

Wake County Familiar Faces Health Collaborative



Cohort:
2020-2023

Team Members:
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Location:
Raleigh, North Carolina

Focus Areas:
Health Care Access
Public, Population & Community Health
Social Determinants of Health

Short Project Summary

Our project involves engaging and coordinating community stakeholders to provide integrated health services to vulnerable individuals with complex needs and who have frequent interaction with crisis systems because current systems are unable to meet their needs. Recent literature shows that the lack of integrated services for those most vulnerable within a community leads to worse outcomes and costly human suffering. The RWJ Clinical Scholars team members all work for organizations (Wake County Government, WakeMed Health & Hospitals, Duke University Health System, and UNC Health) with deep roots in the community. Individually and collectively, they work with and among networks of community stakeholders and service providers who have a substantive understanding of institutional strengths and gaps related to services for the target population. Our team seeks 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. Utilizing existing data sources within our community, our team seeks to understand what it takes to partner, integrate, and deliver a holistic care model to familiar faces, vulnerable individuals who have frequent interactions with crisis safety-net systems. This information will provide valuable insight to improve upon existing

strategies to develop an empathetic human-centered design that addresses systemic problems to improve services and health outcomes. Our efforts will include utilize continuous quality improvement practices to allow for ongoing improvement efforts and broad community adoption.

Wicked Problem Description

Our “Wicked Problem” in Wake County, like many communities across the country, is related to the lack of integrated health services and supports to vulnerable individuals with complex needs and who have frequent interaction with a combination of criminal justice and correctional systems, emergency medical services (EMS), homelessness services, physical and mental health services, substance use detox and treatment services. Several challenges within the healthcare and social services delivery systems combine to make this a “wicked problem”. Some of these challenges include using stand-alone information systems with confidentiality rules that limit the fine coordination of care and services within a community. Second, insufficient, confusing, and chaotic access to non-emergency department crisis services, especially for the uninsured and indigent, without coordination across the care system. Third, the lack of integrated health and mental health medical homes that can provide trauma-informed care where needed. Fourth, insufficient access to resources can address social determinants of health - most notably housing with needed supportive services, nutritious food, transportation, employment, legal services, and personal security. Fifth, vulnerable individuals lack consistent access to necessary pharmaceuticals—lastly, insufficient re-entry planning for individuals leaving the county jail or state prison.

Proposed Project Plan

The project will proceed in three (phases) throughout the grant period:

Problem definition – The RWJ Clinical Scholars team will work with community stakeholders to identify the target population and better understand barriers and challenges associated with their access to integrated, collaborative services. This phase will include interaction with clients, their families, community members and front-line service providers.

Coherence design – The team will take phase one findings and use design thinking methodologies to understand individual experiences and how services are delivered in order to improve and develop care models that cater to this relatively small group of individuals who suffer expensively in the shadows , align necessary service delivery and interdependencies to improve health outcomes. Further, this phase will include an implementation strategy including utilization of real-time feedback loops to allow for ongoing improvement and project evaluation information.

Implementation – The team will work with community providers to implement design deliverables and utilize continuous quality improvement practices to allow for

ongoing improvement efforts. Members will serve as mentors and coaches and will help guide adjustments and improvements as the implementation progresses.

Anticipated Outcomes

Short-Term Outcomes: Define and identify the target population, available services, barriers, and gaps in care. Work with community stakeholders to identify at-risk individuals in our community. Design a client-centered holistic care model that addresses the needs of this population.

Long-Term Outcomes: Implement an evidenced-based client-centered holistic care model that improves our vulnerable population's physical, mental, and social well-being. Implement a system that identifies at-risk individuals early on to prevent them from becoming familiar faces. Use predictive analytics to identify cost-savings that can potentially serve other individuals at risk.

Timeline

Year One

Discovery and Design Phase

Year Two

Implementation of design and decisions (setting up evaluation)

Year Three

Ongoing Continuous Quality Improvement Process

Partnerships

The RWJ Clinical Scholars team will work a broad network of community stakeholders and service providers who have a substantive understanding of this population's needs. These stakeholders include SAS, Wake County District Attorney, Wake County Manager's Office, Wake County Sheriff's Office, Alliance Health, Wake County Housing, and all three healthcare systems providing service in our region.

Evaluation Strategies

The information needed to support the evaluation of project outcomes will part of the project planning process. The team will identify a complete list of variables and metrics needed to monitor progress. These variables include the number of identified familiar faces and their health outcomes, change in frequency of system interactions, number of hand-offs between and among agencies across systems of care. This

evaluation will also include engaging a financial analysis team that will compare increased expenses associated with the interventions with changes in the expenses associated with the utilization patterns changes.

Contact Person Information

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