Toolkit for Familiar Faces Providing Integrated Medical and Social Services to a Vulnerable Population

CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit for Familiar Faces Providing Integrated Medical and Social Services to a Vulnerable Population

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ABOUT

This toolkit is intended to help community stakeholders improve the health and well-being of its most vulnerable community members. It provides strategies to develop a shared understanding of the complex challenges faced by these individuals and a design framework to better understand and address these challenges.

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TABLE OF CONTENTS

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Executive Summary

Person-Centered Design: How we learned how to wrap health and support services around the individual.

Because existing safety net systems often lack needed integrated services to meet the complex needs of vulnerable individuals, these individuals have frequent interactions with these crisis systems, becoming “familiar faces.” Their unmet medical and mental health needs and the current system’s misallocation of resources present a wicked community problem.

This toolkit describes approaches to form a team of community stakeholders, from local governments, community hospitals, health systems, non-profit organizations – in relationship with those with lived experience to identify the barriers to and gaps in service that inhibit the effective interaction of vulnerable community members with front-line service providers.

The toolkit also describes a process to conduct small pilot projects focused on learning to understand and to reduce barriers that inhibit improved care. These lessons also help community partners learn more about the complex systemic nature of these challenges and set the stage for creating immediate and long-term solutions to break the cycle of fragmented treatment of complex needs.

Planning

For more than seven years, Wake County Government has worked with community stakeholders to form a comprehensive, interdisciplinary health task force to address the problems of the general health of the county and our familiar faces. Within this team, a subgroup concentrated on the link between familiar faces and Social Determinants of Health: behavioral health, homelessness, EMS, jail, and substance use disorder. Based on our experience, this team of knowledgeable clinicians determined that, to maintain focus on these efforts, we had to provide a clinical emphasis in the design of a local system appropriate to our community. Our team sought to understand the barriers and challenges associated with service delivery and to find solutions to make the support systems for this population more responsive.

As a result of this community effort, a group of clinical stakeholders came together to better understand and address the health barriers faced by these individuals. With support from the Robert Wood Johnson foundation, an interdisciplinary group of clinical scholars formed to identify workable strategies.

Project Team

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Keturah Beckham: Social Work, Wake Med

Jason Wittes: Pharmacy, UNC School of Medicine

Derrick Hoover: Internal Medicine and health care for the homeless

Kevin FitzGerald: Public Management consultant

Funding

The RWJF initial funding of $540,000 allowed the team to establish a solid foundation to develop effective strategies and plans with community stakeholders. The team designed a comprehensive approach to working effectively with some of the most vulnerable individuals. In response to the COVID-19 pandemic, it applied for and received two mini-grants from RWJF to use healthy meals as a tool to involve these individuals. Totaling $10,000 and $15,000, respectively, these grants were instrumental in providing food and support to vulnerable populations living with chronic health conditions; these individuals were homeless or at risk of homelessness.

The team also received $152,000 from Wake County's ARPA funding, expanding the Heat and Eat meals program to reach more individuals and families. The team also received $100,000 from United Health Foundation to purchase and operate a food truck that will reach vulnerable homeless individuals who live in underserved areas of our community. A Wake County Home Link grant of $300,000 will enable the development of recovery-oriented services for individuals in the Cornerstone bridge housing program, facilitated by peer support specialists. Additionally, Bridge House funding of $247,000 helped the team to pilot a 3-bedroom transitional home that supported additional opportunities to learn from individuals with multiple challenges and to ease their access to various systems in Wake County.

Looking ahead, the team has submitted two grants to SAMHSA, A HomeLink grant of $500,000 per year for five years will support the organization's efforts to provide outreach services. The IPS Supported Employment grant of $780,000 per year for five years will help the organization to create meaningful employment opportunities for individuals impacted by mental illness and addiction.

Community Partnerships

Our work is built upon collaborative work of community stakeholders committed to providing integrated care to individuals who suffer from multiple challenges including physical and behavioral health diagnoses, housing insecurity, frequent interaction with the criminal justice system.

Our team focused on bringing different health disciplines to better understand clinical aspects of this challenging problem, and to provide insights for a more effective community response.

Project work

With community partners input and through case-by-case relationships with familiar faces, our multidisciplinary team took a significant period to learn more about the needs and hopes of the persons we call “familiar faces.” We:

- Listened to their stories and their repeated and often frustrating experiences with “the system.”
- Sought to hear from them first, and then examine the “systems of care” in a more critical fashion.
- Sought to answer the question, “Why is this so hard?”

This perspective was crucial to developing new insights on the problem we aimed to solve. This perspective also shed light on the reality that there are multiple problems to be solved and our systems of care usually worked independent from each other, focusing on DIFFERENT problems. We have come to learn that at a much deeper level that there is not agreement on the essence of the problem itself. This helps to explain why solutions are so elusive. This led us to set up new opportunities – learning pilots – to learn more about the complex and dynamic challenges faced by these persons. These opportunities were informed by “familiar faces” and community workers with frequent and direct contact with them. We were immediately pointed to basic need for food, shelter, and safety (personal and from the pandemic). This involved:

- Meeting the homeless where they lived (in camps) and getting to know them and the community partners who had their trust.
- Figuring ways to address their chronic hunger by finding resources to provide and deliver warm and nutritious meals and then eating with them to get to know them and learn about their hopes and needs.
- Relationship building that helped to provide the basis for trust and mutual respect, and with that trust, we learned so much about their own personal and health challenges. These insights, during COVID, helped us coordinate with public health and hospitals to provide vaccinations, ppe, and other harm-reduction supports.
- With support from Wake County and the public mental health agency. We opened a 3-bedroom home to work with individuals to become stabilized. We have learned important lessons about coordinating assessments, knitting together case management efforts, identifying, and addressing needed supports, engaging peer support workers as part of the services team, and identifying essential informatics requirements.
- With these insights our team is working to help implement a new and significantly expanded facility (Cornerstone).

Overview of Our Approach

- Connect with stakeholders to understand their needs and interests.
- Through tightly scoped learning pilots, dig deeper and learn more about what needs to be addressed and get insights about the hurdles and helpers from the perspectives of familiar faces.
- Using these experiments, inform the standardized definitions for familiar faces, with applicable metrics, for the various systems of care: health, mental health, housing, criminal justice, etc.
- Identify points of systems intersection, opportunities, hurdles, and flaws.
- Embrace opportunities for collaboration, including financial support.
- Improve connectivity to needed support services.
- Work on sustainability for resolution of complex problems.

Heat and Eat Meal Program

Realizing that the issues associated with effectively meeting the ongoing needs of this population, the team realized that gaining insights from the basis of their interaction with the various systems of care was insufficient. The team took an initiative to work with community stakeholders who had developed trusting relationships with these individuals, many of whom are chronically homeless and living together in informal camps. Working with these stakeholders, the team tapped into funding to provide and deliver warm, nutritious meals in the camps. Over time, trust developed between the scholars and the homeless individuals, and with this trust important insights emerged from stories about incoherent and often traumatic experiences with uncoordinated systems of care. These insights helped to develop an abiding appreciation that effectively wrapping services around the needs of each individual required trusting and respectful relationships.

Bridge Housing

The team partnered with Alliance Health the Local Management Entity and Managed Care Organization (LME/MCO) to operate a pilot 3-bed bridge/transitional home. This has been an invaluable opportunity for the team to gain important insights into the unique strengths and needs of familiar face individuals. This experience also underscored the importance of stable and supportive housing. The unit consisted of a 3-bedroom townhouse in Raleigh, close to a public transportation route. Results of this effort show a clear reduction in ED visits for clients who have supportive bridge housing, reducing pre-housing visits from 164 to 32. In addition, there were numerous opportunities to keep learning that these individuals each had their own stories and specific needs to be understood and addressed.

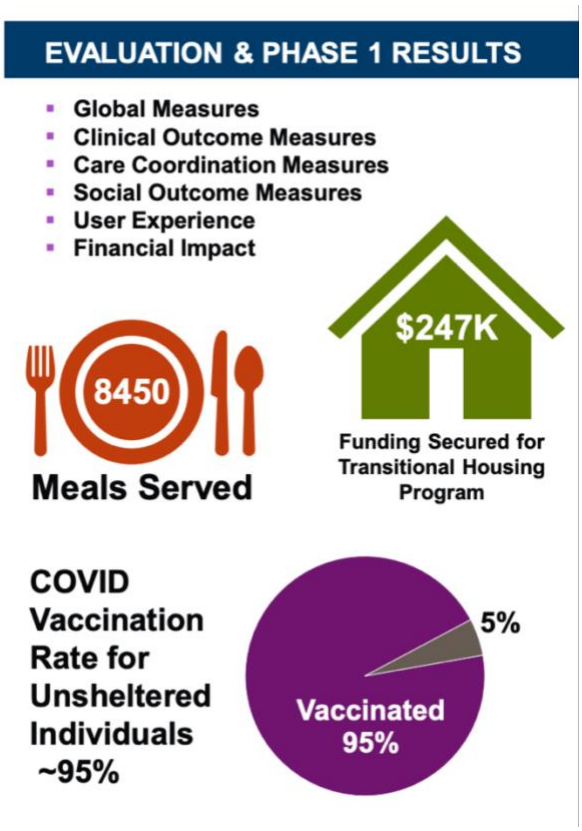
Cornerstone

Opening in late 2023, Cornerstone Center, a program of Wake County Housing Department, will provide expanded and enhanced services for highly vulnerable residents in need of Permanent Supportive Housing (PSH) in Wake County. It will become the PSH “front door” with a best-practice campus approach, including 20 units of bridge housing. As bridge housing, these units will create a space for clients experiencing chronic homelessness and acute physical and mental health needs. While in the process of stabilizing their needs, clients prepare for rehousing in the community with a PSH voucher. The Program components include intensive case management:

- Social Security Outreach, Access, and Recovery (SOAR) benefits assistance
- Vocational counseling
- Peer support
- Life skills training
- Wellness Recovery Action Planning
- Supported employment services

Evaluation

The tightly scoped “pilots” described above have been supported in part by RWJ, but also through separate funding that involved redirection of existing funds flow or taking advantage of new revenues. Each experiment has had its own outcomes, and through weekly meetings, the scholars have improved their collective understanding of the contextual issues involved in each exercise. In terms of improved understanding, the “results” are significant. We are in regular communication with related community efforts working on criminal justice, population health, behavioral health, homelessness services initiatives. Our work has helped these groups develop an improved appreciation for the clinical dimensions associated with meeting this pressing community need. And in turn they are adopting incremental adjustments.



Lessons Learned

We cannot fix all the problems that need resolution. Rather, we learned the importance of addressing the specific and often unique needs of the individuals that we encountered. This required development of a more coherent and ongoing relationship with the individual that took time and special effort. Once established, we were able to develop an assessment and plan that more closely met their needs and circumstances.

We are not trying to fix the healthcare system as a whole. Instead, we are working to respond more effectively to those individuals who have repeatedly fallen through multiple, uncoordinated crisis-system safety nets. We believe that healthcare stakeholders, service agencies, and the familiar faces will benefit through the development of tailored, patient-centered care plans and support strategies.

We have been concentrating on a relatively small number of ‘familiar faces’ to understand their particular histories and needs, helping them to navigate the system and access care. At the same time, we recognize that not all patients need this high level of attention and care. The challenge going forward will be to balance care plans for optimal health for all with available resources.

We have also learned that familiar faces become familiar faces because they do not see “familiar faces,” case coordinators or peers. We noted that these individuals make frequent use of emergency rooms at all three hospital systems in Wake County, and even though all hospitals use the same electronic health record, discharge orders, and prescriptions, follow up procedures are not coordinated. It is the familiar faces who must follow through, acting as their own care coordinator, a role they are generally not prepared for, causing frequent repetitions of the cycle.

From the Heat and Eat Meal Program we learned:

- Access into camp sites 'hiding in plain sight' is critical for establishing trusting relationships.
- The “living conditions” in the camps are challenging and unhealthy-- no running water, no designated toilet areas, trash accumulation, no refrigeration.

- Residents use sophisticated verbal call signs to know when friends are approaching vs. strangers.
- These are also well-knit communities, some with generators on site.
- It takes time to build trust and uncover unmet needs.
- Residents expressed that they are treated as subhuman when they seek help and hence often wait until it is too late. They feel judged as though they are burden going to the ER.
- Based on the way these individuals are treated: in public they feel invisible and when they seek help they feel unworthy of care.

From the Bridge Housing we learned:

- Timing is important and there is no set time for how long it will take, based on individual needs.
- It takes time to redevelop social skills (especially for people leaving the prison system, solitary confinement and/or with mental illness).
- Need help in learning how to be accountable for their actions.
- Change is hard. Change of care manager even with more than warm hand off is amplified for this population (suicide attempt).
- Need for care manager to be proactive to help keep people on much needed meds including antipsychotic or anti-anxiety meds).
- Difficulty and length of time to get public benefits.
- Relatively small tasks take long amount of time.
- Fragility of medical and behavioral health state in this population.
- Location of housing needs to be away from easy access to drugs especially for people with SUD, but affordable housing seems to be close to dealers.
- Deal with frequent turn over in PCPs, BH providers, Care Managers, etc.
- Need for IDT meetings to help navigate our complex convoluted system.

Successes

Our work has allowed us to create new frameworks that help us to see and interact with familiar face individuals in new ways that allow us all to build on assets and strengths rather than needs and deficiencies. With this shift in perspective, the following areas of improvement have been strengthened:

- Community-based engagement programs that are critical to building trust and rapport within a population that lacks trust, due to the failure of the safety-net systems to meet their needs.
- Familiar faces have many complex needs that require multiple interventions beyond addressing healthcare needs. Using a person-centered holistic approach to care addresses the total needs of the individual. An increasing number of community providers are embracing this viewpoint for these most vulnerable populations.
- A key takeaway from our experience is the need to identify a team that assumes primary responsibility for leading these efforts. These capabilities are incorporated in North Carolina's Medicaid Plan for Behavioral Health and integrated health.
- Vulnerable patients would benefit from an enhanced intensive care management model that accounts for SDOH. These insights have been shared with NC Care 360, North Carolina's state-wide assessment network for the delivery of the determinants of health.

Best Practices

- **Listening:** Special attention has been placed on those PERSONS with the most complex needs. From our time together as a team, and through developing relationships with these individuals, we have learned much about their unique and very personal circumstances. Listening with empathy to better understand has helped us to use our professional expertise much more effectively. It has provided insights to help guide our work within and across our complex systems of care.
- **Owning our part of the problem:** Our systems of care often do not communicate with each other very well for several important reasons. They certainly do not coordinate well for these persons with exceptional needs. Policies, information systems, administrative procedures, funding, and professional disciplinary differences all contribute to a chaotic experience and poor health outcomes. And yet, these systems of care find making changes internally to address these exceptional and complex needs very difficult to achieve.
- **Humility:** Effectively meeting the needs of “familiar faces” with compassion and persistence is a long-standing challenge eludes straight forward solutions. This is partly due to the complexity of the problem, itself. In the face of answering the question, “Why is this so hard?”, we have come to realize that we have partial solutions and an incomplete formulation of the problem that we are attempting to solve. In this light, we seek to leverage our personal and professional relationships across multiple disciplines to engage this tangle of issues in all of its complexity.

Appendix

Resources:

- Brown Tim. Change By Design. 2nd ed. New York: Harper Collins, 2019.
- Dorst Kees. Frame Innovation: Create New Thinking by Design. 1st ed. Cambridge: The MIT Press, 2015.
- Rittel, Horst W. J., and Melvin M. Webber. “Dilemmas in a General Theory of Planning.” Policy Sciences 4, no. 2 (June 1, 1973): 155–69. https://doi.org/10.1007/BF01405730.