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No Wrong Door: A Model for Biopsychosocial Health Care in the 21st Century

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As the 21st century enters its second decade, multiple stressors barrage the population in the United States. Macro forces – from economic perils to international terrorism, from the resurgence of heroin addiction to rising rates of teenage pregnancy, from global warming to environmental decay – have compromised the physical and emotional well being of the population (Catalano, 1991, 2009). Equally stressful have been the affects of emerging pathogens such as the H1N1 virus and other ongoing health care related concerns (e.g., obesity, HIV/AIDS, health insurance).

These forces clearly pose complex challenges for public health care providers who have long recognized the interaction among social, economic, psychological, and biological elements in human functioning and the relationship between macro societal elements and the health status of individuals (Krieger, 2008). For example, the effect of unemployment on an individual's health has been well documented (see, for example, Linn, Sandifer, Stein 1985; Colledge, 1982, Turner, 1995); the current “great recession” is negatively impacting on the 10% plus of the population grappling with job loss (Bezruchka, 2009). Bennett, Scharoem-Lee, and Tucker-Seeley, raising the question “Will the public's health fall victim to the home foreclosure

epidemic?” conclude that “although no studies to date have reported the specific health effects of home foreclosure, we posit that foreclosure may be associated with a range of psychological and health behavior outcomes that, in turn, might increase chronic disease risk” (2009). Moreover, the correlation between lower socio-economic status and poorer levels of biological health has been supported by researchers (see, e.g., Pappa, Kontodimopoulos, Papadopoulos, 2009).

In view of the current stressful social and economic context, the administration of public health would be strengthened by service delivery models incorporating enhanced access, comprehensive assessment, and coordinated, multidisciplinary care. This paper describes and discusses one such model, No Wrong Door. This cutting edge contemporary service delivery system was introduced in Nassau County, NY in 2004 by the then County Executive Thomas R. Suozzi as a response to a historically uncoordinated, compartmentalized system of health and human services. No Wrong Door (NWD) enabled the County to better assess and meet residents’ multiple biopsychosocial needs. This paper will examine No Wrong Door and its implications for the enhancement of contemporary public health service delivery.

No Wrong Door

No Wrong Door as a construct is not unique to Nassau County. There have been numerous state and county No Wrong Doors which include one or more, but not all, of the following: one stop shop; single point of entry; coordinated/integrated services; comprehensive assessment and multidimensional interventive planning; web-based tools to enhance access to services. Utah, New Mexico, New Jersey, Oregon, Wisconsin and North Carolina, for example, have introduced web-based applications and/or other web-based information to improve public awareness and expand access. Both Washington State and Louisiana designed No Wrong Door

programs to coordinate case management for selected populations. Montgomery County, Maryland has developed sophisticated technology to actualize its plans for coordinated service delivery; Montgomery County, Ohio has collocated multiple services in its Job and Family Services Department; Alameda County, California has adopted a No Wrong Door for health insurance for children.

No Wrong Door in Nassau County

Nassau County's No Wrong Door has been seen as singular in its breadth and depth. All health and human services departments participated; any resident who applied for any service offered by any of the seven departments could benefit from the approach. No Wrong Door was developed as a response to a health and human services delivery system that was assessed by the county administration as lacking effectiveness, efficiency and compassion. Siloed services funded by the federal, state and local government focused narrowly on a specific presenting issue; the resulting tunnel-vision blocked recognition of other potential and actual needs. A family who was homeless was provided shelter beds; the probable multiple biopsychosocial elements leading and/or related to the loss of housing were largely not addressed. Hungry veterans and seniors were granted Food Stamps, if eligible, but assessment of related life challenges which could compromise their well being and indeed their lives was not practical prior to the introduction of No Wrong Door. When other problems were recognized, there was

no official sanction for staff to intervene; indeed moving beyond one's "job title" was often negatively perceived.

Public service practice in the County had also, especially in the Department of Social Services, been influenced by America's historic ambivalence towards those in economic need (Jansson, 2005). Citizens can be exemplars of charitable giving (note the current outpouring of donations for the victims of the earthquake in Haiti). But this caring can be jarringly juxtaposed with the vestiges of what had been termed a "frontier mentality"; those who apply for "welfare", for example, are often viewed as flawed human beings, whose failed character brings them to the public welfare department (Ryan, 1971). Clients are blamed for their destitution while structural elements such as the economy are largely ignored. Eligibility determination, application, and recertification processes often are cumbersome and complex, designed to discourage participation and to keep welfare rolls as low as possible. In Nassau County, a negative perspective on those in need was expressed at a level not seen anywhere else in New York State. Clients were viewed as not only weak in character, but also as dangerous. While some New York counties had, and still have, security shields in reception areas, in Nassau from 1983 to 2005, glass barriers protected service providers from every client throughout every phase of a visit to the Department of Social Services. Client interviews took place publicly in the large waiting area where protective booths with small communication openings lined the perimeter.

Closely related to this "blaming the victim" ethos (Ryan, 1971) is the emphasis on pathology which has dominated theory and practice in health and human services. Service deliverers all too often ignore or pay minimal attention to the resilience of individuals and the strengths and supports gained from the family, community, peer group, cultural and spiritual

connections (Saleebey, 1997). Illness, indeed, may be the 21st century descendent of the preceding century's character flaw interpretation of the etiology of poverty and other social problems.

In Nassau, “blaming the victim,” an emphasis on deficits, and narrow service delivery silos were recognized and acknowledged to be compromising the full actualization of what government should and could be doing for its most vulnerable residents. No Wrong Door responded by openly declaring that its goal was to “provide efficient, effective and compassionate delivery of government services and assistance to those in need.” (Nassau County, 2009) Reflective of this vision, three implementing principles guided the No Wrong Door service delivery model:

- Silos do not work for clients or service deliverers; teamwork, integrated and interoperable services can prevent problem escalation and can result in better outcomes
- A single point of entry to services and a one-stop shop approach support coordinated and ultimately less costly service delivery
- Compassion does not cost money; indeed, County officials reasoned, communicating caring and respect might actually save taxpayers' dollars by enhancing the probability that clients will cooperate and respond to services

Below are the major steps taken to develop and implement a service delivery system incorporating these principles. We present these in two phases – the first between 2002 and 2008 and the second between 2008 and 2009.

No Wrong Door Phase I: 2002-2008

In the first phase, an organizational structure was introduced, a collocated service delivery site designed and put into operation, and a set of implementing processes initiated. Specifically, the County:

- Established a "vertical" comprised of seven departments – DSS; Health; Seniors; Mental Health/Chemical Dependency/Developmental Disabilities; Youth Board; Veterans Affairs; Office of the Physically Challenged . A Deputy County Executive for Health and Human Services was appointed to manage the vertical.
- Consolidated real estate through a move to one state-of-the-art HHS facility housing 1250 of the 1400 plus vertical staff. The remaining 225 employees, all from the Health Department, were later moved to another building on the same campus.
- Consolidated infrastructure functions: accounting and finance, information technology, human resources, planning and research, staff development, quality assurance, program and grant development.
- Created a single point of entry to services and a coordinated service delivery approach for selected populations, including families and veterans who were homeless, seniors, and the physically challenged.
- Developed a "one stop shop" approach by locating specialized services on site in the HHS building, most notably, behavioral health, domestic violence, homeless case management, and veterans' assistance.
- Designed an inviting and warm reception area environment – the Welcome Center – which included a professionally staffed children's room, a client library, program

activities, and information tables. The following staff were assigned to the Center: a lobby director/assistant director, front desk specialists, a children's room coordinator.

- Created a multifaceted staff development program to implement trainings focused on customer service, holistic assessment, comprehensive intervention, and interviewing skills. Components included Case of the Week, cross-trainings, quality teams, an on site MSW program, a Staff Development Library, and internships from schools of social work, nursing, medicine, public administration, psychology and business.
- Introduced new technology including status tracking software for use by HHS staff, the PATHHS (Providing Access to Health and Human Services) tool offering the public benefit eligibility information, and document imaging of millions of records to initiate a paperless office environment
- Developed a quality management program including: quarterly consolidated management reports; an ongoing client input survey; client focus groups; status tracking system to analyze & monitor daily traffic flow, client activities, and interdepartmental referrals
- Introduced security based on CPTED (Crime Prevention through Environment Design) to replace the barrier approach. Well- trained public safety officers, metal detectors, and panic buttons have been the “smart security” components which have maintained a safe and respectful environment
- Rerouted three bus lines to stop directly and frequently at the front door from 7am– 7pm.

No Wrong Door Phase II: 2008-2009

In late 2008, based on evidence of No Wrong Door's effectiveness, the County decided to introduce the concept to local communities. In addition to establishing outstations of the Department of Social Services in Community Health Centers and offering HHS services to a local challenged school district, the County organized ten Interagency Councils in those villages and cities whose residents most frequently applied for and used health and human services. The Councils included representatives of social service agencies, hospitals, schools, faith-based organizations, the business community, libraries, the police, and other entities. The major objectives were to have the members of the local Councils collaborate on service delivery to the community's most vulnerable residents and to also have the participating organizations serve as portals to care for these residents. Since their inception, the Councils have each developed priorities and agendas which address these objectives as well as specific community needs.

No Wrong Door: Is It Working?

Since the inception of No Wrong Door, interdepartmental collaboration has blossomed and consciousness of being part of a larger entity has emerged. In 2004, the seven health and human services departments began to meet weekly to discuss complex case situations. Community based service providers also participate whenever their clients are the focus of the case conference. This "Case of the Week" process has been named a promising practice by the New York State Office of Children and Family Services and has been replicated in other New York State counties. Over 300 cases have been presented and later updated. The seven departments have also formed multidisciplinary teams to work on grants, new programs, and a continuum of staff development activities including an MSW degree program for county employees taught by a local university on site at the HHS facility. An external evaluation of the

Staff Development Initiative concluded, “The County has launched creative and innovative staff development strategies as part of its system reform with ...very positive and noteworthy results” (Center for Governmental Research, 2007). Since 2005, an aggregate of approximately 8400 participants have attended trainings; over 65 students have completed internships; fifteen County employees will complete the MSW degree program in 2011.

Data supports the emergence of a new culture with its emphasis on teamwork, compassion and holistic assessment. Between 2006 and 2008, the rate of people served by both DSS and non- DSS department staff increased 174%. Comparing September 2004 – August 2005 and September 2007 – August 2008, 47% more referrals were made to the on site domestic violence counselor. There was no Behavioral Health Unit before NWD. Now averages of 153 individuals a month are referred for an immediate behavioral assessment. Outcomes data are emerging. For example, as of 2008, with interdepartmental collaboration and case management, the time families remain homeless was reduced by 46%; foster care was prevented for 73 children through the use of family unification vouchers and housing support services; PINS petitions filed were reduced from 25.9% of probation intakes to 4.2% of intakes.

While the flow of clients has increased every year between 2006 and 2009 (and at an escalating rate of increase), average wait time has remained stable at under 2 hours. Staff has not increased, but client satisfaction as measured by the HHS Client Feedback Survey has improved. While 63% of clients surveyed in 2004 reported that they were treated with respect that percentage rose to 82% in 2009. In 2004, 69% of clients surveyed reported overall satisfaction with their visit; in 2009, that percentage rose to 82%. Client focus groups suggest that those being served are sensing that “here people care and listen to me”. The collocation has already

yielded efficiencies, e.g. savings have been estimated to be up to \$10,185.00 per caseworker and \$666.00 per client because of the elimination of inter-building travel for both staff and clients.

Lessons Learned

Critical to the introduction of No Wrong Door and the transformation of health and human services that it entailed was an environmental context open to change and teamwork. Lessons learned from Nassau's experience are related to the development of an organizational environment receptive to broad innovation:

.Organizational cultural change can only occur if the leadership at the highest levels is committed and passionate. Without the explicit and demonstrated support of those in power, new norms are likely to be sabotaged.

. Staff at all levels must be involved from the very beginning of the change process and staff members need to understand the direct benefits to their work. The introduction of NWD required a change in the staff's perspectives, assumptions and practices. Each of the 1400 plus staff members had to be exposed to the new expectations. An ongoing staff development program, while necessary, was not sufficient to change the culture. Agency management, including commissioners and executive level staff had to, in word and deed, actualize NWD values and behaviors. Many leaders were on the ground with line staff serving clients for months after the opening of the NWD facility, and leadership also participated in staff development activities.

. Confidentiality is always a challenge in integrated service delivery. In Nassau, multiple layers of laws related to privacy and information sharing had to be understood; legal consultation

was sought to develop an approach which would permit interdepartmental collaboration on behalf of clients.

.Unanticipated challenges are to be expected. For No Wrong Door in Nassau, there was a sharp increase in clients related to the sudden economic downturn. The traffic flow to the NWD facility went from 600 per day to well over 1000 and even into the 2000 plus range. This meant that some assessment and referral processes were no longer feasible and had to be reconsidered. However, the most critical challenge to NWD was the unforeseen change in the government following the November 2009 election for County Executive. The administration that had created and supported NWD was no longer in power. Although the future of NWD as an expressed organizing principle and guiding perspective is currently in question, there is some indication that normative practices and programmatic changes related to the model have been institutionalized and will continue.

No Wrong Door and Public Health

The values underscoring No Wrong Door – service accessibility, interdepartmental collaboration, cultural competence and a holistic lifespan perspective- are compatible with the Nassau County Department of Health’s practice philosophy and programmatic orientation. In the tradition of public health, the Department has long been concerned about meeting the multiple needs of the underserved and ensuring their access to services, while continuing to provide the more traditional public health functions such as communicable disease and environmental control. Among the Department’s hallmark programs are the Community Health Worker Program, Women, Infants and Children (WIC), Perinatal Services Network and the Healthy Nassau campaign. Through these programs, the Health Department provided fertile soil

for the actualization of NWD and NWD, in turn, has helped these programs flourish. This synergistic relationship is illustrated in the following three examples.

The Community Health Worker Program (CHWP) is a home visiting case management program for at risk pregnant women developed to ensure improved pregnancy outcomes. CHWP is based on an outreach approach and many of the families served are impacted by multiple environmental stressors. The community health workers quickly recognized the value of NWD in connecting their clients with needed resources and were-and remain- active participants in NWD's Case of the Week. One such case presented was that of a 23 year old woman, the mother of a 6 month old infant. The child was born prematurely at 29 weeks and was showing signs of developmental delay. The mother and child were residing in a roach infested basement apartment that lacked adequate heat. The mother had no health insurance, had been denied public assistance for lack of proper documentation, and was reported to be in despair about her situation. The NWD team worked with the CHWP to assist the client with reapplying for public assistance and Medicaid, facilitated an early intervention referral, connected the client with mental health support services, referred the case to housing services, and also called in Child Protective Services and Child Welfare Preventive Services. Soon thereafter the mother acquired public assistance, Medicaid and new housing and was actively participating in a group program for new mothers. Early Intervention assessed the baby and began providing services. CPS brought in Preventive Services for case management and other supports.

The Office of Tuberculosis (TB) Control also has a holistic orientation to care that has benefited from the NWD culture. One example was that of a 30 year old man with diagnoses of TB, AIDS, B-cell lymphoma, Hepatitis C and syphilis. The individual left Guatemala in 2007

and is in the United States without documentation. He lives with his brother in a rooming house with 10 other individuals, some of whom are children. The brother is employed as a day laborer and is unable to pay for his brother's basic needs. While the medical situation is under control through directly observed therapy (DOT) and administration of preventive medications to the house residents, the question of how to provide for the individuals food, shelter and other needs was unresolved. Through the NWD team, the client has been connected with several local agencies including a parish outreach program and legal services for those without documentation. The DOT worker and representatives of these community agencies continued to meet as a team to provide for this client and ensure the public's health.

No Wrong Door set the tone for the creation of Healthy Nassau, an effort designed to make Nassau the healthiest county in the country. Among Healthy Nassau programs are those specifically addressing the health of mothers and babies, youth, adults and the senior population. These programs focus on tobacco use, nutrition, and physical activity. Other components focus on Healthy Land, Air, and Water and Healthy Homes which included a bed bug task force and fall prevention for senior citizens. All HHS departments participate in Healthy Nassau.

No Wrong Door: Implications for New Directions in American Health Care

The philosophical foundations of public health have always underscored the need for holistic understanding of the impact of environmental forces on human wellness. This is illustrated in the WHO Conceptual Framework on Social Determinants of Health which includes variables such as social class, gender, ethnicity, SES status, political context and culture in its consideration of inequities in care (Krieger, 2008). Since the late 1960's, the American Academy of Pediatrics has supported the concept of a "medical home", recognizing the value of

a single source for care and emphasizing the importance of coordinated, integrated services for children. The Academy describes the concept of “medical home” in terms very reflective of the NWD approach. It is “a central source...that is family centered, accessible, continuous, coordinated, comprehensive, compassionate and culturally effective” (Sia, et al., 2004). The effectiveness of holistic care has been established; for example, in a national study of children with special health care needs, those served by a medical home approach were found to be “approximately half as likely to experience delayed or forgone care, less than half as likely to have unmet health care needs, and less than a third as likely to have unmet needs for family support services than children without a medical home” (Strickland, et al, 2004, pg. 1491).

Also closely related to NWD is the patient navigator approach, pioneered at Harlem Hospital in New York in 1990. This program assisted underserved community residents with breast cancer in “navigating through the complex health care system to overcome barriers in accessing quality care and treatment” (Fowler, et al, 2006, pg 0974). A study of this first patient navigation system found “significant improvements in diagnosis and five year survival rates among patients with breast cancer and attributed the improvement to patient navigation services” (Fowler, 2006, pg 0975). The success of this and the hundreds of programs that followed resulted in the passage of the “Patient Navigator Outreach and Chronic Disease Act of 2005 (US Public Law 109-18). Through this Act the federal government currently funds six navigation projects nationwide to support non-medical health workers, especially in communities with significant health disparities and barriers to health services.

These models incorporate a biopsychosocial approach; they ensure access to care, care coordination, cultural competence, and family support. They understand that care and recovery

must be viewed within the larger context of family and community, and that client empowerment and advocacy are critical to negotiating the complexities of contemporary health care delivery.

Evidence based outcomes as described above suggest that comprehensive and integrated approaches to health care are both effective and efficient and should be seriously considered in the national health care debate. Health care reform provisions which could promote comprehensive practice include support for social work case management, multidisciplinary teams linking hospitals and community services and evidence based home visiting programs for pregnant and parenting families and the elderly. Unfortunately, while the House bill for health care reform included Medicaid reimbursement for case management services, the Senate bill removed this benefit and its future is questionable.

Despite this, advocacy for integrated care must persist. The current “great recession”, the ongoing specter of war, and other environmental stressors make it imperative that coordinated comprehensive care be supported in any health care reform bill that is put forward. No Wrong Door in Nassau County and related models demonstrate a new direction in American health care that should not to be ignored.

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