WHOLE PERSON CARE
MONTEREY COUNTY
Physical Wellness • Behavioral Health • Social Services

Updates from WPC program from January 1 through June 30, 2017

Administration

- Round 2 of WPC application has been approved. See revised 1-page handout for new strategies
- Our focus population goal has increased from 500 to 600 for the duration of the pilot
- Case management staff currently include 1 PH RN, 1 BH Aide, Supervising PH Nurse, and PH Bureau Chief. Recruitment is in progress for Deputy PH Director, Director of Nursing, and additional PH RNs
- MCHD Project Manager has been named. Other administrative support includes an Epidemiologist and Chronic Disease Prevention Coordinator.
- RFP for population health software is in NMC hands for releasing to potential vendors
- Patient Referral Form is under revision based on the newly issued State Health Information Guidance (SHIG) on Sharing Sensitive Health Information. See http://www.chhs.ca.gov/OHII/Pages/shig.aspx
- Referral Response Form is under revision based on newly issued SHIG
- Patient Consent Form is under revision based on newly issued SHIG
- Request to delete "at-risk for homelessness" from contract with DHCS has been filed and approval is pending
- Agreement for referrals from CCAH to MCHD is in development; the MCHD HIPAA compliance review is done.
- MOU between NMC and MCHD is in development
- Agreement with CHISPA for use of space at Junsay Oaks (40 unit housing for WPC & mentally diagnosed clients) is in development
- Agreement with MidPen for case management services at 21 Soledad Street is pending other priorities
- BOS has named WPC as a focal point performance measure for HH&S in 17-18
- WPC presentations made to Community Voice for Aging (Supervisor Parker)
- 1-page WPC description has been revised (attached) and posted on WPC webpage

Field Report

- 30 clients enrolled (found and consented) as of June 30
- Anticipate at least 42 enrollees by July 31st
- Total of 88 potential clients have been vetted to date
- 50 WPC-eligible individuals have been assigned to the Public Health Nurse Complex Care Management Team; enrollment is pending.
- Over 125 referrals received to date; many are in process to determine eligibility and locate clients
- Number of homeless clients since inception who have been helped into housing:

Permanent: **4**	Assisted Living: **2**	Hotel: **2**	Rehab: **2**
Transitional: **2**	SNF: **1**	Respite Care: **1**	

- Focus of Complex Case Management is trifold: Health, Housing and Behavioral Health (SUD and MI)
- RNs or Behavioral Health Aides are accompanying clients to health appointments, housing interviews, behavioral health interviews, social services interviews
- Case managers advocate for clients in housing and treatment placement and are convening multidisciplinary collaborative case conferences bi-weekly
- The internal referral process has not changed

Partnerships

- WPC is enjoying strong supportive collaboration from the Clinics and Behavioral Health. Clients are often slotted into the schedule when the team calls
- Referrals coming in from NMC, Clinic Services, PH Nursing, CHOMP, Gathering for Women, Franciscan Workers, Coalition of Homeless Services, and a few others, including self-referrals

Client Experience

This WPC Client has been homeless off and on for approximately 30 years, has served 3 prison terms, is wheelchair bound, has been a victim of sexual and physical abuse, is malnourished, has a diagnosis of schizophrenia, and is opioid-dependent. With coordination between the WPC Registered Nurse Case Manager and behavioral health assistants, and partners Dorothy's Place, McHome, and the Coalition of Homeless Service Providers, the client was placed in assisted living. Case managers continue working with this client to address opioid dependency. The client said the WPC experience was "the first time people had showed kindness to me in a very long while" and told case managers that everyone in similar situations should know about the WPC program.

COUNTY OF MONTEREY
HEALTH DEPARTMENT
Elsa Jimenez, Director of Health

Administration
Behavioral Health
Clinic Services
Emergency Medical Services
Environmental Health/Animal Services
Public Health
Public Administrator/Public Guardian

2017 Awardee of The California Endowment's Arnold X. Perkins Award for Outstanding Health Equity Practice

WHOLE PERSON CARE

MONTEREY COUNTY

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Whole Person Care (WPC) is a program of Monterey County Health Department and its community partners to provide comprehensive case management for our county's most vulnerable Medi-Cal recipients who are high users of hospital and emergency department facilities. This focus population may also:

- be homeless/chronically homeless,
- have mental illness or substance use disorders or both,
- have multiple chronic disease

The WPC program Registered Nurse case managers assess WPC enrollees for health, housing, and social services needs, and then provide warm hand-offs to primary care clinics, mental health/substance abuse therapists, social services, housing supports and placement, and employment training. Case managers will also assist WPC enrollees will be assisted in their normal environments with benefit assessments, setting and keeping appointments, transportation, food and nutrition, peer support groups, and housing counseling and skill development training.

New strategies to be developed by WPC include cross-system data sharing systems between WPC case managers, four hospitals located within the county, Monterey County Clinic Services and community clinics, substance treatment providers, and homeless services providers. New facilities include an 8-bed sobering center for stays up to 24 hours, a 6-bed respite center for medically fragile WPC enrollees who need are discharged from a hospital but are unable to recover on their own.

Approximately 600 individuals will be served between now and 2020. WPC enrollee health outcomes and delivery system improvements will be measured. We expect Emergency Department and hospital use to decrease for our WPC Population, and corresponding improvements in managed diseases such as diabetes and high blood pressure.

To be a referring partner, or refer a potential client to Whole Person Care,

Please contact us at 831/755-4630