make an appointment when they aren't sick and in need of immediate care, so they can become known to the system and establish a health history. Once a patient is known, it is much easier to get appointments quickly.
- Patients who are undocumented don't trust the government; don't trust the people in health care delivery. It takes a concerted educational effort to get people to understand that services are available to them.
- Families are afraid to talk to government agencies because of their immigration status. They go to other agencies in between, such as a church or the school.
- Language: it's easier to trust someone that speaks your language and looks like you. The doctors and nurses out there don't look like the population that's being served.
- Language is particularly problematic for behavioral health services. It is difficult to do a behavioral health evaluation through an interpreter.
- For undocumented, they look at health care as a quick fix, wanting to get a problem resolved immediately rather than seeking an on-going relationship with a primary care provider. Trust is a challenge – people seek to be invisible due to fear about immigration status.

What is Working

- The FQHCs are well-located, in very busy areas with high visibility. They are strategically placed in very high-immigrant communities.
- FQHCs provide comprehensive services and adequate care, but that doesn't resolve Nassau's challenges of geography and lack of services.
- In cases where health services are co-located with other services, it facilitates collaborative work and provides entrée to other things. Colleagues are willing to help link clients to other needed services, but it's based on personal relationships rather than policies or procedures.
- Churches and CBOs have a reputation in the community for helping patients and have the community's trust. Religious groups are often the frontline emergency assistance providers, and will respond to health care needs. Providers and CBOs work with churches to promote health insurance enrollment and connection to care, but those are informal relationships.

- Schools are an important resource. It is a trust issue – there is a perception of trust within the education system, probably more so than any other system that the family can tap into. Having services such as behavioral health, dental available at a site where every child is going would be ideal. We need to be thinking differently about how we provide are for people.

What's Not Working - Delivery System

- Stand-alone physician offices that are unaffiliated and work on a sliding scale.
- Pop-up storefronts like where you can get your taxes done: "the storefronts pop up knowing that people are in dire need of filing their taxes and getting some amount back so they pop up and charge a ridiculous amount. In some ways it feels like health care providers are doing the same thing." People use these sites, but they don't create a permanent primary care provider or a medical home; they are just an easier place to go as compared to an ER.
- Transportation issues contribute to inability to regularly access care, resulting in ER visits as the place to go for reasons of accessibility and cost.
- For the uninsured, post-hospital care is a huge challenge. Hospitals can get emergency Medicaid for an inpatient stay, but it is very hard to find post-acute services (rehabilitative care, hospice, home-based nursing and other supportive care) to be able to discharge an uninsured individual.
- Health plan outreach workers can connect new enrollees to a primary care provider at the time of enrollment, but if someone is undocumented and uninsured, they have no way to link them to care.
- Lack of mental health services is a huge problem, especially for children. Everybody has waiting lists. Medicaid reimbursement for mental health centers have been cut, decreasing their capacity to serve clients. Nassau has cut funding to every mental health agency.
- Nassau County is receiving very large numbers of minors arriving from Latin America, and all are suffering from trauma. This exacerbates an already over-stressed mental health system.
- While the County agencies have tremendous interaction with the public through the Department of Social Services, they do not have enough resources to communicate in other languages. "Certainly there are not adequate services for those with limited English proficiency.

What is Needed - Communication

- While there are web sites that list all of Nassau County's sliding scale programs, financial assistance, and insurance, the most successful outreach strategy is being out in the community sharing information directly.
- We need to create communication and/or house the communication across agencies so that we all know what services are actually available.

What is Needed

- Community Health Navigators will be necessary because it's not just the physical health piece, it's all the other social health pieces. For people needing a place to live having individuals that are well-versed in housing at the same time that they can provide support on health care as well will be important.
- It is really hard to find an entity that can do a comprehensive evaluation of an individual family's needs, and how those needs can be met. There are a lot of moving parts, and it is hard to know where to refer people.
- Looking at the whole family and looking at a child within a community, as part of a community.

What Would it Take?

- Universal health coverage that includes immigrants
- More community-based services
- Better communication across providers
- Greatly improved transportation

Dual Eligibles: Skilled Nursing Facility
September 22, 2014

What Works

- Some SNFs are equipped to serve as a med-surg unit of a hospital.

What's Needed

- **Need a vested full time medical director that drives quality with coverage on weekends. Need RN's for clinical care management.**

Inadequate clinical coverage in the SNF results in hospitalizations/readmissions. Most SNFs have an LPN staff whose scope of practice does not allow them to do assessments. Bachelors-prepared RN are required to care for many of these patients. The fact that patients are being released sooner after surgery further increases the need RNs.

Rep from SNF: "Many admissions arrive Thursday night, Friday night or even on the weekend." "SNFs are taking more pts directly from home, PCP offices, from the ED – you need very strong clinical skill set embedded in the organization when those patients arrive to discern [what they require clinically]." "…or else that patient may turn around and go right back to the hospital."

- **Need continuity of providers and continuity of treatment plan implementation.**

Lack of provider continuity and poor hand-offs result in poor implementation of the treatment plan which may results in preventable hospitalizations/readmissions. SNF sometimes changes to a lower cost medication to be able to survive financially.

Potential solutions.

- Hospitalists to care for patients in the SNF to provide some level of continuity of care from hospital to SNF.
- Need to have evidence-based clinical protocols continued across settings.
- Need RNs – RN or NP liaisons between hospital/SNF/home. CMS grant-supported program was tested in several states.

Rep from SNF: "One of the hospitals that we're dealing with we are seeing a nurse navigator for about 6 months now and it has made a tremendous difference. They're there to help up discharge the patients; they're there to help us get resources that we need with home care."

- **Need improved communication between hospital and SNF**

Receiving call backs from the ED/hospital, obtaining a hospital report in a timely manner, and the ability to access/view medical records are critical to a safe return to the SNF. Relationships between hospitals and SNFs are important as hospital providers are more comfortable sending patients back to a SNF if they have a relationship with them and understand the capabilities.

Rep from SNF: "We have an interface with Huntington Hospital EMR. We've been utilizing the information and it's been wonderful, but I don't think there's anything that's going to replace a phone call in real time."

Rep from SNF: "One of the initiatives to reduce avoidable hospitalizations is to improve communications. We had our med director speak with the ED directors and I spoke to the nurse managers and said, 'We're going to call, we're going to let you know that we want the patient back. We can't do a CT scan but you can. Send them back."

Rep from SNF: "Sometimes we send a patient to the hospital just to request diagnostics, then the hospital finds a reason to admit but it might be something that we've been treating in place at the SNF. Improving the communication with the ED is critical."

- **Need to align incentives so that hospitals are not incentivized to unnecessarily admit**.

- **SNFs need support with discharge planning process**.
  This process can be overwhelming for patients and their families particularly if they are navigating this process for the first time. Assisting residents in getting Medicaid, guardianship, etc. would be of great support to the SNFs.

- **Need evidence-based protocols.**
  Treatment protocols would help with fear of liability for delays in treatment. Best if there were universally accepted protocols used among all nursing homes/hospitals. Many SNFs need to adapt current protocols because patients are being released from hospitals sooner, e.g., ortho patient coming to SNF on day 2-3 post-surgery instead of day 4-5; implications for pain management , therapy, assessment, family involvement.

- **Need to overcome barriers to retaining residents at the SNFs when appropriate.**

Rep from SNF: "The physicians hired by the SNFs that are unaffiliated with the hospitals are afraid to keep the residents in-house. 'Send them out, send them out.' And they don't want to come in on the weekends [so again they are sent to the hospital.]"

Rep from SNF: "If the resident is not a DNR, they automatically send them out [to the hospital.]"

- **Need patient/family education**.
  Patients and families need to: understand the role of the SNF versus the hospital, advanced directives, financing for long-term care; have realistic expectations for what the SNF can offer, realistic expectations on the healthcare trajectory of the patient, etc.

Potential solutions:

- Education for families to have reasonable expectations/culture change. This needs to start up-stream, perhaps a universal set of expectations, with community partners like senior centers, elder care attorneys, etc. that could spread the messages.
- Education of families to understand the capabilities and limitations of the SNF; a bridge from acute care to home. Patients/families are better educated/have more realistic expectation when they are being discharged by clinical care managers.
- Education of families regarding advanced directives/DNR

Repurposing:

The group anticipates a continued move towards de-institutionalization, but not everyone is on board with this, e.g., unions. SNF beds will be less in demand; the higher quality facilities will survive, the lower quality facilities will fold.

Rep from SNF: "SNFs in Nassau County are at about 91% occupancy which means on any given day, there are hundreds and hundreds of empty SNF beds."

Dual Eligibles: Community-Based Long-Term Care
September 22, 2014

What's Working

- Some providers have robust programs to avoid readmission, e.g., LIJ has disease management programs with tele-health for home care (video and audio), provide IV Lasix Includes transition care program /provide IV Lasix at home to prevent readmission/hospice and palliative care program works closely with hospitals to avoid readmissions

- Managed long term care and case management is improving transitions of care from hospital to home; the established relationships and protocols improve communication and reduce the possibility of patients falling through the cracks. The LHCSA is now joining with the MLTC; upon discharge the LHCSA gets alerted, the aide goes to the hospital and helps to ensure appropriate follow up in the home.

What's Needed

- **Patients and home care workers need consistent (24/7) access to high quality clinical advice.**

Accessible phone assessment and triage by a clinician that has access to patient records would be invaluable in managing a patient in place.

Rep from Home Care: "That's the heart of what we need to build. We need to build that response. Currently the person who picks up the phone at the [LHCSA or CHAA] after hours is not necessarily trained at the level they need to be to respond to medical questions."

Potential solution: Shared 24/7 contact center.

- **Patients need support to ensure that they are not discharged from hospital to a home environment that can't support them.**

This is particularly relevant when the patient lives alone, there is a lag between discharge and when the home health aid is placed, when discharge planners lack awareness of [new] programs for in home support, or the homecare services are insufficient to meet the needs. Unless the patient belongs to a plan and the plan verifies that they're safe to go back home, there really isn't anyone doing this; discharge planners are operating without information.

Potential Solution: Support CHHAs in being able to send RN liaisons to the hospital to assess the patient and bridge the communication gap between hospital and home.

Rep from Health and Social Services Org: "The frailest of the frail who are dual eligible often fall through the cracks. CHHAs are in for a certain length of time then the supports are discontinued; they exacerbate and wind up back in the hospital."

Rep from Health and Social Services Org: "When patients are discharged with inadequate home care services, they pick up the phone, they call 911, they go back to the hospital because to them, that is the safe place."

- **Need to improve communication between and among healthcare and social service supports.**

Regular interdisciplinary discussions between MLTC, Health Home and CBOs that are already involved in and knowledgeable about the client's home situation is critical. This is now happening in hospice and palliative care and is effective. Technology should be leveraged to improve communication. Alerts from hospital/ED to PCP, home care, MLTC, etc. are needed to ensure that everyone is on the same page in preparing for the patient to return home. An efficient system for patient consent to facilitate communication within the PPS is needed.

Potential Solutions:
Ensure integration of community services (e.g., Area Agencies on Aging and other CBOs) that go into the home and provide critical services to enable people to stay in their homes -- food stamp applications, housing re-certifications, Medicaid re-certification, etc.

Rep from Home Care: "There's always tension between the privacy issue and service coordination; I thinking we've gone a little too far on the privacy issue and sacrificed coordination of care."

- **Social Service Needs**
  - Available Transportation, 8 mile limit for Medicaid med transportation.

Rep from Health and Social Services Org: "Someone who had lived and had all their doctors around LIJ and because of finances moved a little further out; all of the doctors who know them well and have been taking care of them are no longer accessible to them."

  - Affordable Housing
  - Accommodations to make homes accessible
  - Assistance with home repairs, snow removal
  - Nutrition support, e.g., shopping services, Meals on Wheels eligibility/wait list

- **Healthcare Needs**

- Medication costs – disconnect between the physician's prescription, the formulary, and what patients are able to pay for medications
- Medication administration – some individuals could be very well managed at home if the health aide were allowed to administer medication, eye drops, etc.
- Not enough physician home visit programs
- Not enough psychiatry/mental health services; long wait lists for mental health services result in ED visits
- Access to pain management services is not good and patients wind up going to the ED. [iSTOP has been successful in preventing people from going from provider to provider to get controlled substances, it has also caused providers to give up their narcotics license and reduce access to pain management services.]
- Delays in placement of home health aides. The Department of Labor eliminated the companionship exemption which means any home care workers that works more than 40 hours was getting time and a half on minimum wage. Now, there's not going to be a home health aide in Nassau County that's going to be allowed to work more than 40 hours.
- Clients are most closely connected with a good aid; aides should be trained to become navigators of the healthcare system.

Chemical Dependency Services
September 22

What's Working

- County: "NUMC has one of the closest models to one-stop shopping where you can get primary care, you can get mental health, chemical dependency, all at one location, but most entities don't have that."
- Communication with the criminal justice system works better here because it is mandated, although there's a lot of variability across parole officers. Long Beach Reach: "Generally speaking, there is more communication from the criminal justice system and to the criminal justice system because, for better or worse, that marriage has been there, and the expectation and the requirements are there, so there's some letter writing and communicating that takes place, whereas on the medical side, it's never been the mentality that there should be this kind of coordination of care."
- Many clients have co-occurring disorders, and require access to an array of services, which are hard to find. Co-locating mental health with addiction services helps enormously.

What is Needed: Integration and Coordination

- Getting medical feedback about a client is very difficult, regardless of where they are receiving primary care (hospital clinic vs. FQHC vs. private physician – "They're all bad." Phone calls don't get returned.
- Community service agency: "Sometimes even within the hospital itself there's lack of communication between behavioral health and physical health, and while there may be communication between the behavioral health component and the community-based agency, we're still not getting the physical health information that sometimes can be really important."
- Personal relationships help, but it depends on the relationship the case managers establish with staff in medical offices, which are disrupted as staff turns over, rather than being based on formal linkages.
- Agreements between executives do not funnel down to line staff, who are not responsive. HIV provider: "The hospital execs may know, but that information is not filtered down to the line staff, nurse managers, department heads."
- Resources are needed: Even when medical records are shared, they are difficult to interpret. Agencies don't have medical staff available to interpret medical records for them. Trying to reach people by phone is always hard, and having designated staff times that could be devoted to making phone calls and getting callbacks would help.

- Electronic Health Records exist, but are not linked across agencies. Even within a health home there isn't interoperability. Individuals are expected to carry their paperwork and medical record with them. Clinical information is available through PSYCHES but it needs to be printed, and then a clinician has to interpret it for the counselors. Most agencies don't bother.
- The cost of EHRs puts a great burden on agencies. OMH provider: "For community-based agencies it's quite an obstacle to overcome because you have to lay out money that you really never had to lay out before, and all of a sudden you have to lay it out, and it quite a large amount."

What's Needed - Communication

- OMH provider: "We need to improve communication between the different services, whether it be mental health or physical health or getting feedback from the hospitals." Integrated physical/behavioral sites don't exist for most agencies in Nassau. "When a client is being seen by a PCP, or getting medication-assisted therapy from a physician outside of the agency, getting communication is next to nil." Getting communication from outside is very difficult.
- Everything is siloed. The history of communication between silos isn't great, and largely relies on personal relationships.
- OMH provider: "A patient of ours may end up in a rehab, in a detox, on a psych unit, in the ER, and we have no clue. We have no clue, and it really speaks to us as the addiction world, how do we improve the way we communicate… We need to look at what we can do now to improve our communication so that if somebody ends up on a psych unit and they are identified as being at Central Nassau that Central Nassau knows." The social worker working with a patient should know to immediately make a contact.
- OMH provider: "From even the inpatient units we're not getting an alert, you don't even get alerted they're coming back to you and you didn't even know they were gone, and they're back with no medication." Many of the OASAS programs do not have doctors there all day, every day, so getting medication in a timely way can be hard.
- Improving communication will require a change in mentality. A partnership is necessary that has a fundamental expectation that communication is going to take place. Youth and family service agency: "It needs to be a requirement. It is the expectation now, but it's still subjective… There are a lot of people that may do the bare minimum because they're overwhelmed and that should be just as important as finding an appointment, making that contact, that should go along with it, a liaison that just makes those connections."

What's Needed - Connections to Primary Care

- Providers in the chemical dependency system feel that the primary care providers are unaware of the chemical dependency world. Primary care providers are reluctant to deal with substance abuse patients, whether it's a question of willingness or capacity. In many cases the reaction is to get rid of them quickly. Chemical dependency provider: "The communication that a primary care site wants to hear is, 'can you come get this problem out of my waiting room in the next 30 minutes?'"
- County: "One of the justifications for the much higher caseloads in health homes was that there was going to be this ability to exchange clinical information in this electronic manner, which isn't on the horizons, and caseloads in health homes are much, much larger than they were, putting more pressure onto supported housing providers. " "The purpose was to expand case management outside of mental health, to bring in chemical dependency, to bring in physical health, and it's not happening."

What's Needed - Community Supports

- In order for ambulatory detox to work well, an individual has to have a stable home to go back to.
- Peer services do not exist in Nassau County. OASAS is establishing recovery centers across the state, but none exist on Long Island. There is an informal recovery network on Long Island, LIRA (Long Island Recovery Center). Agencies have informal associations and gatherings. The veteran community is good with peer support services.

What's Needed - Language and Cultural Competence

- It's difficult to recruit Spanish-speaking staff, especially at the clinical level. It's a challenge across the board. The Hispanic Counseling Center is there. Agencies use language lines, but it's not the same.
- On the substance side the Latino patient generally are mandated, not coming in voluntarily. As a result the population is more resistant to treatment.

What's Needed - Resources

- Long Beach Reach: "Resources for the case management, and resources for the treatment slots, both inpatient and outpatient. The reality is the big gorilla in the room here is that we want to save money and we want to have fewer people in the hospital. The reality is, there are people that need to be in the hospital and there are no hospital beds. There are some people who need to be in inpatient, supervised, medically

managed treatment environment, and those resources don't exist. Certainly not anywhere near the need is."

- Better services for adolescents, especially for co-occurring disorders. Adolescents experience a lot of ping ponging between the mental health system and the substance abuse system. Adolescents are often involved in the legal system as well.
- Serious lack of community-based substance abuse detox beds in the county. NUMC turned away about 4,500 applicants for detox services in 2013. It's not a service capacity issue, it's a dollars issue. OMH provider: "We now have the ambulatory crisis teams, and the problem with us is that we can't refer directly to detox, the only thing we have is to send them to NUMC because otherwise, what do we do with somebody who's out in the community and has that kind of need. We can't just leave them there."

Mental Health Services
September 22

What is Working

- Co-location of services is a successful strategy, but is limited by resources.
- Providing services in a bundled way is very successful – NS Family Guidance has organized to provide a full range of services in Spanish one night/week that has programs for mothers, adolescents, siblings, all at the same time and place. "If it's done in a traditional way of making appointments all over the place, the cancellation and broken appointment rate was phenomenal, but now the attendance is phenomenal and excellent."

What is Needed: Integration and Coordination

- Linkages are not working well. People are seen in the ER and discharged, and cycle back in. NUMC has gotten more restrictive about admissions, particularly if they evaluate the problem as behavioral rather than psychiatric.
- Communication has deteriorated in recent years. In previous years, out-patient programs had relationships with hospitals' social workers, and communication happened more easily. Now, there is high turnover on inpatient unit staff. OMH provider: "They don't know who the patients are, they don't know who we are, and we don't get documentation once they've been discharged, so the doctors don't even know which medicines they've been discharged with."
    - Potential Solutions: OMH provider: "The biggest impediment is reimbursement. Every mental health or behavioral health agency would love to collaborate with the medicine people. The medicine people don't want to collaborate because they're not going to get paid." Coordination of care does not require physician-to-physician communication; it could successfully be managed at the care manager level.
- When a known out-patient ends up in the hospital the out-patient program is not informed. The social workers do not reach out. They do not see this as part of their role. Medications are changed during an in-patient stay, and no communication is made to the out-patient program.
    - Potential Solutions: When someone is hospitalized questions could be scripted into the intake interview, identifying connections to supportive housing, health homes or care management. Linkages with the appropriate agency staff could be made immediately, and those resources brought to support the patient during

the inpatient stay and during the discharge planning. Similarly, intake could ask if you are part of a health home or receiving care management services, and those connections could be established while the patient was inpatient (although many don't know that they are part of a health home).

- Health homes have been trying to reach out to primary care providers, but they frequently refuse to talk to the care coordinator without a release. Despite the presence of the health homes, and the Single Point of Access in Nassau County, primary care physicians do not refer their patients for care coordination. County: "We're putting a lot on the behavioral health system, but there needs to be an education and responsibility put on the primary care and specialist to interact with the behavioral health system."
- Systemic barriers continue to exist preventing communication between primary care providers and care coordinators – health home consents, HIPAA consents, and concerns about liability issues. Concerns about confidentiality get in the way. OMH provider: "Even some of the mental health agencies or hospitals don't talk to each other about patients because they've got this confidentiality hiccup and they're afraid to talk. Communication is a key thing throughout the system."
- Many people that show up in the ER do not require an admission. But alternatives are missing. Residential and respite programs that could provide an intervention don't exist. And being in an emergency department increases agitation, increasing the likelihood of an admission.
    - Potential Solutions: Alternative crisis services would reduce the need for admissions. The current partial hospitalization model is not successful because it requires that the client attend all day, every day. Some modified service, with residential back-up and access to clinicians who can stabilize a patient, would be an important addition.
    - An emergency observation unit could meet this need, allowing people to be watched for up to 72 hours. The EOB unit in Suffolk has led to reduced admissions.

What is Needed: Communication Across Agencies

- The health home concept is premised in the ability to exchange information electronically. That isn't happening, creating pressure on the care coordination system. County: "There is going to be a lack of coordination probably made worse than it was even a few years ago since there is less care coordination going on now and the clientele we serve are increasingly less stable psychiatrically and more medically involved than they were just a few years ago."

- The communications between mental health providers and the criminal justice system is limited. Agencies frequently don't know if one of their clients is incarcerated, or when they will be released. Treatment and housing agencies are supposed to be informed pre-release, but care coordinators can be looking for clients who have they can't locate, and will check public web sites to learn whether they have been incarcerated.
    - Potential Solution: Nassau County has recently entered into an agreement with the sheriff that provides a daily list of who has been incarcerated and who is due for release. They plan to share those lists with the health homes, and depending on the health homes to share that information with other providers.
- Schools are referring to emergency departments more often than before. Schools are extremely cautious. If a child talks about suicidal ideation, they are likely to be sent to an ED even if they have a relationship with an out-patient facility, as the safest decision.
    - Potential Solution: Mobile crisis teams are available, but there is a lack of knowledge about the mobile crisis team services. The children's crisis team has a 45-minute response time in Nassau County.

What is Needed - Peer Services

- OMH provider: A lot of the people who are generating avoidable hospital use are people who touch the health care system but do not connect. Peer supports and health coaches have demonstrated success in helping facilitate connection to the delivery system, including helping with communication and transportation. When it is attached to care management, peer support is a powerful connection that can act as glue in the whole system.
    - Potential Solutions: Nassau County has a consumer link operated by the Mental Health Association. They will be opening a peer respite service on January 1. It will have 3 beds, and provide a place where a consumer can come in and work on wellness, surrounded by peers. Health homes are adding a peer component as well.

What is Needed – New Paradigms

- OMH provider: "We don't have a concept of what the paradigm of a hospital is any more. Hospitals are not a place where treatment occurs, they're a place where a person is in danger of either hurting themselves or hurting someone else, and they're admitted, and the platform the hospital works on is simply to stabilize that person and then discharge. There is no more long-term treatment."

- The mental health population has become more challenging behaviorally, and it is harder to find community placements. If someone who is aggressive or violent is admitted, the agencies are reluctant to take them back post-discharge. No uniform standards exist to evaluate need for an admission, or the kinds of extended services needed post-discharge. If someone is agitated they may be in danger of hurting themselves or others, but they may not necessarily need an admission to a psychiatric unit.
- County: "Hospitals are very cautious not to admit someone who's behavioral or someone who really has a co-occurring developmental disability or the presenting issue has been exacerbated by substance abuse and they don't really know what they're dealing with until the person has sobered up." NUMC has a bed capacity problem; they have patients who have been inpatients for months for whom they can't develop a discharge strategy. Inability to admit is not always based on clinical criteria, but rather the lack of an actual bed.

What is Needed - Disparities

- African Americans tend not to seek out services; endurance is a part of their cultural history.
- Most mental health professionals on Long Island do not look like their patients, they are not of the same race, gender, or culture.
    - Potential Solutions: Increase efforts around culturally diverse staff recruitment.

Persons with Intellectual/Developmental Disabilities
September 23, 2014

What's Working

For those in residential placement, there appear to be limited gaps in primary health care and related services given the specialized clinics for these populations; these clinics have capacity (Article 16, 31, 28 clinics.)

What's Needed

- **Intermediate level of care for people with cognitive and/or behavioral issues.**

  When a problem arises in a residential program, the ER is typically the first answer. A triage approach is needed with additional levels of service that can divert people from the ER because it is expensive, and it's actually not necessarily the best place.

  Rep from DD Member Org: "Particularly for people with behavioral problems, [to be removed from their situation], to have the opportunity to spend time in a comfortable place with a TV on for a while and be observed, to see whether the situation resolves itself under observations, may be very inexpensive compared to sending someone who is agitated to a very agitating location -- an ER."

Potential Solution: Keep one Article 28 clinic open as a "functional intermediary" between the community and the hospital with access to med records across these clinics. An urgi-like center open on 24 hour basis for observation/decompression staffed with bare bones medical and behavioral health staff. (Urgi-centers are popping up all over but they don't all take Medicaid, not all open 24/7, not equipped to address the needs of this population.)

- **Changes in regulation and reimbursement are needed to support the use of technology to enable people to live more independently.**

  Patients may either not have the dexterity to take medications on their own or they may require supervision due to cognitive limitations. Current regulations do not allow home health aides to touch medication and so these individuals may need to live in a more restrictive/often more expensive environment.

Potential solution: Technology -- video for supervision of self-administration of medication. Box with alert to take meds; box opens, if not closed, someone is called.
Other technology solutions such as blood pressure machine in an apartment where results are sent to provider.

- **Residential program staff support for healthcare/utilization decision-making.**

> Residential program staff have primary responsibility for arranging medical care and treatment for persons living in a residential placement. Residential program RN feels that they have no back up if they make a mistake, so they err on the side of caution and send residents to the ER often when unnecessary. Policies to send residents to the ER are sometimes too stringent, e.g., send everyone who has had a seizure to the ER. With supplemental clinical support from a provider that is familiar with the resident, a more informed decision could be made about the need for ER.

Potential solution: Telemedicine can back up that RN and bring to bear another clinical opinion – NP, PA, MD.

> Rep from DD Member Org: "The point is that using high-quality video telemedicine can actually save money, time mediate transportation costs and at a very low cost to the system. We need someone to say that telemedicine is just as good in more densely populated or richer health service areas as it is on the St. Lawrence River."

Potential solution: More services that can come to the residence to avoid ER visits, e.g., 24/7 mobile radiology van which is working well. There are limits to in-home intervention from the Article 28 clinics.

Other gaps in services/needs…

- Transportation is a critical concern. Able-Ride is can only cover where public transportation covers. An ambulette is extremely expensive ($75-$150 each way). [Telemedicine can reduce reliance on transportation.]
- Medicaid enrollment assistance
- Provider training on Autism Spectrum Disorder to improve competence
- Need positive behavior support to families at home
- More respite services/support for families caring for a family member with I/DD
- Language and cultural issues in the Haitian and Latino communities. Need to raise awareness, improvement in early diagnosis, need to spend enough time with family to discuss diagnosis and treatment needs
- Hospital discharge summaries in pictograms for limited literacy
- Funding for sign interpreting [telemedicine/tele-interpreter could help here as well.]

DISCOs

The group sentiment was that more robust care coordination, care management, implementation of plans, can be supported without diverting hundreds of millions of dollars

into salaries, rent and ancillary costs of a fiscal intermediary. There are people with I/DD who are unserved or underserved who need those dollars.

Persons with Chronic Conditions
September 23, 2014

What's Working

- **Development of a Technology Infrastructure**

RHIO – FQHCs send patient feed to the RHIO every day, and receive alerts if any of those patients show up in a hospital. Need to obtain patient consents which can be difficult. [Frustrating because not staffed well enough to really follow up on all the alerts.]

FEGS health home arranged a partnership with United Healthcare which send alerts when one of the health home clients has been in the hospital.

- **Engaging disengaged people with chronic conditions in the healthcare system**

Health Homes are doing extensive outreach to identify and engage people with chronic conditions in care.

- **Programs to Reduce Readmission**

NuHealth Care Transition Team – follows selected chronic disease patients for at least 30 days; significant reductions in readmissions for targeted conditions.

American Lung Association's BREATHE program. Pediatric asthma intervention in the hospital and follow up home care calls, visits.

What is Needed

- **Need more resources to support patient education, self-management, medication adherence**

There are limited clinical resources dedicated to patient education, self-management, medication adherence. Managing a chronic condition with medication, diet, etc. is critical. Understanding the signs and symptoms of a worsening condition and what to do about will reduce ER visits. There appears to be a lack of evidence-based chronic disease self-management programs in Nassau County, though care coordinators in some programs are trained in self-management support, goal-setting, motivational interviewing. School nurses used to assist with education in the schools but are too busy to do that now; programs that go into the schools are more piecemeal now than they were.

Rep from Beh/DD Treatment Org: "Whether it's asthma or diabetes, they tell us that they know what they need to do. They tell us that they understand their medications. But when push comes to shove, they really don't have any idea what they're supposed to do."

Rep from Disease-Specific Org: “Education is really the biggest challenge for us. For people to understand the chronicity of their condition is really a hard concept to get across, so that they keep their mediation on hand, understand why to take their medicine even when they’re well. But educating the providers first, to be able to education their patients. For them to have the time to educate their patients is another challenge.”

Rep from Health/Social Services Agency: “Auto-refills of chronic disease medications would help with medication adherence.”

- **Public education in needed**

Public education on common chronic conditions and appropriate use of hospital/ED is important. Faith-based organizations were identified as a target for this type of education.

Rep from a Behavioral/DD/Disease-Specific Support Org. “Educating the public about not sending someone to an ER every time a person has a seizure. This is a big issue.”

- **Need to overcome barriers to medication/supply costs**

Medication costs for the uninsured is significant program. Some medications are not generic. For example, an inhaled corticosteroid like Advair could be $300 per month. Co-pays for Medicaid managed care is $1-$5 per prescriptions, for people with multiple chronic conditions with several medications that can be a barrier. Testing supplies, e.g., glucometer strips are not covered by insurance.

Rep from Health Center: “Some providers are not attuned to the costs of medications. There may be appropriate generic equivalents that are on a $4 drug program. This is a big problem, especially at hospital discharge.”

- **Need to overcome home and community barriers to follow through on treatment recommendations**, e.g., fresh foods, home environmental exposure to asthma triggers, low salt food for CHF.

- **Patient activation/self-advocacy/system navigation support is needed**

In addition to lack of education about their chronic condition, many patients are disempowered and lack knowledge of the health care system. For example, one participant recounted a patient with CHF that started to exacerbate. She just went to bed and waited a couple of days and then called 911 ‘because those people were so nice and always took care of my congestive heart failure.’

Rep from Home Care: “We have a one nurse go in and provide home care, and the other nurse is going in strictly as a coach to work with the patient to learn how to advocate for

themselves. This is not a reimbursable service. I know the MLTCPs are filling that gap a little bit because they can authorize those non-skilled visits."

- **More robust social services are needed**

Need more boots on the ground social services: assist with Medicaid recertification, applications for food stamps, housing, navigating the healthcare system, reinforcing patient education/self-management, service coordination, etc.

Rep from Health and Social Services Org: "The reimbursement stream for these [social] services really doesn't exist. Many of the social service agencies around the table who do this kind of work are doing it with a grant or the organization is paying for it."

- **Need to overcome barriers to care coordination**

MLTC, FIDA and Health Homes are helping to fill a gap in care coordination. They are getting some organizational leaders on board, but having trouble communicating this to line staff, e.g., discharge planners. Case loads are getting larger and it's very difficult to maintain those face-to-face visits in the home, which are critical.

Rep from Health and Social Service Org: "With MLTCs and FIDA face-to-face visits are no longer a requirement. It's telephonic. And when you're not going in there, and you're not looking at the medications, and you're not seeing the home environment..."

- **Transportation needs**

Transportation is a significant barrier to health care and appropriate utilization. While there are several transportation programs -- Access-A-Ride, Able-Ride or Medicaid transportation – they are not extensive enough or timely enough. For example, a Medicaid taxi is scheduled 72 hours in advance, but if you're having an exacerbation and need to be seen right away, the only thing to do is to call 911.

- **Triage needs**

Access to high quality clinical information/triage is important in supporting patients with chronic conditions. Ideally, their primary care provider or home care organization would assure access although there are additional alternatives currently in use described by participants below.

Rep from Hospital System: "We've been piloting, through our EMS department community paramedics who can make the decision in the home whether or not to bring the patient into the ER, or if they can manage the patient at home or call in other resources."

Rep from FQHC: “We have an underutilized ‘Ask a Nurse Hotline.’ We need a campaign to advertise it.”

- **Access to behavioral health services**

Access to behavioral health services is problematic. There are insufficient behavioral health resources to meet the needs in the County.

Rep Hospital System: Even though we’ve brought an Article 31 clinic into the FQHC, we still sometimes have a hard time getting appointments for folks.”

- **Other**
    - More emphasis needed on prevention of chronic disease – obesity prevention in the schools, famer’s markets in the communities, getting people to exercise, walk, etc.
    - Need to support workforce competence in language, literacy, culture
    - Hospitalists typically not good for chronic disease patients – don’t have history and at discharge don’t necessarily make contact with the PCP.

Services for People with HIV
September 23

What's Working

- The NuHealth services are centrally located and near transportation hubs, making it easier for people to access services.
- The NuHealth program has a full-blown treatment adherence program that has developed extensive tools to help keep people engaged in their care – wellness report cards that offer small gifts for successful treatment compliance; electronic pillboxes; health literacy education.

Barriers to Care

- Preventive care is unavailable, especially for the uninsured. Access to care in the clinics is limited, and private physicians are frequently unaware of current, appropriate treatment.
- Stigma remains an issue among clinicians, leading people to avoid care. There is an on-going need for increased education about HIV, including among the provider community.
- Lack of services for LGBT, including support services, specialty care
- Mental health providers with competence in HIV/AIDS are lacking
- Need for single-stop agencies where dental, vision, physical and behavioral health can all be found at a single site
- Transportation barriers
- Safe, secure, stable housing, including mental health supportive housing
- Case management services for people with HIV have been scaled back dramatically as a result of the transition to health homes. Due to increases in case load, people are receiving much less time with their care manager
- Stigma remains for those seeking substance use services, and services are not available as widely as is necessary

Basic Needs
September 23

What are the Most Pressing Needs

- Safe, secure, habitable, affordable housing.
- Emergency housing services all have wait lists; the capacity if vastly inadequate to meet the need. Housing voucher programs have waiting lists of years, and those wait lists are closed to new entrants.
- The number of people seeking shelter through the emergency shelter system with substance use and mental health complications is up sharply in recent years.
    - Potential Solutions: Budgets from DSS are not aligned with the cost of housing in Nassau County.
- The large geography of the county makes it hard for people to know where to get services. Services are so spread out, and people with complex needs have multiple and competing needs to be met. For people struggling with housing, food, and their children's education, taking care of medical needs is not at the top of their list, especially when all those services are in geographically dispersed settings.
    - Potential Solutions: Multiple services located at a single site. Establish networks that make it less burdensome for a family seeking multiple services so they don't have to spend time traveling from place to place.
- Relying on telephones to communicate can be a problem as numbers change frequently. Trying to navigate the health care system using a phone is a challenge because navigating phone trees and waiting on hold takes time. Social service agency: "Just calling to know who your PCP is or who your providers are, you're on hold for a long time just to do that. And it does eat up their minutes and they literally hang up."
    - Potential Solutions: Provide phone banks for people to use in making appointments and navigating the health system.
- People tend not to use the computer resources at the library because of limited hours because of decreased funding, lack of geographical convenience and inconvenience of using library services when you have children with you.

Connections with the HealthCare System

- On the medical side, access to care is better. On the behavioral health side, wait lists at the community mental health centers are common.
- With a transient population the ability to share information across providers and agencies is challenging.

    - Potential Solution: Social service agency: “In terms of the segmentation of medical delivery systems in general… The ability to be able to see where an individual has been before, what treatment they’ve gotten before… Exchange of information among providers is key. “ It’s difficult enough within an institution, but with mobile populations having information sharing will allow you to better serve them.
- Care coordination for this population is essential. Social welfare agency: In our experience the key element of all this is going to be care coordination and care management, because individuals are lacking the community supports. They're lacking ways to follow-up on their medical appointments or follow-up on their behavioral health issues. And they need the individual who is going to support them through all of it, and prioritize what's important and what needs to happen.”
- Connections between social service supports and care management/care coordination are largely informal. Referrals are made, but follow-up is unusual. The basic needs providers are very respectful of maintaining confidentiality for their clients, making linkages more difficult. Housing agency: “One of our concerns from a housing perspective is information management and privacy concerns. We’re not in the business of managing people’s health care, so there is a lot of hesitation on how much information you can know about somebody, without taking on the responsibility or liability for their health.”
- Community events where information about health insurance and access to services are made available happen regularly. Many agencies and services have partnered on these events, but no central planning takes place. No formal coordination or collaboration has been established. All the agencies have worked with health care providers in the county, but the connection tends to be event-related rather than a formal, on-going relationships. Collaborations and partnerships have occurred, but tend to be grant-funded, and are discontinued when the funding ends.
    - Potential Solutions: Formalize linkages between community agencies and health care providers and centralize information about community events.
- Undocumented people have even bigger challenges, as they lack a social security number and state ID. Finding anything from dental to physical health to basic needs is really complicated.

What Works

- United HealthCare has a program it operates with Catholic Health Services where it can refer people without insurance, but it has a long waiting list.

- Island Harvest operates a Senior Mobile Food Pantry that makes weekly visits at several locations. In addition to providing food, they invite a community partner to provide other health-related community resources, such as blood pressure screenings, providing access to additional services.
- Care management is better than it was, although it remains under-resourced. Health homes have expanded the old case management programs into care coordination, and more resources are available. But the consensus in the room was that there is still a long way to go.
- NS-LIJ had a mobile crisis van that visited a large soup kitchen on a weekly basis, but the physician providing the service concluded it was ineffective in meeting the needs of the population, that what was needed was a referral to a community provider that could manage their care and provide a more comprehensive range of services.

What's Needed

- Nassau County does not have any Healthcare for the Homeless programs. One model being used in NYC is where a shelter has formalized relationships with particular care management agencies, where care managers come into the shelter and recruit clients, and then connect them to services and care as appropriate. No formal relationships exist between shelters and care management, between shelters and health care providers.
- The County does not do an effective job in connecting people to services. People still get information largely through word of mouth, and despite the presence of managed care for the last 15 years, people still get care through emergency departments because of lack of information about how to navigate the health system differently.
- Most agencies can provide services in English and Spanish; many also have Haitian-Creole staff and materials. Other languages are very problematic.