Wake County Familiar Face Collaborative 2020-2023

Robert Wood Johnson Foundation (RWJF) Clinical Scholars (CS)
Introduction

- Derrick J. Hoover MD, FAAFP
- Family Physician
- Duke Urgent Care/Duke Primary Care
- Robert Wood Johnson Clinical Scholar
- Special Interest in Homeless Medicine and Hepatitis C
- An interesting fact about me: I’m from the Bahamas
Clinical Scholars is a national leadership program for experienced health care providers supported by the Robert Wood Johnson Foundation.
RWJF selects 35 people in the country each year.
Only 8 projects were selected in the nation in 2020.
During the program interdisciplinary teams consisting of 3-5 members work together to create equitable solutions for complex health challenges in our communities.
Our team members all work for organizations with deep roots in the community.
Organizations

WakeMed  UNC  Duke Health  Wake County
RWJF Clinical Scholar Fellows

TEAM MEMBERS

- José G Cabañas, MD, MPH
- Derrick Hoover, MD, FAAFP
- Keturah Beckham, MSW, LCSWA, CHC, CPA
- Thava Mahadevan, MS, LCAS
- Jason Wittes, PharmD
There are significant legal privacy issues that limit sharing personal information.

This makes it difficult to implement automated robust intuitive identification tools.

Even if a patient wishes, it is difficult to share data across systems.

A team of subject matter experts is working to address this in a way that balances privacy and better coordination of care.
Meet Mr. C

- Friendly, obese, shirtless, African American gentleman laying on pink comforter under tree eating canned tuna.
- Brought from neighboring county and dropped outside Oak City Cares with his walker early on a Tuesday morning.
- Appears mildly short of breath with swollen ankles. (?CHF)
- Does not know his medical history other than OSA and ‘some cardiac problem’.
- He was robbed and meds were stolen more than 1 month ago.
- Doesn't remember medication names, wants help to get back on his meds.
- Wants to stay under tree again tonight until he can get into shelter tomorrow while awaiting COVID-19 test.
Mr. C

• 3 days later able to get meds, but pharmacy says 2 new meds added a few days ago in his bubble pack.
• PCP and specialists at health system A don’t know about new meds.
• After much digging Mr. C remembers he was in the ER at Health system B the day prior to being dropped off at Oak City cares.
• In the ER some meds were stopped and new meds added.
• PCP unable to access to health system B’s records despite having ‘Care Everywhere’.
• Pharmacy puts all meds into bubble pack including the ones the ER stopped and added as they have no way to know meds were stopped.
• Patient does not know which meds added and which ones were stopped.
Mr. C

What to do?

• 1 month of meds placed in bubble pack making it very difficult to remove meds that were supposed to be stopped.
• Patient has been out of meds for over a month, needs to restart asap.
• Patient at significant risk for complication from taking meds that should have been stopped in addition to new meds.
• No easy/quick way to find what meds were stopped and why.
Mr. C facts

- He has mobility issues, cardiomyopathy (25%), OSA, COPD, HTN, mental health issues and known substance abuse disorder.
- He is known to the criminal justice system.
- Stays between 2 counties, has no transportation and is homeless.
- Receiving care from at least 8 organizations just this week!
- Thinks his PCP is at Health System A, but PCP actually at FQHC in neighboring county.
- His heart and lung doctors are at Health System A.
- Meds changed in ER at Health System B.
- He uses a community pharmacy not affiliated with his care providers.
- He is insured.
- He is not yet a Familiar Face!
Wicked Problem

- The lack of integrated services for those most vulnerable within a community leads to poor outcomes and costly human suffering.
- Systems working in silos without robust communication tools.
- Right hand does not know what left hand is doing and in some cases does not even know left hand exists.
Objectives

• To engage vulnerable community members and front-line service providers to understand barriers and challenges associated with service delivery and support systems for this population.

• Develop **sustainable** care models to better serve this population thereby increasing quality, efficiency and decreasing societal cost of care, but more importantly **decreasing preventable suffering**.
## STRATEGIES AND INITIATIVES: FAMILIAR FACES

Stabilize frequent users of crisis services.

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<td>A</td>
<td>Develop an early intervention approach to provide prevention services and calculate return on investment for these services.</td>
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<td>B</td>
<td>Implement a data system that identifies high utilizers and helps coordinate services for them.</td>
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<td>C</td>
<td>Develop an approach that prioritizes those in highest need for services.</td>
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<td>D</td>
<td>Assign high risk individuals to a coordinated team who will take responsibility for aligned care and continuity of services.</td>
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<td>E</td>
<td>Provide front line responders with needed information about these individuals and close the gap between front-line responders and case managers.</td>
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<td>F</td>
<td>Work to improve the use of NC Care 360 as a tool to help meet identified gaps in social determinants of health.</td>
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Familiar Face perspectives

- Many of us think of Familiar Faces from our perspective as someone who is a ‘High Utilizer’ of services.
- From this patient perspective we are the ‘Familiar Face’.
- They need a ‘Familiar Face’ to help them navigate these convoluted systems currently in place.
- They need a ‘Familiar Face’ they can turn to and depend on.
Sneak peak: Bridge housing pilot

- Bridge housing for 3 individuals with complex health needs.
- Supported by a case manager and a peer support specialist.
- Currently working on a fair identification/selection criteria.
- Evaluate needs and gaps in care.
- Develop/design/facilitate better system for patient centered coordination of care.
Heat and Eat meal program

- We received an additional COVID Rapid response grant from RWJF in January 2021.
- Deliver 100 healthy nutritious Heat and Eat meals weekly to individuals with severe mental illness, health risk factors and those living unsheltered.
- Restaurants like Breakaway café prepare and package meals to be picked up and delivered in person by ACT team staff and peer support specialists.
- The restaurant incorporates fresh produce and vegetables (seasonal) from the Farm at Penny Lane and other local farms.
Goal of meal program

• Provide healthy meals to strengthen immune system to help prevent and fight COVID-19.
• Address loneliness (worsened by pandemic).
• Engage reclusive unsheltered population.
• Build rapport and trust.
• Provide access to resources.
Meal program to date:

- Started 2/11/21 (able to mobilize quickly and effectively).
- So far over 700 meals delivered.
- Collaborating with other local outreach teams.
- Received 2\textsuperscript{nd} grant to expand and collaborate with CS team from Harvard.
- Starting to build rapport - helping with vaccination efforts.
Glass Window Bridge Eleuthera, Bahamas

Thank You!