West County Health Centers
Caring for our Communities

West County Health Center's (WCHC) CARE+ Success Story

History ***(Basic demographics, diagnoses, history of mental health / addiction and reason for enrollment in the program):***

Patient A is a 74-year-old female who was referred to the CARE+ program by her primary care provider for case management and coordination of care for internal and external community supports. PCP reported patient was in acute distress and in need of comprehensive assistance, following an abusive 25-year marriage that recently ended in her husband leaving the her suddenly for another relationship. Patient has a history of childhood trauma and domestic violence. She has the following diagnoses: Anxiety and PTSD. Patient is retired and living on social security and was unable to maintain high cost of her rental home after her husband left her without any monetary supports or assets. Patient scored a 27 on her intake PHQ-9 screening.

Interventions ***(Case management, group/ individual therapy, PSR groups, WellCARE visits, PCP and specialty service visits, housing assistance, employment assistance, referrals and linkage to community agencies, etc.):***

Patient A was referred to Adult Protective Services following a domestic violence report one year prior to establishing care with WCHC. While enrolled in the CARE+ program, coordination of care occurred between APS case worker and the CARE+ Coordinator. CARE+ Coordinator assisted patient with housing application and move to affordable senior housing. CARE+ Coordinator assisted with financial application for local utility assistance from HEAP and North Coast Energy. CARE+ Coordinator arranged for WellCARE visits with an in-house physician's assistant from the CARE+ program to treat the patient's physical symptoms during this stressful time in her life. Treatment included prescription medication for acute headaches and insomnia related to environmental stressors. Cognitive changes were identified and additional case management support was provided such as assisting patient in sorting her belongings and packing up her home on at least five separate occasions. CARE+ Coordinator also provided the needed emotional support when patient became overwhelmed with the task of sorting through photos and mementos from her marriage and childhood, helping the patient to stay focused on moving forward rather than regressing and experiencing worsening symptoms. CARE+ Coordinator was the only support available to help patient pack her belongings for a successful move.

Outcomes ***(How did patient improve due to the interventions provided (i.e., obtained housing, developed coping strategies, developed support system, better management of mental and physical health, reduction in PHQ-9 scores, self-reported improvement including personal statements about recovery, etc.):***

Patient A is now living in a subsidized senior living complex, is financially stable and comfortably maintaining a fixed rent rate at one-third of her SSI income. Her most recent PHQ-9 score was 0 and she is now successfully managing her mental and physical health Her symptoms of anxiety have greater reduced. Patient reports she has developed supportive relationships with several of her new neighbors, while maintaining the relationship with her CARE+ Coordinator that was built during her difficult transition. "I would not be where I am now were it not for the angels who came into my life. I wanted to stay in bed and wait to be turned out on the street but I couldn't bear to let down the people who came to my aid when I didn't think I was worthy of rescue." "I am safe; I am secure. Dare I say that contentment has found me. What a lucky, lucky woman I am."

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History ***(Basic demographics, diagnoses, history of mental health / addiction and reason for enrollment in the program):***
Patient B is a 56-year-old male with a history of Recurrent Depression and PTSD. His medical diagnoses include Type 2 diabetes mellitus with diabetic neuropathy, obesity, and acute diastolic heart failure. Patient reports childhood sexual abuse and poverty, drug addiction now in full recovery, and a past conviction for misconduct with a minor that resulted in a 9-year imprisonment. Patient was referred to the CARE+ program by his primary care provider for case management and support with care coordination and connection to internal and external community resources. Patient scored a 20 on the PHQ-9 screening at intake.

Interventions ***(Case management, group/ individual therapy, PSR groups, WellCARE visits, PCP and specialty service visits, housing assistance, employment assistance, referrals and linkage to community agencies, etc.):***
CARE+ Coordinator referred patient to internal behavioral health services to address issues of childhood trauma and unresolved grief following his girlfriend's suicide two years ago. Patient enrolled in weekly psychosocial skills training groups co-facilitated by the CARE+ Coordinator and medical provider. Groups have focused on the following topics: Coping skills, relationships, and positive self-talk. CARE+ Coordinator arranged for nutrition education through WCHC's Wellness Center in order to better manage his diabetes. CARE+ Coordinator advocated for pain management care with special sensitivity and emphasis placed on the patient's past addiction history. CARE+ Coordinator provided additional individual education on exercise, health eating, and pain management and helped to enroll patient in a second CARE+ group focusing on mindfulness and stress management through movement. CARE+ Coordinator aided patient in applying for Calfresh food assistance and emergency county rental and utility financial relief (ERAP). CARE+ Coordinator was present to support patient during SSI appeals and unemployment EDD interviews. CARE+ Coordinator arranged for PCP visits to address patient's unique SDOH's and assisted with referrals and appointments for external specialty care services for chronic pain and injuries. CARE+ Coordinator provided additional emotional support, employing active and empathic listening to encourage patient insight and self-improvement through patient centered goals.

Outcomes ***(How did patient improve due to the interventions provided (i.e., obtained housing, developed coping strategies, developed support system, better management of mental and physical health, reduction in PHQ-9 scores, self-reported improvement including personal statements about recovery, etc.):***
Patient B is now attending two weekly psychosocial skills training groups co-facilitated by the CARE+ Coordinator and medical provider. His engagement in services has increased and he is utilizing coping skills and grounding techniques he has learned in group sessions and applying to everyday life experiences. He has reported finding these techniques especially useful in situations where he gets angry and confrontational… "I was skeptical about all this breathing and have to admit that it does work. I remember to stop and use what we've talked about before going into a stressful thing. When you're a 6'8 Black man you can't just walk into anywhere worked up, people get scared. I stop and breathe. When I'm calm, I can think about what I need to say and it's a much better outcome." Group participants have recognized the Patient as being a supportive peer mentor, encouraging others with his insight and dedication to working on improving himself. Patient PHQ-9 score after 3 months in the Care+ program is 13.

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Patient C is a 33-year-old transgendered woman with a diagnosis of depression, anxiety, and type 1 diabetes mellitus. Patient was diagnosed on the autism spectrum two years ago and reports a history of behavioral and relational difficulties due to growing up without appropriate supports for her disability. Patient was previously unsheltered but now resides in a small trailer/mobile home with her father, whom she describes as "alcoholic and withdrawn." Patient has a history of psychiatric hospitalizations and admissions to the crisis stabilization unit due to suicidal ideation. Her most recent psychiatric hospitalization was one year ago. Patient reports difficulty with maintaining employment work and relationships and difficulty with basic life management skills due to deficits in executive functioning. Patient was referred to the CARE+ program by her behavioral health specialist for case management, care coordination, and psychosocial skills training. Patient's PHQ-9 score at intake was 20.

Interventions ***(Case management, group/ individual therapy, PSR groups, WellCARE visits, PCP and specialty service visits, housing assistance, employment assistance, referrals and linkage to community agencies, etc.):***

The CARE+ Coordinator assisted patient with the application process for Calfresh and Social Security Disability benefits. CARE+ Coordinator has also provided assistance with obtaining documentation for the Social Security appeals process. Care+ Coordinator aided patient in completing paperwork and obtaining official documents for legal change of name and gender and accompanied patient to the local courthouse and county clerk's offices. Care+ Coordinator facilitated legal aid for patient when her SSDI application was denied and accompanied patient to the DSLC office for orientation. Patient has consistently attended the CARE+ psychosocial rehabilitation skills training groups co-facilitated by the CARE+ Coordinator and medical provider. Groups have focused on coping skills, relationships, and mindfulness. CARE+ Coordinator advocated for provider support and insurance appeals to ensure that patient was supported in gender expansive treatment and transition.

Outcomes ***(How did patient improve due to the interventions provided (i.e., obtained housing, developed coping strategies, developed support system, better management of mental and physical health, reduction in PHQ-9 scores, self-reported improvement including personal statements about recovery, etc.):***

Patient was approved for her legal name and gender change and is in the process of transitioning all identification and accounts to her preferred name. Patient has begun attending a second in-person psychosocial rehabilitation group to help decrease her isolation while increasing her socialization skills and natural supports. Patient reports the following about in-person groups, "it feels good to have a place to be and people to support me." Patient has not had any psychiatric hospitalization or crisis stabilization unit admissions during her 9-month participation with the CARE+ program. In addition, her PHQ-9 scores have reduced by 5 points. Patient reports feeling hopeful and more positive and is looking forward to her surgical transition in the near future. "I could not have come this far without all of the help I have received. I get stuck and need that accountability, just having someone there makes a huge difference and then I can get things done. I'm finally starting my life and have I big goals. I don't want a mediocre life. I have too much potential."

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