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

Report for Operational Year 1

Health and Human Services Committee, January 18, 2018

COUNTY OF MONTEREY
HEALTH DEPARTMENT

County Of Monterey
Health Department
Leading the way

WHOLE PERSON CARE BACKGROUND

WPC coordinates comprehensive health, behavioral health, and social services case management to

- **Improve beneficiary health & wellness and**
- **Reduce overutilization of hospital resources**

Minimum 600 Medi-Cal and potential Medi-Cal Enrollees who are

- **Homeless/chronically homeless and**
- **May have mental illness and/or**
- **Chronic disease diagnoses**

WHOLE PERSON CARE BACKGROUND

WPC in effect now through December 2020

$34 M for five years (½ Federal Funds, ½ County Match)

County partners are:

- **Health Admin, Public Health, Behavioral Health, Primary and Specialty Care**
- **NMC**
- **DSS**

The goal beyond 2020 is for the WPC model to become the "new normal" with sustainable Medi-Cal funding

WHOLE PERSON CARE BACKGROUND

Community Partners are

- Central CA Alliance for Health
- CHOMP, SVMH, Mee hospitals
- Community clinics
- Coalition of Homeless Services Providers
- Mental health & substance use services providers
- Social services providers
- Housing Authority, low income housing providers, & low income housing developers

WPC NEW APPROACH

Complex, comprehensive care coordination

- Interdisciplinary teams headed public health nurses
- Health, mental health, housing, and vulnerability assessments
- Health & services appointment navigation and transportation
- Individual health care plans
- Warm hand-off referrals
- Individual health, housing, & services plans and coordination
- Crisis support, substance use treatment, life skills, tenant education & coaching, paths to employment

NEW FACILITIES & PROGRAMS

Facilities

- 8-bed, 24/7 Sobering Center opened December 2017
- 6-bed Respite Center for medically fragile enrollees – RFP pending
- 88 units at 21 Soledad Street. WPC providing funds for MidPen case managers
- 47 apartments in Marina. WPC providing CHISPA with case managers

Programs

- Comprehensive case management, services, supports – in effect
- Peer Navigators – RFP pending
- Rapid Rehousing – proposal pending DHCS approval
- Service integration for qualified individuals leaving jail

2017 ENROLLMENT OUTCOMES

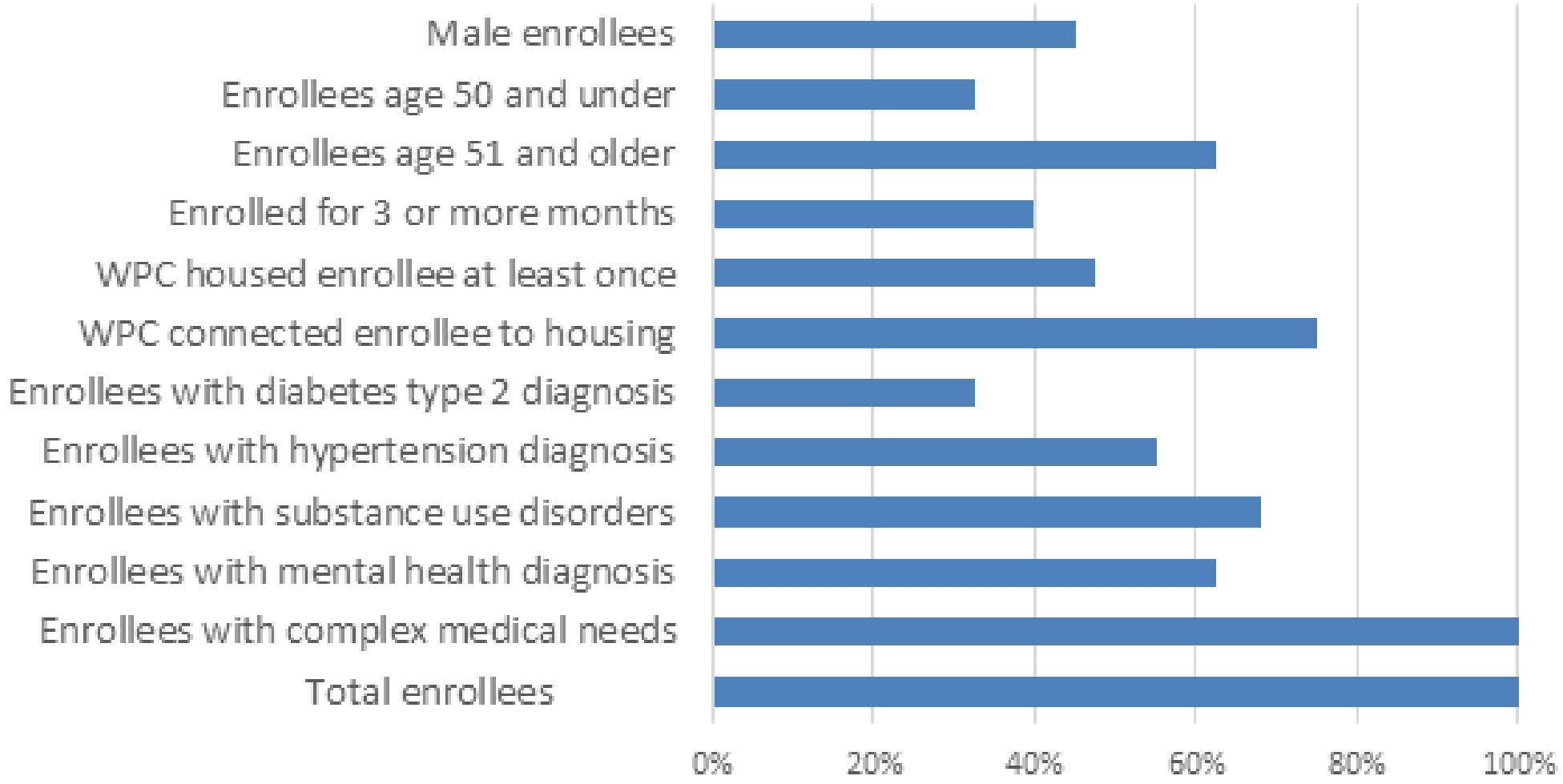
Referrals received in 2017	**276**
Referrals vetted for eligibility	**270**
Current pipeline to find & consent for services	**119**
All enrollees including dropped and deceased	**48**
Current enrollees	**32**

Challenges: HIPAA and other protections prohibit unsolicited inquiries; potential enrollees are difficult to locate or don't want services.

STAFFING AND HOUSING OUTCOMES

- Case Management is fully staffed with four, 2-person teams
- Referrals coming from all hospital EDs and soon from CCAH
- Monthly Social/Clinical meetings are strengthening partnership communications and problem-solving
- 41 enrollees helped into housing:
  - Permanent: 11 Assisted Living: 4 Hotel: 5
  - Transitional: 12 Skilled Nursing Facility: 5
  - Respite Care: 4

ENROLLEE PROFILE



SUCCESS STORY 1

70-year old person had been homeless for 30 years. The person suffered from multiple chronic diseases that lead to over-use of CHOMP's Emergency Department.

Since WPC program enrollment in October 2017, the enrollee has had no ED visits, has been assigned to a primary care provider, has received a full range of health related services from the WPC Public Health Nurse case management team and partners, and has obtained housing at a board and care facility.

SUCCESS STORY 2

73-year old person had recently became homeless and was referred to WPC by an emergency department that the person was frequenting as a place of shelter. The person suffered from multiple chronic illnesses.

Since WPC program enrollment in August 2017, the enrollee has been assigned to a primary care provider and no longer seeks care at the ED. The WPC Public Health Nurse case management team helped the enrollee find housing at a board and care facility and assigned them an in-home health support (IHHS) worker at 70 hours a month to help with a wide variety of activities of daily living.

SUCCESS STORY 3

A person had been homeless off and on for about 30 years, had served 3 prison terms, had been a victim of sexual and physical abuse, was malnourished, is wheelchair bound, and has a mental health diagnosis.

Since WPC program enrollment in July 2017, the enrollee was placed in assisted living. The WPC Public Health Nurse case management team continues to work with this enrollee to address substance dependency. The enrollee said the WPC experience was “the first time people have showed kindness to me in a very long while.”

FUTURE GAME CHANGER

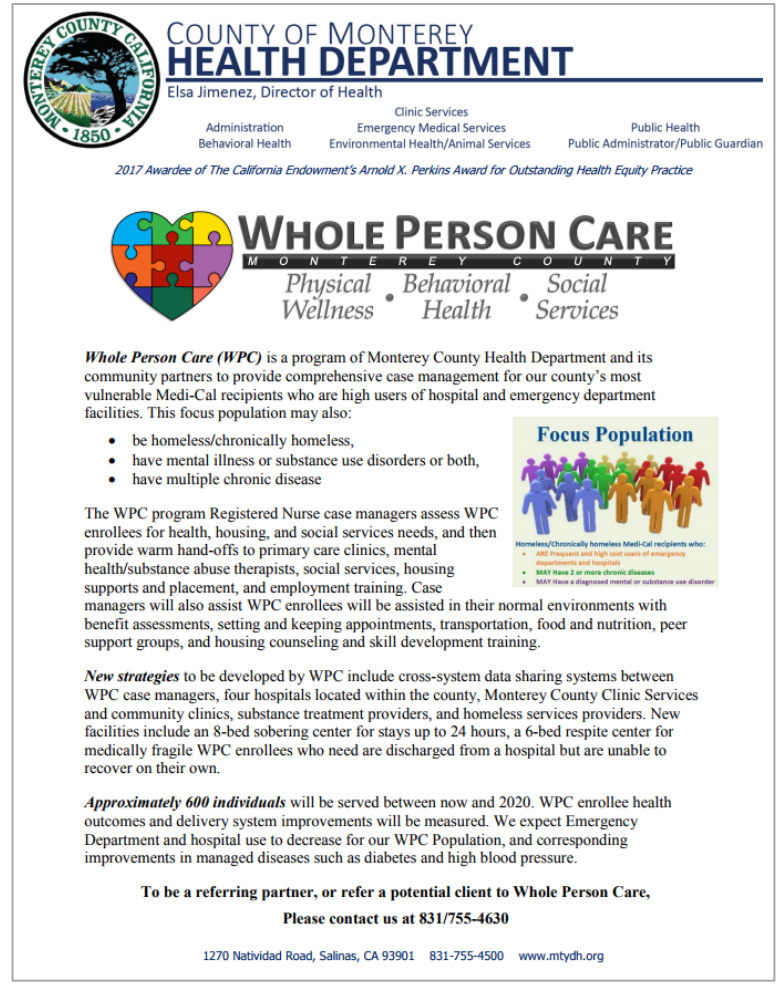
Integrated IT systems to share health data among hospitals & clinics, and service data among providers

Developing with NMC for WPC and Prime application:

- Master Patient Index – est. start by December 2018
- Case Management System – est. start by fall 2019
- Data Warehousing – discussions now taking place

WEBSITE MATERIALS

- 1-Page Description (English, Spanish)
- Referral Form (English, Spanish)
- Social Clinical Workgroup Contacts
- Social Clinical Meeting Schedule
- PowerPoint presentations
- Contract with State
- Quarterly Performance Updates



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
Physical Wellness • Behavioral Health • Social Services

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

Focus Population

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

1270 Natividad Road, Salinas, CA 93901 831-755-4500 www.mtydh.org

http://www.co.monterey.ca.us/government/departments-a-h/health/public-health/whole-person-care

THANK YOU

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http://www.co.monterey.ca.us/government/departments-a-h/health/public-health/whole-person-care

CA Department of Health Care Services

http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx