Pathway Home October 2018

Newsletter

Volume # 2 | Issue# 4 | Coordinated Behavioral Care, Inc.

Announcements

Welcoming Angelo and Sarah

Angelo Barberio and Sarah Abramson recently joined the CBC Pathway Home team as a Program Directors!

Special Shout Out

Cheers to Jovannie on her new bundle of joy, her baby girl Jolie. And a big mazal tov to David N for his marriage!

Family Expansion

CBC awarded Post Graduate of Mental Health as the agency chosen to represent one of the new Adult Home team in Brooklyn. Another great addition to our current CMA teams. Congratulations!

Inside This Issue

Barry's Message

"Everything is naturally related and interconnected." - Ada Lovelace

Collaboration. Imagine an ecosystem; A community of interacting parts where complex networks are interconnected. Each organism distinct. Yet the unique features ensure functioning and survival of the system. How can we redefine community-based care to create a healthcare ecosystem where community supports can be interconnected and structured, yet maintain their individuality?

No matter how incredible one individual may be, there is only so much we can accomplish alone. Those we serve need the input and participation of all the healthcare and community supports to reach their goals. At Pathway Home (PH), we value the collective efforts and expertise of our colleagues in hospital, clinical, housing, physical health or other settings. Our conjoined energies and strengths together create improved care and increased experience – for both the member and direct staff.

This month's theme is on developing this interdisciplinary and collaborative practice. PH staff shared stories on how they take a leadership role in aftercare planning and creating successful care relationships with other providers and systems.

PH Teams hold scheduled partner meetings, perform activities that improve gaps of service without "pointing the finger", and take steps to include all supports in care.

We practice values of listening to each other, daring ourselves to be optimistic, being transparent – the ingredients of building trust.

CBC's approach takes practical actions by investing in technology and activities that bring us closer to more collaborative practices. GSI enables the interdisciplinary teams and programs to collaborate on care, access and share information, and consolidate care plans. CBC organizes networking series where sectors share knowledge and resources, problem solve, and network. CBC's PH staff organize partner meetings with programs within CBC's network to discuss what is working, explore opportunities for partnership, and determine how to improve user experience and outcomes. Pathway Home, as a model administered by CBC, connects the CMA teams that make up PH - SUS/ICL/CCNS. This allows the values and benefits of each CMA to influence positively all Pathway Home teams. By participating in CBC's programming, PH staff can leverage the 50+ agencies and their hundreds of unique community and population focused programs.

Through these collaborative activities, we are fortunate to meet and build improbable partnerships with dedicated and remarkable folks across the healthcare continuum. Over the last year, PH teams have been embedded at Bronx Psychiatric Center and Metropolitan Hospital Center as well as partnering with community housing providers for tenants moving into newly developed supported housing units. Our next project is to join the adult home plus initiative and develop partnerships with two acute care hospitals.

Our ambition is that together with the partners, we create this ecosystem of interconnectedness, where those around the person served are united in a meaningful and actionable manner. The PH team serves as a tool to bond together the disparate systems and give birth to this healthcare ecosystem.

I am deeply grateful for those who have shared their stories. Thank you all for your contributions.

With warm regards,

Barry Granek

Hot Press

NACM Conference

CBC Senior Director, Barry Granek and SUS Senior Mental Health Clinician, Nikenya Hall presented at the annual National Association of Case Management Conference on October 3rd, 2018 held in Indianapolis. The Theme of the conference was "Start Your Engines, Leading the Race towards Excellence in Case Management. The breakout session held on the first day was titled Pathway Home: Rapidly Closing the Gap on the Race from Hospital to Home and was well attended. The interactive session described the novel and innovative Pathway Home approach to case management.

Year One: Celebration of Our Embedded Teams

One year ago, the Embedded Teams in Metropolitan Hospital Center (Met) and Bronx Psychiatric Center (BPC) were born with a dream and just mere concepts of what it could look like.

One year later, the Embedded Teams have integrated well into the BPC and Met families and are known by most staff as great additions to each hospital.

We have seen a great deal of progress with our clients, which is because of you all, individually and collectively.

Many times, you may wonder what we are doing here, but we are changing lives!! It is not always easy, and, at times, there can be a lot of pressure. It, however, is all to help the individuals of these fragile populations who need us the most. As you know, many of them have lost trust, have lost hope, and have no idea of what life in recovery can be. Through your work, you have built trust and have instilled hope, and we will continue to work on getting them to their next stage in life and recovery.

I appreciate your dedication, hard work, and passion for what we do.

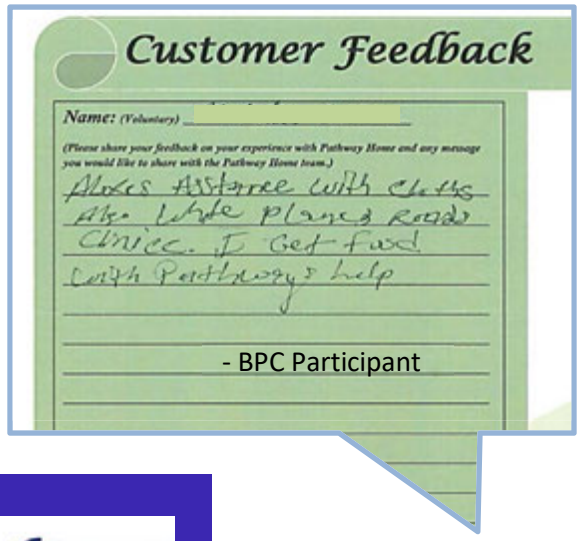
Continue to be creative. Continue to face challenges head on. Continue to change lives!!

Happy 1 Year!!!! – *Monisa Lane, team leader*

Sugarcoat Free with Li

By Leslie Chamorro, SMHC

Li is a 40-year-old married Chinese male. For the past 8 years, he was living at a Rockland County transitional living residence in Orangeburg NY. Historically, Li becomes suicidal and aggressive while symptomatic and non-adherent with medication nor treatment. Since Li' residence was closing, the inpatient team hit a snag making a clinic referral in NYC. The PH team recommended Inwood clinic as they would accept Li regardless of immigration status. Since being discharged from Rockland Psychiatric OTR, Li has not been hospitalized, visited emergency room for either psychiatric or medical reasons, and has had no legal concerns. Li has been adhering to his medication recommendations, attending his scheduled medical and mental health appointments. For additional support the PH team worked to enroll Li in Wellth, an app that assist participants in taking their medication regularly. Li has been actively participating and has received a payout of $56 since beginning using the application. SMHC Leslie assisted Li in getting connected to an outpatient medical clinic to address his diabetes and supply him with the required diabetic medication. In addition to his successful connection to community providers, Li continues to receive support from his family, especially his wife, whom he lives with. Recently, Li and his wife started attending marriage counseling. Mr. Jiang and his wife have been granted weekly visits by the Foster Care Agency to visit their 3 year old son.



Proactive Kelly

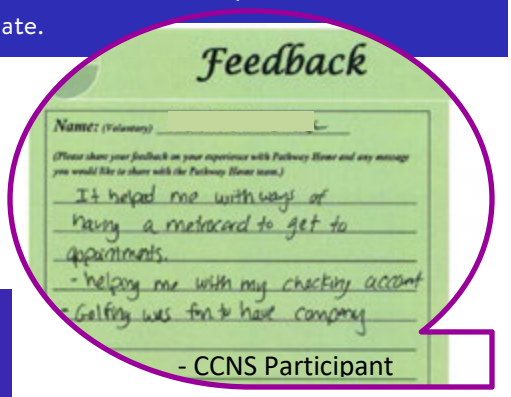
By Steffany Martinez, SCM

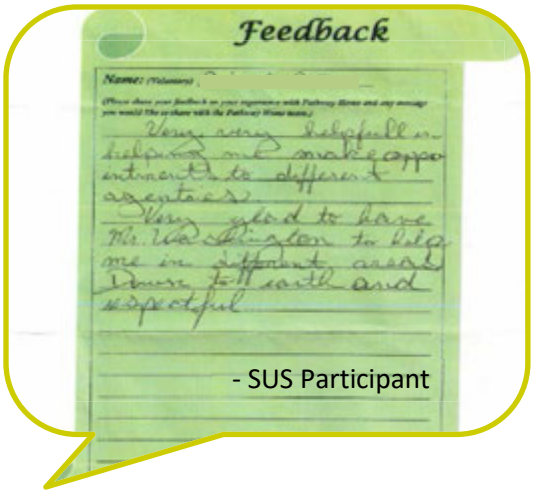
Yearning to get back into the community, Kelly enrolled in the Pathway Home in June after being referred while inpatient at Creedmoor Psychiatric Center. Determine to put her history of homelessness and non-compliance with prescribed medication in the past, Kelly remained adherent to treatment in order to be discharged Creedmoor's Polaris House. Pathway Home Senior Case Manager, Steffany, discussed with Kelly's CPC care coordinator (CC) areas where they could both support Kelly to become acclimated to her surroundings and positively remain in the community. SCM Steffany and Kelly participate in social activities such as going to the library and shopping for additional clothing, while her CC assisted on entitlements activation and obtaining key identification documents. Through this team collaborative approach, Kelly has become very independent, able to advocate for herself, attending appointments and taking her medications as prescribed. Recently becoming an active member at Venture House, Kelly is working towards joining the workforce in the near future. A goal that was once forgotten is now front and center.

A Carol Grows in NYC

By Nyasia Forde, PS

Carol is a 49 year old African American woman who has had a long history of homelessness. She was diagnosed with Schizoaffective disorder; however she relates her mental condition to major depression after losing her stability. Carol became involved with Pathway Home after coming through the Metropolitan Pathway Home Embedded Team. Upon discharge from her inpatient stay, the Embedded team worked to make sure Carol was stably connected to the appropriate Pathway Home team. This involved quite a bit of collaboration given that Carol had moved boroughs, this required that she be transferred from CCNS Pathway Home to the ICL Pathway Home team. Since her transition, Nyasia (Peer Specialist) has worked to build trust and shift Carol's focus from feeling "bamboozled" by previous service providers. Carol's distrust made it difficult got her to move forward with her goals, especially housing. Nyasia decided in order to help coordinate with other service providers and meet Carol's needs she would have to model a positive relationship. As Nyasia continued to strongly encourage Carol to redirect her focus on accomplishing her housing goals, Carol was more willing to participate with other providers. She has made great progress in the last few months. Eventually, the pair was able to coordinate an interview and collaborate with an agency she had previously been turned away from. Carol successfully interviewed and is awaiting a move-in date.





Destiny for Greatness

By Kristen Nocerino, SMHC

Destiny reconnected with her birth mother while inpatient and wanted to rebuild their relationship. She asked to be discharged to the family shelter that her mother was residing at. Pathway Home and Bronx Psychiatric Center Intensive Case Manager were put into place for wrap around services in the community as well as outpatient treatment at White Plains Road Clinic. Destiny's treatment team consists of different disciplinary members including a psychiatrist, psychologist, social worker, and a mental health counselor.

This co-hort was able to effectively communicate to ensure collaboration of care for Destiny starting with email chain with Destiny's BPC ICM, and her treatment providers at White Plains Road Clinic. Destiny and her mother were transferred to a Brooklyn assessment shelter the weekend

Destiny was discharged. I coordinated with BPC ICM who then met Destiny and her mother at the clinic and then sat in on the intake appointment. Destiny ultimately had to be hospitalized at Interfaith Medical Center in Brooklyn due to suicidal ideation but as a team we continued to coordinate phone calls and obtain information from the inpatient team at Interfaith. Once Destiny was ready to be discharged, PH myself, BPC ICM and even Destiny's previous inpatient team traveled together to Brooklyn for a case conference to discuss a discharge plan and continued community support. As a team, we coordinated on the days that we would see her because we realized that she needed intense, community support while residing at a new place.

Since Pathway Home is on site, we were able to provide the necessary support and crisis intervention when needed. To ensure Destiny did not go a day without one on one support, the team collaborated daily on a visit schedule. Destiny is still currently inpatient, but her health continues to improve day to by day due to her own resilience but also the endless support that she has been receiving from her interdisciplinary team.

Enzo's Journey to Home

By Shannon Cameron, SMHC

Enzo, is a 57 year old, Dominican male, who was arrested for Criminal Mischief and Burglary. He had a history of multiple hospitalizations and treatment non-adherent. He was brought to Metropolitan Hospital under 730.40 status. He reported not understanding why he was arrested and feeling as though he did not need any Mental Health Services.

When I arrived, I was able to engage Enzo in Spanish, his preferred language. Enzo shared that all his medications were at the son's home in Coney Island. Dr. Morris, ER Psychiatrist, was hesitant about letting him leave the hospital on his own. Upon speaking with Enzo and his son, via phone, I was also able to gain confidence from Enzo's son that his father would be able to travel and would only need guidance to get on the train.

We agreed that I would also be able to escort with Enzo to ensure he got to his son's home safely. The treatment team and I agreed that once Enzo made it home, he and his son would review the medications and they would text the list so that we can work on treatment planning post discharge. Enzo agreed to work with the ICL Community team case manager who arranged to meet with him the following day at his son's home.

Enzo shared that he had a voucher for Section 8, active SSD, and that he had been staying at a shelter near Bellevue Hospital where he was also receiving services for housing. However, he expressed wanting more support locating his own residence. He reported not liking being in a shelter and would benefit from having housing before it gets cold outside. I assured him that in his work with the ICL team, they would assist him in addressing his goals. Before leaving Enzo, I shared both my and CM Carmelina's contact information, he thanked me and stated that he had never received any support like this in the past and looks forward to meeting Carmelina from the ICL Community team the following day.

Boots on Ground

By Angelo Barberio

This past month I had the pleasure of shadowing Marlon Powell, Senior Case Manager with the ICL Pathway Home Team and decided to pick his brain a little bit about his background, interests, and overall thoughts about the Pathway Home Program.

Me: So Marlon, How long have you been working for ICL? Pathway Home?
Marlon: "Well, I started to work part-time with ICL's IBD program assisting individuals with development disabilities while I was a teacher between 2003-2006. In 2006 I decided to leave teaching and started working with ICL full time and have been with the Pathway program since its inception with ICL."

Me: You were a teacher!? That's awesome! Where did you teach and why did you stop teaching?
Marlon: "well I realized through my experience working with ICL my true passion for influencing others for the better was better spent in a one-on-one setting rather than in a classroom"

Me: So tell me why you decided to join the Pathway Team?
Marlon: "I also worked with ICL's residential programs and sat in on various boards and meetings. Through this, I was given the opportunity to meet Mark Graham (Vice President, CBC) and the rest was history!"

Me: How do you like working for the Pathway Team?
Marlon: "I love it! If I could describe it in a few words I would say "Impactful, self-defining, wholesome, and meaningful". Pathway has given me the opportunity to have that one-on-one-difference making experience I was looking for"

Me: What do you find challenging working in Pathway?
Marlon: "working with difficult providers who do not collaborate nicely as well as non-thorough discharge planning"

Me: One lesson you'd give to new Pathway members like myself?
Marlon: "Teamwork. ICL pathway team is like a family. Its important not only for our members but for ourselves as well. We stick together."

MARLON POWELL
SENIOR CASE MANAGER, ICL

DID YOU KNOW?!?
Marlon is a father to a 8 y/o son and has a BA in History Education and a MA in Sociology!

He's also in the process of getting certified in Sign Language!

Strengths: "People person, engaging, and creative"

Weakness: "Documentation"

Outside of work: Marlon loves spending time with his son, sports, and being involved in the community whether its volunteering or getting involved in politics!

Greatest Achievement: Personally: Being a father; Work wise: graduating clients

Personal PH Motto: "changing lives one step at a time"

Staff Spotlight

We take this opportunity to congratulate Shannon Cameron (MET), Harley Romelus (ICL), Eva Beltran (SUS) and Steffany Martinez (CCNS) recipients of this month's Staff Appreciation Award!

Oct 2018
Staff Appreciation
Awards

Shannon Cameron
Senior Mental Health Clinician

Shannon has been a major asset to the Metropolitan 730 project since the start of the Embedded team. She has shown herself to be very dedicated to the project and challenging population. She works diligently to build relationships with hospital staff and outside providers to ensure that these members receive the best comprehensive and person centered care post discharge and reduced recidivism. Despite being one staff down, client care and discharge plans has been maintained. Shannon, your tenacity under pressure is remarkable. You Rock!! – *ML, team leader*

Harley Romelus
Registered Nurse

A dependable performer, a steady, responsible worker who assumes a heavy workload." Otherwise known as "workhorse". Being the only Registered Nurse on the team, Harley is tasked with paying visits to almost every single member. He will visit 10 people on the same day if necessary, beginning his work day well before 9 am. Classic Harley. He is known affectionately to the team as "Grumpus" due to his serious nature, but in reality it is a reflection of his focus and dedication to the work. As such, his moments of levity make us appreciate him that much more. Harley takes pride in his work and in providing care to his members. He is a firm believer in Integrated Health and often reminds staff of its importance. He has given numerous presentations and resources to the team to keep us well informed and has recently been asked by ICL's main office to assist with training various agency staff. We could not ask for a better RN…and we won't. – *AG, team leader*

Eva Beltran
Senior Case Manager

Eva has been very proactive and diligent with her clients, showing initiatives and creative ideas. She has recently agreed to provide in-service about Latino culture for the team, and is very helpful to the team in explaining culturally-sensitive care for clients from Latino backgrounds. Eva also took on responsibility to write meeting minutes from case reviews, and she is independent in collecting care coordination data. She is also driven to develop professionally, and has been recently accepted to Hunter College School of Social Work. – *SA, team Leader*

Steffany Martinez
Senior Case Manager

Steffany joined Pathway Home team in July 2018. Since that time she has jumped right into the work with poise, confidence, and dedication. Steffany has risen above and beyond expectations as a new worker. She has been a pleasure to have as a support and does not hesitate to volunteer herself when the team is in need. She has quickly been able to prove herself to be well deserving of employee of the month with her advocacy, follow through, and desire to never let up for her clients. We are so thankful for your addition. Congratulations Steffany! – *AH, assistant team leader*

Celebrating you!!!!

New Staff Alerts

Fun Facts about Angelo:

- Rides a motorcycle
- I love the New York Yankees
- I have a fun sock addiction

Fun Facts about Sarah:

- Previous golf captain in h.s. and competitively on a junior tour
- I love cheese and would eat it for every meal
- Avid soul cycler

Get to know the team!

Fun Facts about Octavia:

- I love to bake and design cupcakes
- Big old school horror movie fan
- I really enjoy taking photos

Fun Facts about Rennie:

- I am from Philadelphia but have spent half of my life in NYC
- I love cats and kung fu movies
- Favorite places in NYC are the Bronx Zoo and the American Museum of Natural History.

Pathway Home Training Institute

CTI Workshops – Pathway Home Model

In an effort to enhance the practice of person-centered recovery oriented care within the Adult Home Plus Care Management community in New York City, The Coalition for Behavioral Health, funded by the New York State Department of Health, is providing a year-long training series grounded in our skills-based workshops on recovery oriented care. CBCs Pathway Home Training Institute's Mark Graham and Barry Granek were brought in to facilitate a series of 4 trainings on Critical Time Intervention (CTI). The workshop reviewed the phased approach and core components of CTI. Participants were engaged in interactive discussion and activities to learn how to implement CTI in day to day practice.

Peer support from individuals with shared living experiences to offer counseling, advice, and other supports is a growing trend. NYC is fortunate to roll out Peer services to members of the Adult Home settlement with 60 newly hired peers. During a recent training from the Pathway Home training Institute for Adult Home Case Managers and administrators, a **SUS Pathway Home Peer, Gerald Washington** was invited to talk about his experience in working as a peer in the Pathway Home care transitions program. Gerald shared how he works along a multidisciplinary team to help individuals transition to the community from institutional settings and how he uses his own experiences to connect and support individuals.

All the Way International: 새로운 친구를 환영합니다

CBC hosted 8 visitors from South Korea on October 24th. The visitors are from the Kyung San Welfare Foundation in Korea and include 1 MD, 5 SWs and 2 Board Members. This foundation run several mental health clinics and transitional residential programs for mentally ill population. Korea is going through emotional turbulence due to a stressful, competitive and jobless society. However, adequate mental health services are not available for those who need immediate help. Strong

stigma is still attached to mental illness and getting to right help is big challenging. In addition to that, Inpatient, outpatient and residential services are neither coordinated nor integrated. Therefore, CBCs Pathway Home program was identified as a perfect program for them to learn and incorporate lessons into the continuum of care. Jorge Petit, Mark Graham, Barry Granek, and Aja Evans from CBC met with the visitors and talked about CBC, Pathway Home, and about the wonderful efforts Kyung San Welfare Foundation is doing in transforming care in Korea.

Collaboration Corner

wellth

As we begin to close the first 3-month round of Wellth, we are excited to acknowledge the champions on each of the teams who have assisted in piloting Wellth. We are excited to see how this cutting-edge technology continues to assist and motivate the people we serve.

Total Enrollees: 20
Adherence Rate: 88%

$261 to be paid out for participates in October.

Team Breakdown:

- SUS-6; ICL-10; CCNS-2; BPC-2
  - One participant connected from MET

Healthify

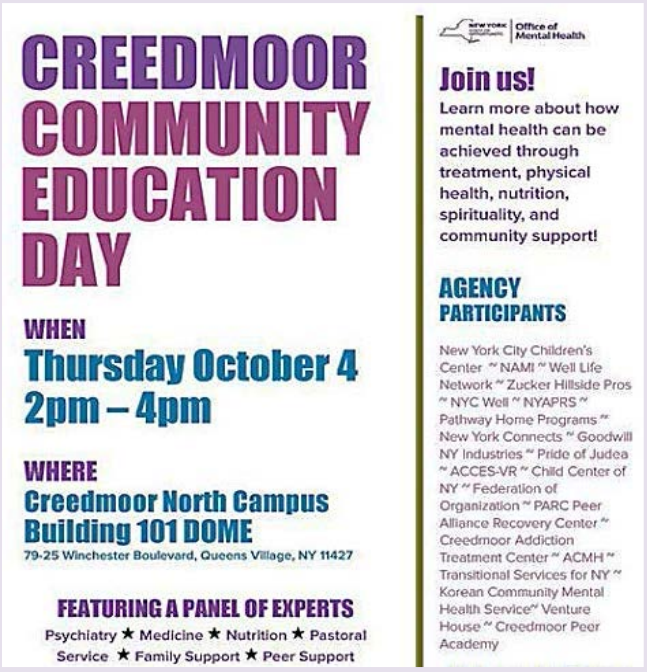
Our Healthify Challenge has come to an end, join us in congratulating our winners: Jovannie Menard (SUS), Kristen Nocerino (BPC) and Sirina Aveya (ICL)

Healthify is expanding within the CBC Network SUS is now operating Coordinate!

Coordinate is a function within the Healthify platform that allows agencies to create, manage, and monitor referrals that are made through the Healthify system. Closed looped referrals will assist in how agencies communicate and provide the best care to the members they serve. Please congratulate SUS on being a pioneer and early adaptor in creating a seamless referral process across CBC's network!

Creedmoor Psychiatric Center Community Education Day

Our CCNS team were recently chosen to partake in Creedmoor's Community Education Day. Agency participants from Queens gathered together to join hands in celebrating, educating, and advocating for the mental health community. Each agency had a table and was able to engage both providers and consumers in a conversation about mental health. Long standing Creedmoor employees spoke about their experiences & research that have led to success in stabilizing the most challenging cases. Pathway Home was able to speak with already connected providers & educate those who did not know about the program. The team was available to make Pathway Home a participating provider in the Queens Community. The team has now been in Queens two years and is showing a lasting impression on both consumers and colleagues. As asked by Creedmoor, we hope to be a panel speaker next year.



Peer Corner: On Beat

"You had to learn what I had to live" by Nyasia Forde

"How are you today?" This is my go-to first question. For a clinician meeting an individual with a mental health diagnosis, I feel this question is asked as a way to clinically assess or evaluate the individual. Is it offensive to ask how one is doing as an assessment? Probably not. Is there a way this question could be asked more genuinely? Absolutely! "How are you doing?" means so much when it shows you care and are truly and personally concerned with the answer.

Far too often an individual with a mental health diagnosis is being treated as their diagnosis and not as a *person*. As a mental health professional today, I resonate with the statement "I am not my diagnosis!" My role as Peer along with my Pathway Home team is to continue putting "human" back in Human Services.

When I began my journey with PH almost two and half years ago, I was told the following quote. "Just meet them where they are at." So *yes*, occasionally I literally meet them at the coffee shop. But more symbolically, I strive to be with them, present, on the journey, wherever this may take me.

Upcoming Events and More

Specialty Meetings

Peers

Date: Wednesday, November 14th

Specialty Meetings

Case Managers and Mental Health Clinicians

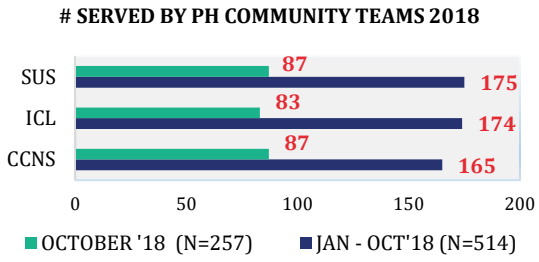
Date: Winter '18

#ThinkPink Breast Cancer Awareness

The ICL team celebrated National Breast Cancer Awareness Month during their monthly gathering. ICL utilizes Integrated Health as one of their principles of care and has been educating clients on early detection, stages, and treatment, as well as helping clients to schedule mammograms. A number of staff have been impacted both personally and professionally by this illness and as such, wanted to show their support. "Together, we're tougher than cancer." #ThinkPink

Coordinated Behavioral Care Pathway Home (PH) Program OMH Report – October 2018

Community Teams



2018 Demographic Data *(Recipients Served)*

Age: 18-30 years (27%) & 31-40 (24%) years old

Gender: Male (67%) Female (33%) Transgender (0.5%)

County: Queens (32%) & Bronx (26%)

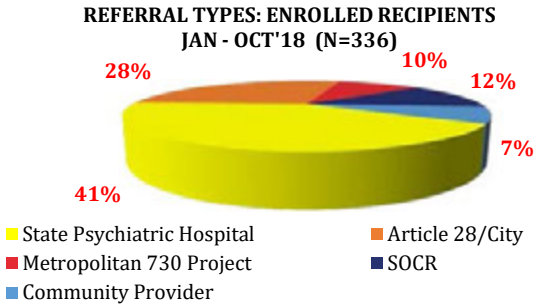
2018 PH Enrollment & Program Data:

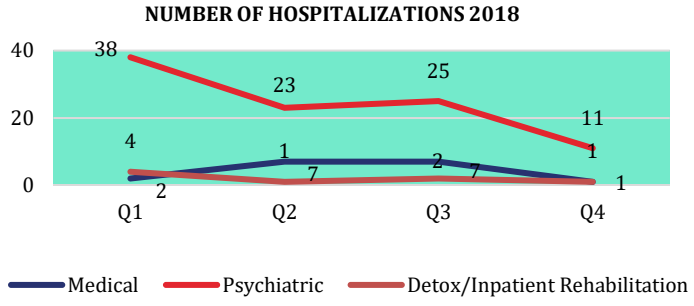
52: Referrals were enrolled in October 2018

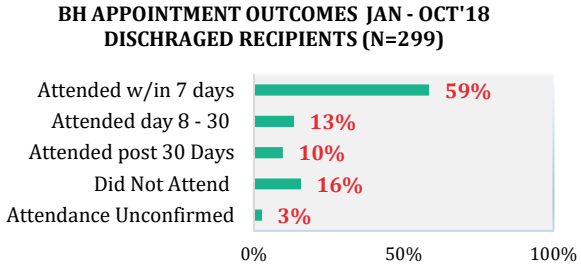
3: Average # of days between referral and enrollment

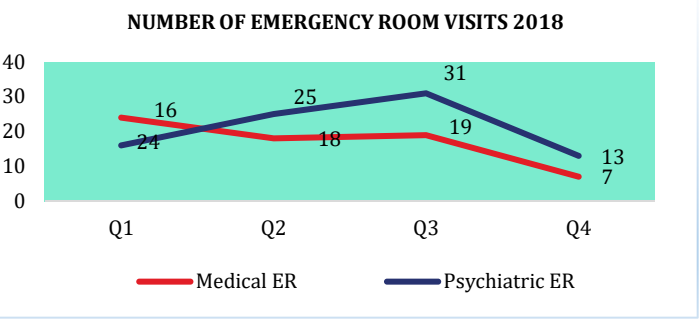
1460: Total # of Services Provided

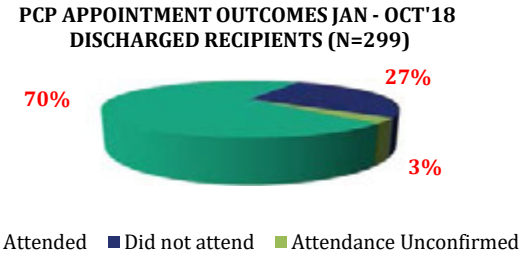
299: Recipients discharged in 2018

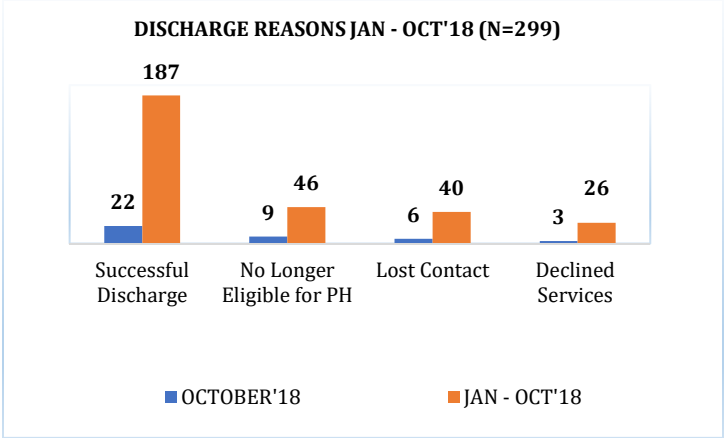


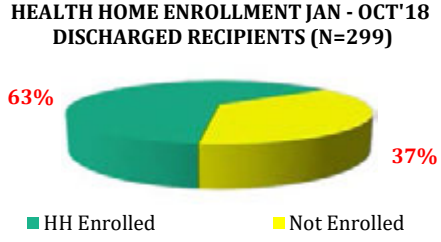








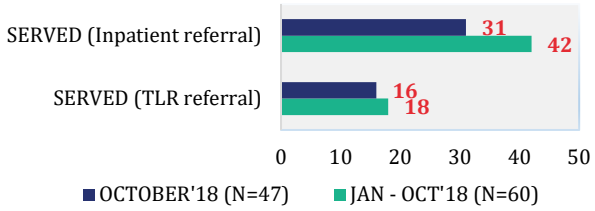




Coordinated Behavioral Care Pathway Home (PH) Program OMH Report - October 2018

BPC Embedded Team

 # SERVED BY EMBEDDED TEAMS 2018



2018 Demographic Data

Age: 51-60 years old (30%)

Gender: Male (72%) & Female (28%)

County: Bronx (98%)

2018 Enrollment and Program Data:

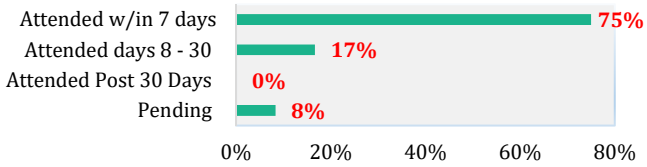
3: Enrolled into the PH program in October 2018

308: Total # of Interactions September 2018

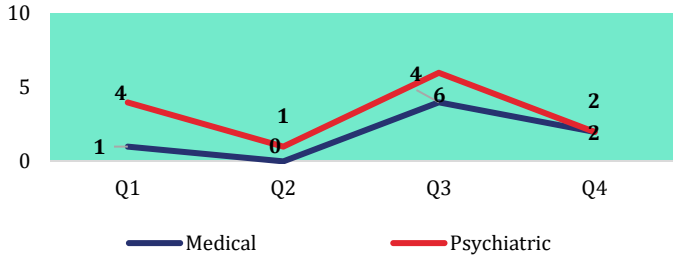
16: Individuals moved off BPC campus since Oct. 2017

42: Served in community (Inpatient Discharged + TLR)

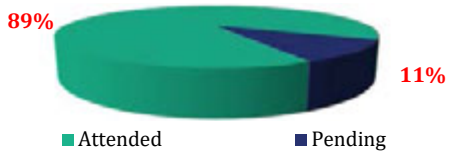
BH APPOINTMENT OUTCOMES JAN - OCT'18
INPATIENT REFERRALS ENTERED COMMUNITY (N=24)



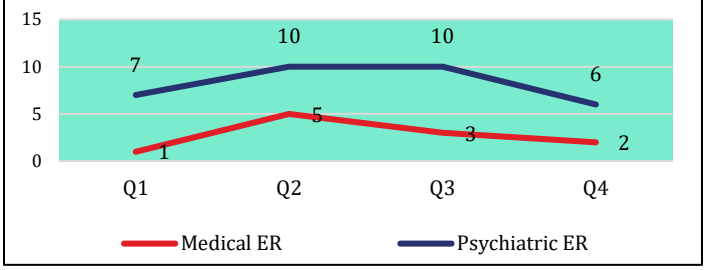
NUMBER OF HOSPITALIZATIONS



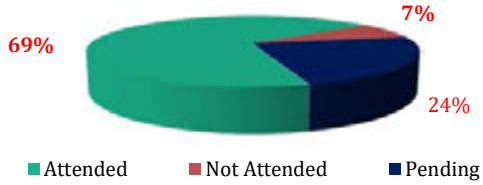
BH APPOINTMENT OUTCOMES JAN-OCT'18
ENROLLED TLR REFERRALS (N=18)



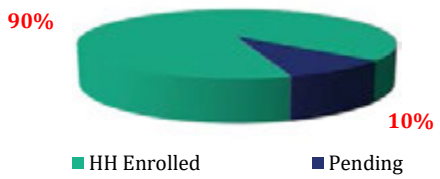
NUMBER OF EMERGENCY ROOM VISITS



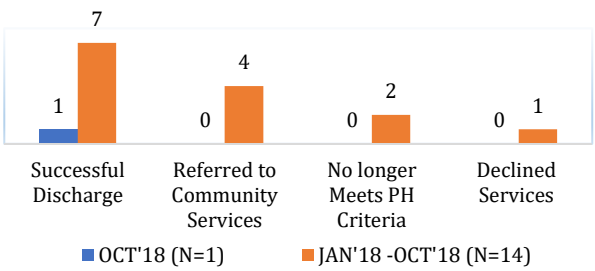
PCP APPOINTMENT OUTCOMES JAN-OCT'18
ENROLLED RECIPIENTS (N=42)



HEALTH HOME ENROLLMENT JAN-OCT'18
ENROLLED RECIPIENTS (N=42)

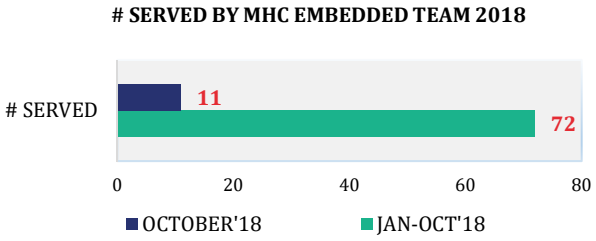


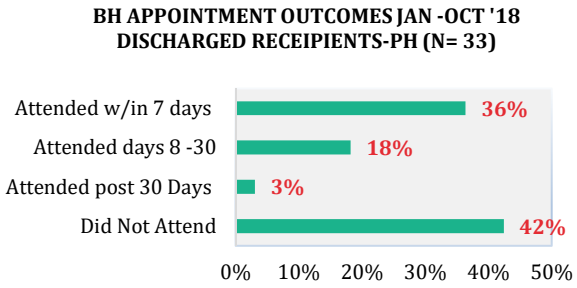
DISCHARGE REASONS 2018 (N=14)

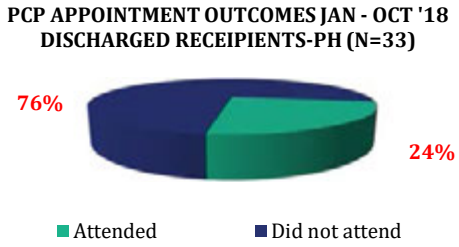


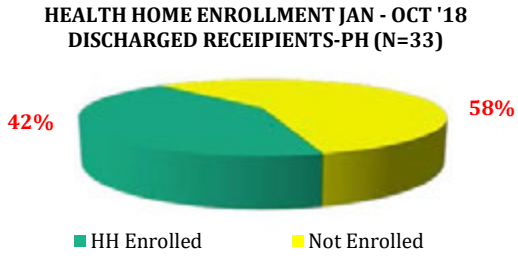
Coordinated Behavioral Care Pathway Home (PH) Program OMH Report - October 2018

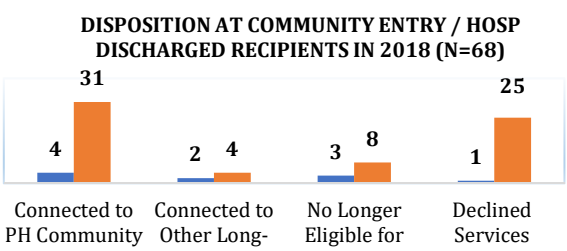
MET Embedded Team











2018 Demographic Data

Age: 18-30 (35%) years old and 31-40 (29%) years old
Gender: Male (78%) & Female (22%)
County: Brooklyn (25%) & Manhattan (22%)
Housing: 43% with family, 41% Homeless

2018 Program Data:

72: (100%): Designations enrolled in MET 730 Project
33: Served and discharged by PH Community Team
1: Average number of days for enrollment
9: Average days inpatient stay
57: Total # of October 2018 Interactions
7: # of individual rearrested