NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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Commissioner

SUNCMI Concept Paper
Summary of Provider Conference

The NYC Department of Health and Mental Hygiene (DOHMH) held a virtual provider conference on May 24, 2024, from 10am - 11am for the Substance Use Nurse Care Manager Model Concept Paper. The questions presented are listed below along with the comments and feedback received from the 14 attendees during the Provider Conference. Most participants in the conference did not provide feedback.

The concept paper remains open for written comments, which can be submitted to RFP@health.nyc.gov with "Nurse Care Manager CP Comments" in the subject line until July 1, 2024.

DOHMH presented the following questions to the providers in attendance:

1. Thinking about the health care services that are included as part of service delivery:
    a. Are there any health care services that are not included that should be?
    b. Do you foresee any barriers to the proposed services that would prevent your agency from being able to provide them?
    c. Are there any specific barriers to providing substance-use related wound care?
2. Are there any supports other than the resources DOHMH plans to provide (training, TA, clinical mentorship, learning communities and public-facing educational materials) that would help agencies successfully implement this initiative?
3. Do you have any suggestions for deliverables to be used for this deliverables-based contract?
4. What do you think is missing from this concept paper?

Responses/Questions/Comments/Concerns from the Providers in attendance

All language in the posted comments is reflective of the commenter's diction choice and is not reflective of the DOHMH's beliefs and preferences.

Additional Services

1. A nurse care manager is important when talking about substance use, but so is the implementation of a mental health practitioner. Substance use goes hand-in-hand with mental illness. This should be explored and considered when seeking an RFP, and it can be accomplished through the utilization of a psychiatrist or a mental health nurse practitioner.
2. Some programs are integrated with primary care and outpatient programs. Having a nurse care manager providing care management services for patients on methadone would be a huge asset here that has never been done before.
3. Having a "CASAC" (Credentialed Alcoholism and Substance Abuse Counselor) or a peer counselor would help with providing holistic care and by providing patients with someone who has experienced something similar to them, such as engaging with AA/NA. Hearing from a peer who's gone through something similar, that has a very powerful effect in their recovery.
4. Would you consider implementing TA sessions and video consultations (including regular case consultations) to include providers, nurse practitioners, medical doctors, etc. in these sessions?

5. Because we are taking care of such a wide range of patient needs (opioids, alcohol, social supports etc.), sometimes the nurse care manager can really use extra support. This support can range from general outreach to assistance with the non-clinical work, and support can be offered through either a mental health provider or peer support.
6. For patients who are unable to pay or have co-pays, can we have a card instead of going through the current buprenorphine payment assistance reimbursement process?
7. Will there be follow-ups for patients admitted into the program? Is there going to be anything in terms of individualized follow-ups and/or a specific person assigned to 4 or 5 patients with frequent contact (maybe weekly) that perhaps involves using drug screening to check for ongoing substance use?
8. Targeting areas where there is poverty and targeting community centers to do outreach will be one potential opportunity to expose and bring awareness to this program.
9. Is this going to truly be a substance use initiative where we talk about and provide care for other substances besides opioids (like cocaine use) to create a better, well-rounded approach to care for all these patients? Including all substance use [as part of this initiative] would be very effective.
10. There can be an incentive for sites that have a large volume of patients, such as additional funding if they are serving patients above a certain number. More funding can be provided either in additional nurses or help from peer support or another treatment coordinator on the site.
11. Are you considering adding therapists as well, since we are dealing with mental disorders and addictions?
12. Are you including MOUD, and which ages are you thinking of? Are you starting at a certain age? So many children are dealing with addiction. Is there a minimum age limit?
13. When serving a large number of patients, there are times when you need to juggle and prioritize who you are getting in contact with. This is a struggle that most often arises when someone is having an emergency. Having someone, like a program coordinator or a peer counselor, to assist with scheduling and calling patients would be a huge help.

Barriers

1. Language barriers are prevalent, and they need consideration when developing staff.
2. For patient-to-nurse contact, this should be face-to-face rather than over the phone. The human connection makes the program far more effective, but this is only doable through a proper patient-to-nurse ratio. If the conversations are informal, then there is more room for error in terms of patients not being truthful and responsive. This is especially the case if the patient-to-nurse contact is over the phone because patients can simply decline the call.
3. A physical, dedicated space to meet with patients is a huge barrier in getting together to have a one-on-one, private conversation.
4. For screening HIV, hep C testing, wound care, and things like that, it sounds like there will be additional supportive nursing staff apart from the care manager to provide these kinds of resources. Is that accurate, and is it something we will be exploring?
5. The program will face ongoing barriers as it gets started, so it will need to be constructed in a way that allows it to be restructured and incorporate new implementations.
6. If there is a major problem identified, but the finances are not there, then what would that look like? Would there be a restructuring of the program and/or additional funding added if it's a major deficit within the program that needs to be rectified?

Support

1. When talking about funding, considering money for data would be important. There is such an emphasis these days on data collection, and it involves staffing and programs that require money to be focused on that.
2. Is there going to be any type of marketing done on social media (Instagram and Facebook) to bring awareness to the program? Will there be a budget for that, and will it be involved in the program?

Deliverables

1. There needs to be some structure and/or evaluation process for patients, such as program dates and monthly follow-ups. As we're having quality assurance and quality improvement meetings, we talk about patient-centered outcome protocols and whether the patients are progressing and doing well. There should be core measures or things that we aim to achieve through a checklist containing goals like negative drug tests and whether they are showing up to meetings.
    a. Disagreement with this "checklist" proposal – toxicology shouldn't be a measurement of patient and/or program success. That puts pressure on a nurse care manager in a way that isn't patient-centered at all. It's not an accurate measurement of success and how well a program is doing. Toxicology shouldn't be used for determining deliverables.
    b. Without a checklist of sorts, how will we determine if there is a need for additional education and/or support? It would be a modality for identifying issues and struggles.
2. Would you consider quarterly reports, KPIs, etc. for deliverables?

Miscellaneous

1. Rewarding 14 contracts, how many nurse care managers will we need to operate this program effectively, and how many patients will they each be responsible for?
2. If you have 200 patients, one nurse care manager cannot provide that outreach through the frequent contact with patients we are aiming for. 100 for one nurse would be a lot – somewhere around 50ish would be more appropriate, especially for sites that are new to this and just starting out. For them, even 50 would be a huge number.
3. How can we minimize healthcare disparities through getting this program to people in under-resourced communities who will not have access to this? (Community outreach? Additional funding? Etc.)
4. When talking about wound care and HIV testing, would that only be for patients who are getting the substance use care, or could it be open to any patients (not limited to who is under their group)? That is a great way to get patients more involved in the program.