PETERYOUNG
HOUSING ● INDUSTRIES ● TREATMENT

Engaging Community Partners for Whole Person Care

Jackie Foster & Cassandra Becker

UPLIFT
WARREN WASHINGTON
A Ride Back To Health

Whole Person Care

What is it?

- "Whole-person care can be defined as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."
- Recognizing that even if you do your best work with a client/patient that you may not see improved outcomes
- Recognizing that a person is part of a whole system that impacts their wellbeing
- Recognizing that you cannot help a client alone

Where to Start?

- Identify Community Needs
  - *Attend community meetings*
  - *Attend Forums*
  - *Research data*
  - *Ask frontline workers*
  - *Work with the County/State*
- Begin asking "how can my agency help?"
- Begin asking "can we tackle this need on our own or do we need partners"
- Begin looking at how partnering would improve the overall health of your client
- Look at the financial impact
- Research grants or other financial options

Engaging Community Partners

Identify the shared benefit

- Successful partnerships are developed when there is a clear understanding of the benefit of the partnership.
- Identify an overall goal of the partnership
- Discuss if additional partners are valuable to the over all goal

Build the partnership/s

- Communicate expectations
- Identify who is responsible for what parts of the project/partnership
- Identify how you will track the success of the partnership
- Be prepared to have to rework the details of the partnership as the program grows/molds

Examples:

Community Health and Wellness Program

ABLE

- Goal- Help inmates or those at risk of incarceration connect to services as soon as possible to provide the best transitional success
- Partners- Baywood Center, Warren County Jail, Washington County Jail, Office of Community Services, Warren Washington Association for Mental health
- Program- Jail transition coordinator meets with inmates that are referred by the jail, probation, courts, lawyers, family members, ect to identify unmet needs. Coordinator works on setting up resources for the individual then follows the individual while they connect to the services and improve their life mentally, physically, and socially.
- Coordinates with- Department of social services, long term case management services, mental health services, substance abuse services, legal aid, legal entities, food pantries, employment assistance programs, shelter/housing services, transportation…….

ABLE

"Joe"

Before

- In jail, multiple incarcerations
- "if this does not work I'll go back to selling drugs"
- No housing options
- No social supports
- Pending additional charges in another County
- No insurance

Services

- ABLE became involved 6mo prior to release
- Insurance navigator
- Uplift for transportation
- Worked with other county to resolve charges
- MAT
- Sanctioned by DSS, removed due to coordination
- Personal care needs through community action

Now

- Went inpatient
- Found Housing
- Working with CRPA for support
- Not back in jail!

Community Health and Wellness

- Goal- Improve mental, social, and physical fitness
- Partners- Baywood Center, YMCA of Greater Glens Falls area, Council for Prevention, and the Alliance for Positive health
- Program- Participants work together with a CRPA and Wellness Coordinator to identify how to utilize YMCA services to improve not only their physical health but also their mental and social health.
- Areas addressed:
  - *Social- Group activities geared toward Wellness participants monthly*
  - *Child care assistance while in treatment or at YMCA*
  - *Physical – BMI, Blood Pressure, Body fat monitored for improvements*
  - *Emotional- availability to talk with wellness coordinator, CRPA, or physical trainers- Bonds built*
  - *Nutritional Supports*
  - *Case management support from CRPA*

Community Health and Wellness

"Jane"

Before

- Homeless-Living in car
- CPS involvement with Son
- Active Addiction
- No social supports
- No DSS services (new to the state)
- Diabetic

Services

- Baywood Center
- YMCA- showers, childcare, camps, working out
- DSS- Housing, financial assistance
- Medical
- Care Coordination meetings

Now

- Has her own apartment
- Foster care has returned Custody of her son
- Sober
- Works with CRPA, found support in groups
- Receives DSS benefits to live on her own and raise her son
- Diabetic- medication compliant

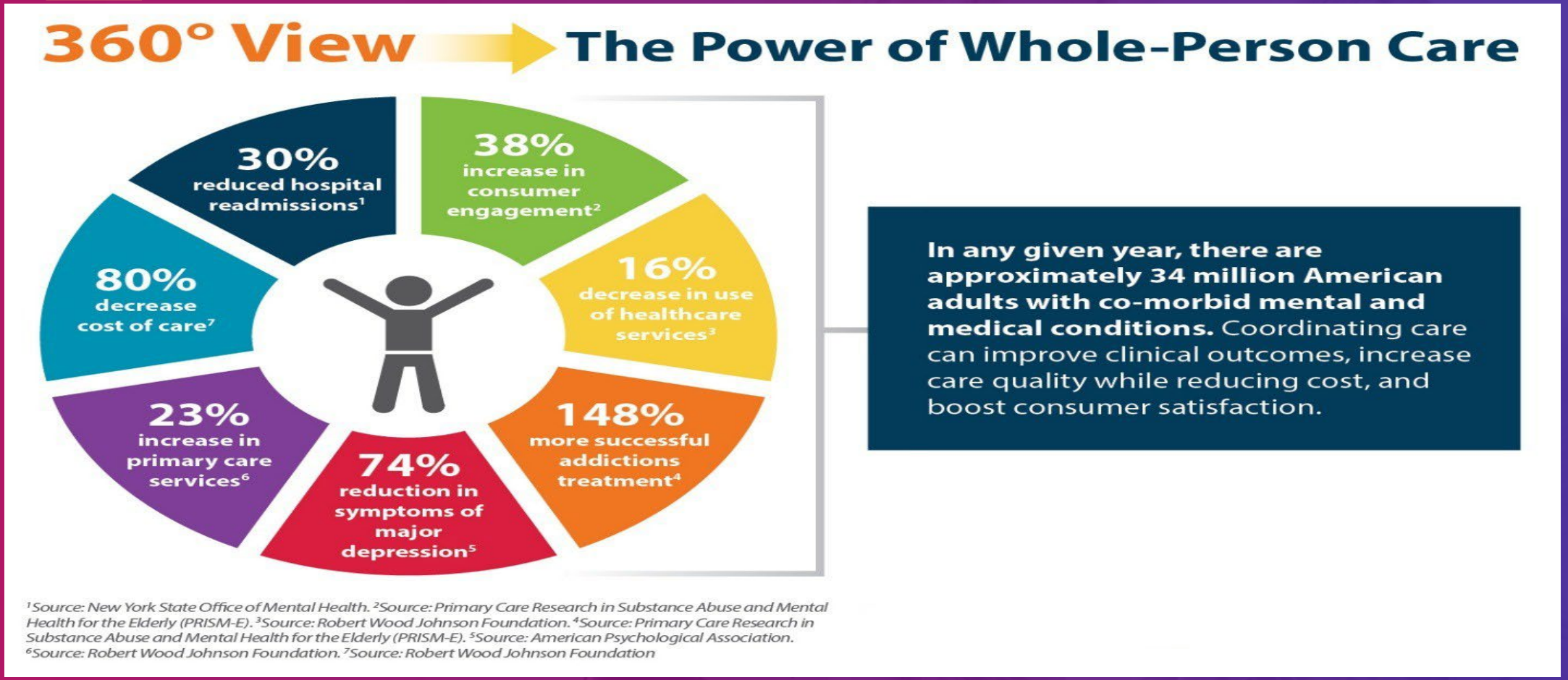
Uplift

- Partners- Baywood, United Way, Greater Glens Falls Transit, Warren Washington Association for Mental Health, HHHN, Glens Falls Hospital, Center for Recovery, Washington and Warren County DSS and other agencies in the Warren, Washington and Northern Saratoga county region.
- Details- Through community engagement and outreach, we were able to help the "launch" of the Uplift program. Attending care management meetings and by being easily accessible with the willingness to meet the individual "where they were", we were able to meet a tremendous need within our community and hope to continue adapting Uplift to meet future needs.
- Goal- to promote preventive health by giving individuals increased access to care services by relieving the hardship of lack of transportation.
- Program- We provide transportation to individuals with recent health issues to help stabilize their condition and prevent ER visits/hospitalizations by allowing them access to medical appts, counseling appts, department of social service or care management appts, court appearances, participation in community based support programs, to obtain medical equipment or prescriptions, and to access grocery stores or food pantries.

Challenges of Whole Person Care

- Finding a common purpose and benefit for all parties
- Communication – speaking different languages
- Work flow
- Oversight agencies
- Funding streams
- Silo Care- Old mindsets
- Client buy in
- Technology
- Data sharing
- Understanding improved health among silos

Why try???


360° View
The Power of Whole-Person Care
30% reduced hospital readmissions[1]
38% increase in consumer engagement[2]
16% decrease in use of healthcare services[3]
148% more successful addictions treatment[4]
74% reduction in symptoms of major depression[5]
23% increase in primary care services[6]
80% decrease cost of care[7]
In any given year, there are approximately 34 million American adults with co-morbid mental and medical conditions. Coordinating care can improve clinical outcomes, increase care quality while reducing cost, and boost consumer satisfaction.
[1]Source: New York State Office of Mental Health. [2]Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). [3]Source: Robert Wood Johnson Foundation. [4]Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). [5]Source: American Psychological Association. [6]Source: Robert Wood Johnson Foundation. [7]Source: Robert Wood Johnson Foundation

Why try??

- Greater staff satisfaction
  - referral flow
  - healthy clients= less staff burn out
  - Less staff turn over

- Better outcomes
  - Insurance Contacts
  - Additional funding, Grants, reallocation of funds

- Reducing barriers for clients
  - More likely to engage with services that are easy to obtain
  - Healthy can be contagious
  - Longer lasting change/health

- Healthier communities
  - Ending cycles
  - Your community too

Jackie Foster
Director of Outpatient Services
Jackief@pyhit.org
518-798-4221

Cassandra Becker
Transportation Coordinator
Uplift Warren Washington
upliftwarrenwashington@gmail.com
518-320-6692