Pathway Home 2018

Annual Report

CBC COORDINATED BEHAVIORAL CARE

Barry's Message

Elyn Saks depicts the experience of adjusting to mental illness; "if you are walking a path thick with brambles and rocks, a path that abruptly twists and turns, it's easy to get lost, tired, or discouraged. You might be tempted to give up entirely." It is foreseeable one would be scared, overwhelmed, and unsure over the course of a transition. Change is peerless and subjective, therefore deeply personal. As Carl Jung quipped, "If the path before you is clear, you're probably on someone else's."

Saks give us grounds for hope; "if a kind and patient person comes along and takes your hand saying, 'I see you're having a hard time - here, follow me, I'll help you find your way,' the path becomes manageable, the journey less frightening."

The path is filled with common and uncommon obstacles and the journey insists that "taking your hand" not only mean providing emotional support, it includes paying careful attention to the tangible things.

Individuals worry about their basic needs. Who will show them where to buy bread, eggs, and coffee? Where to cash a check? Where to find fresh produce? Where to see a Saturday night movie? One PH recipient described this period as "scary" because "it was disorienting to not know what resources would be available" to them. Many are lonely and bored, looking for relationships that provide friendship, love, entertainment, and purpose.

In addition to the array of basic needs that require tending to, there are treatment needs. One gentleman worked for years to achieve sobriety and then moved into a neighborhood with reputation for its substance use. A woman struggled when the community ostracized her eccentricities. Another isolated without ability to afford a phone. A gentleman discharged with two weeks of medications had no appointment for the next four weeks.

There are a variety of case management models that follow remarkable best practices. "Person-centered" approaches are in abundance, emphasizing the importance of active participation in the decision-making process of one's own care. Critical Time Intervention, which PH is modeled upon, concentrates on the few most critical goals during a transition.

These models are both important though conceivably indifferent to the urgency of care, speed delivered, and thoroughness of response. I would not propose abandoning these two accepted practices, they produce impressive results. Still, the needs during the first few weeks and months after a transition can be staggering and numerous.

PH staff express a distinct perspective on care. People are scared and vulnerable after a transition, they may not be looking for "participation" in decision making only, nor will settle for only a few needs covered. PH holds firm that people deserve immediate action to address the full scope of care needed with the urgency that breeds success. PH does more than hold one's hand and keep them comfortable, despite the significance of this. We respond to every minuscule issue - all those stated above and more - with a rush of importance.

Jeff Bezos, describing one of Amazon's principle of success, says that Amazon proactively brings value to users and delights them, building attachment and trust. Build enough of it, and you create a connection with your customers that becomes hard to break. Being what Bezos calls a *"customer obsessive"* culture, drives one to delight the customer and intervene on their behalf before they ask. I suspect that attachment and trust come from satisfaction with a concrete product or a service offered quickly and completely.

Similarly, by customizing the care experience and striving for excellent customer service, PH has the palpable affect often referred to as a "human touch." Being sensitive to the experience allows for tangible intervention, leading to a connection hard to break. It is those tangible interventions – the concrete services offered quickly and to completion - that make all the difference.

Evident in the success stories below, PH covers the critical treatment needs. Like when an individual received extensive support through a complicated medication change. It is also those interests and passions like art, photography, and writing. It is assisting with returning to school and obtaining employment. It is helping one make friends, reunite with family, and find a home.

At PH, our experience (of serving over 700 just in the last year) is that we know transition. It is combining emotional support, placing interests in the center, and intervening instantly in a tangible and thorough manner (sometimes before one can ask). The evident results breads a genuine customer satisfaction, trust, and the incredible outcomes demonstrated here in this newsletter. I am grateful to be part of this innovation and appreciate all who contributed in sharing the success stories.

Warm Regards,

Barry Granek

2018 Top 5

3 Pathway Home published articles: Frontline Report, Behavioral Health News and Office of Mental Health

FRONTLINE REPORTS

Frontline Reports

Pathway Home: An Innovative Transition Program From Hospital to Home

Successful transitions from inpatient care to the community often demand navigating a complex, fragmented health care system. Extended hospital stays lead to additional challenges; patients often have not been effectively connected to ambulatory care and are frequently ill prepared for community living. Traditional case management services often do not adequately meet the needs of individuals with mental illnesses who are transitioning from inpatient care; many remain disconnected from services and have high readmission rates.

In 2014, Coordinated Behavioral Care (CBC) implemented an innovative care transitions program called Pathway Home (PH), which has, through a multidisciplinary team approach, specialized attention, clinician assessment and short-term counseling, peer engagement and emotional and practical support, case manager skill building and entitlement support, and information from the nurse about specific medical needs, preventive care, and access to and utilization of community health services. This "high-touch" model facilitates a personal connection where patients receive understanding and personalized care, leading to increased

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Office of Mental Health

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October 19, 2017

NEW YORK STATE OFFICE OF MENTAL HEALTH ANNOUNCES EXPANSION OF PROGRAM HELPING INDIVIDUALS TRANSITION FROM INPATIENT HOSPITALIZATION TO COMMUNITY-BASED SERVICES

Program Reduces Readmissions, Length of Emergency Room Visits; Helps to Improve Outcomes and Reduce Avoidable Costs

today announced the expansion of the transitional program, City hospitals. This innovative program which helps individuals inpatient care to community-based services, has started accepting ller and Metropolitan Hospital Center. This expansion is funded from the Office of Mental Health (OMH).

BEHAVIORAL HEALTH NEWS - SUMMER 2018

www.nbnews.org

A Virtual Pathway to Technology-Assisted Care Models: Keeping Up with New Technology in Behavioral Health Care

By Jorge R. Petit, MD, President and CEO, and Barry Granek, LMHC, Senior Director, Pathway Home Coordinated Behavioral Care

Community-based behavioral health organizations and the individuals they serve would benefit from embracing new media and digital technologies. Technology-assisted care allows providers an additional set of tools to supplement engagement and establish more meaningful lines of communication. With the expansion of audio, video, mobile and other digital devices and/or multimedia programs, we are seeing this technology shift in all sectors of behavioral health care delivery. Organizational tools, apps and communication systems that utilize innovative technology allow healthcare workers to be better attuned to customer needs, with increased information and in real time; boosting patient engagement, leveraging support systems and providing critical cost and time saving advantages.

Jorge R. Petit, MD

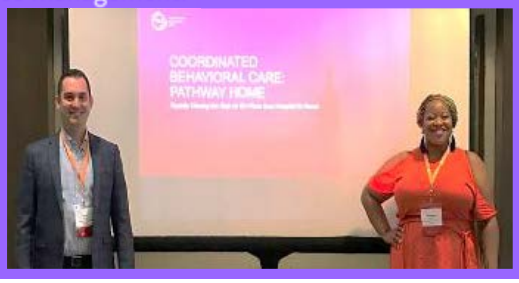
Barry Granek, LMHC

management needs, PH uses *electronic medication reminder & dispenser machines* as a tool and reminder that addresses adherence. The machine is programmed by a PH nurse and is set to dispense medications at the appropriate time, prompted by the user. Visual and audio alarms continue to sound from the dispenser and are not dismissed until the medication is dispensed. If not dispensed, the PH Team nurse receives a message and can follow up with a call or visit to the individuals setting and address the lack of adherence. One PH nurse noted, "The medication dispensers is a good starting point to help increase awareness of the benefits of medication adherence."

In one instance, PH was serving Malcom, who was prescribed 12 oral medications to be taken daily. Malcom had reported past challenges with medication adherence and concerns about forgetting to take them on time. For three months, the PH nurse assisted with medication management using the dispenser machine. The machine alerted Malcom to take notice of the prescribed times, increasing awareness and adherence. Practicing this routine led Malcom to trust only on the electronic

NACM Conference: Start Your Engines, Leading the Race towards Excellence in Case Management.

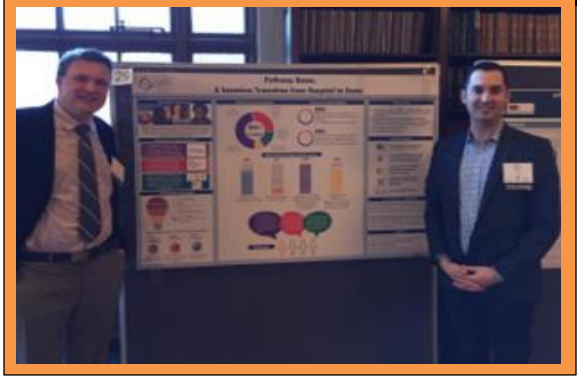
CBC Senior Director, Barry Granek and SUS Senior Mental Health Clinician, Nikenya Hall presented the interactive session describing the novel and innovative Pathway Home approach to case management.



Doubled in staffing size

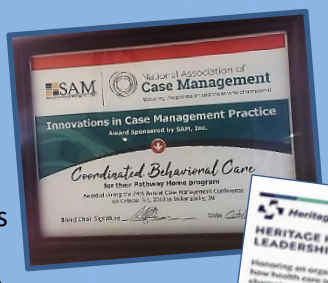
+

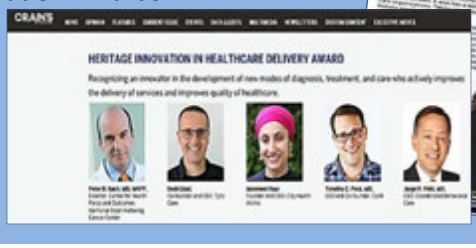
New York Academy of Medicine's Population Health Summit IV: Working Across Sectors to Address Social Determinants



2 Awards Won & 1 Nomination

- National Association of Case Manager Innovation in Case Management Practice Awards
- CRAIN'S Heritage Innovation in Healthcare Delivery Award
- Nominated for CRAINE's Heritage Healthcare Innovation Awards





Issa: Art Always Wins!

"I returned to live my life as an artist and author." This is how Issa described his discharge from Creedmoor Hospital, where he had been inpatient for nearly 20 years. Issa is a published author and renowned artist throughout the literary and art worlds. He has many pieces on display at the Creedmoor Living Museum and was an integral part of the on-going workings of the museum during the 90's and early 00's. He spent years attending art openings and book tours, first while hospitalized, and then for eight years after in the community after leaving Creedmoor.

> *"I returned to live my life as an artist and author."*

Issa was unfortunately hospitalized two years ago after some challenges with his medication and unforeseen life events. As Issa was preparing to return to the community again after a much shorter stay in the hospital, he chose the Pathway Home team to help support him.

Jessica, CCNS's Mental Health Clinicians, has been working with Issa and supporting him in his journey. Jessica says about Issa; "he had a hard time dealing with the embarrassment he felt going back inpatient after being so successful in the ccmmunity. He has had to take a look at how he overwhelmed himself with too many tasks in the past as he felt he owed something back to the community; and as a passionate artist it was hard not to get caught up in an idea and run with it until it ran him down."

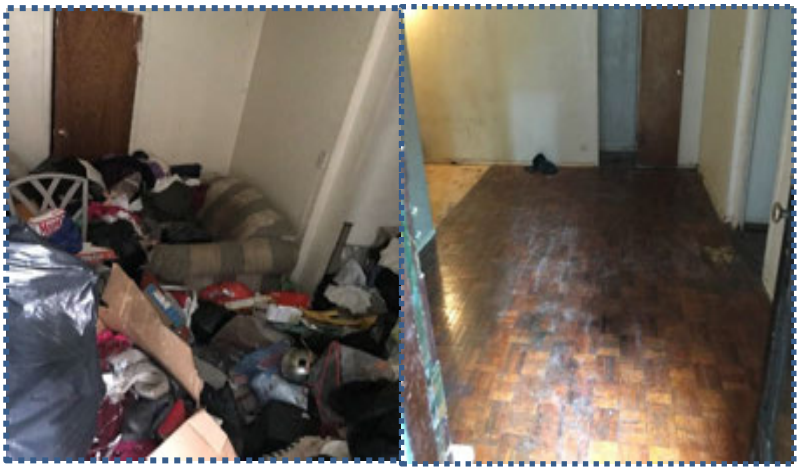
Together Jessica and Issa continue to discuss strategies for slowing down when things feel out of control and building a solid foundation of projects he feels really connected to as to not feel as though he is spread too thin on his work. Jessica and Issa focus on mindfulness and self-care to assist in these goals. Using step down enhancement funds, PH replenished art supplies so the Issa could continue to work on his art.

Issa is currently working on curating his own in home gallery, and working on selling his art through Etsy; https://www.etsy.com/no-en/shop/IssaIbrahim.

Maryah's New Desire for Life

Accustomed to being in and out of the hospital, engaging in outpatient treatment was challenging for Maryah and often led her life to quickly unravel. During one APS visit where they discovered the poor condition of the home; it was clear that Maryah had been severely hoarding. This led to a hospitalization and a transfer to Bronx Psychiatric Center for a long-term admission. Here, **she was introduced to the Pathway Home Embedded team.**

With PH step-down funds, the team helped pay for a de-clutter and deep clean of the apartment. The team promptly began preparing Maryah to transition back to her apartment. Alexis, Senior Mental Health Clinician, began addressing motivation to improve living skills and understanding on how to care for self and apartment.



The pair worked to practice and build life skills to maintain the apartment when Maryah moved back in. PH and the management company collaborated on the repairs needed to make the apartment livable: replacing parts of the floor, refurnishing her home, and ensuring that Maryah would have the necessary items to thrive. This was a big change for Maryah, who was given opportunities to process her feelings of loss especially around her furniture being thrown away. Three months later, Maryah transitioned back to her apartment. PH clinician Alexis explains, "Maryah needed hands-on skill development around maintaining her home and caring for her health and hygiene. While we saw her through a deep cleaning and significant repairs, we knew how important it was to maintain the gains and not slip back to old habits." This was not easy for Maryah, and the team was worried about her progress. "A turning point was when we went clothes shopping," Alexis explains, "her mood quickly shifted, as did her desire to care for herself." This new-found confidence launched her passion to care for her newly cleaned and repaired apartment and attend to her personal care. "We found Maryah to be a fast learner when motivated."

Several months and dozens of long visits from the PH team later, Maryah is successfully managing her apartment, attending outpatient appointments, and caring for her hygiene. Maryah's self-reliance and mood increased as she continues to live autonomously in the community. A year after transition, Maryah graduated from PH, successfully completing her goals, linked to care coordination, and thriving in the community. She maintains a positive relationship with her providers, past and present, and is happily living in her apartment. When the team last met with Maryah's she shared *"I am most grateful for assistance in becoming independent enough to live on my own again"* and "regaining my relationship with my daughter" was a highlight of her experience with Pathway Home.

Riding with Jordan

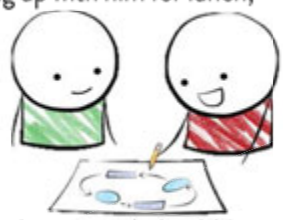
Jordan was hopeful that an experimental treatment at the hospital would improve his symptoms. After participating in 2 different medication trials, which had to be discontinued due to side effects, Jordan continued to struggle. Eventually, the inpatient Team used a combination of ECT treatments, medication, inpatient therapy to stabilize Jordan. After 8 months of working on his depression. Jordan was ready to begin his transition back into the community, the inpatient team made a referral to Pathway Home to assist him in maintaining positive gains in his life.

The ICL Team began meeting with Jordan on the inpatient unit to begin building rapport. From these early meetings, we learned about his love of coffee and unique foods. We spoke about his desire to get a side job as a barista and one day complete college. Prior to admission into the hospital Jordan had been living with his family in New Jersey. While he described his family as close, Jordan reported that significant stress within the family unit was a major trigger for his anxiety, particularly his twin brother's struggles with substance use.

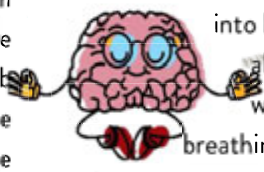
The PH team had regular meetings with the inpatient team, collaboratively meet Jordan's needs post discharge. Due to the significant stressors at home, the inpatient team and PH team agreed moving Jordan into his own apartment would be the best plan. Jordan expressed concerns about feeling a part of community. The team began supporting Jordan's integration into the community by taking him off unit to explore his new neighborhood.

Once Jordan was discharged from the hospital the team shifted into high gear, meeting with Jordan several times a week. Peer Specialist, Nyasia, met with Jordan to arrange benefits and support him in developing life skills. Once his basic-essentials were met, Jordan expressed his lack of self-esteem and difficulty making friends. The team helped to connect him peers through Fountain House and a day program. The team worked tirelessly in supporting him in becoming more open, engaging more within his community, and building social skills.

Things were going well for Jordan until an unexpected tragedy. Jordan' twin brother passed away. The team rallied around Jordan during this time, offering support by meeting up with him for lunch, case conferences, and calling him regularly to give him an outlet to share his feelings. The team used this time to let Jordan be present without always having to focus on the death of his brother. Jordan expressed his providers meeting him where he was at helped him remain in treatment and feeling supported.



Jordan noted that he wished to try different medications and worked with his psychiatrist to do a medication washout while in the community. With support of the team, Jordan worked through his medication washout completely in the community. He worked with the senior clinician during this time to gain improved insight into how his anxiety functions and becoming better able to recognize his anxiety driven fears. He was able developed coping skills, like deep breathing to help cope with his anxiety without medication.



Following Jordan's medication shift, he started a new medication regime which consisted of fewer prescriptions. Simplifying his medication regimen improved his overall functionality. Jordan became more open in group and his mood improved. The team recommended Jordan start a physical activity and encouraged him to engage more with people at his housing program. Eventually, Jordan shared that he had started to make friends and attending weekly trivia night.

In the final stage of the program, the Senior Mental Health Clinician talked to Jordan about his future and encouraged him to envision the next chapter of his life. The pair talked about his interests and struggles in school. Jordan identified strengths such as writing and noted feeling inspired by his experience taking a journalism course. This led to Jordan shifting majors to Journalism.

Jordan's strength to overcome obstacles is inspiring. He is a notable example of how proper support from hospital to community can bring great change and recovery to someone's life.

AR:
Don't Call It a Comeback

AR had so much to live for. She was completing a Master's program in Special Education and employed as teacher's assistant. However, shortly after AR was sexually assaulted by a family friend, she began to "hear the conversations" she previously had with relatives. As the sexual assault was haunting AR, she sought support of a church which she later perceived as a cult. Over the course of the next few months, she became increasingly depressed, anhedonic, had poor sleep with nightmares, binge eating which resulted in gaining 15-20lbs, low energy, poor concentration, and feelings of worthlessness and hopelessness. As this worsened, she withdrew from the master's program and lost her job. She began believing she would be better off dead.

Despite, medications and therapy AR began planning to overdose on her medication. Miraculously, she told her roommates her plan, they reached out to the pastor's wife who immediately came to AR's home. AR was accompanied by the pastor's wife to CPEP

the next day where she was evaluated for further treatment of a major depressive episode complicated by suicidal ideation.

In the hospital, AR was introduced to Pathway Home and her case manager, Eva, who provided emotional support while she began a new chapter in her life. She was placed in a new apartment in the Bronx.

Since being discharged from the hospital, AR has been attending therapy and receiving mental health services at Payne Whitney while working with Eva to stick to her medication schedule. Using step down funds, the Pathway Home team took AR shopping for clothing, reinstated her benefits, and referred her care coordination services. AR worked with Pathway Home to glean an understanding of a healthy lifestyle and worked hard to maintain a proper diet for herself in the community. Connecting with Fountain House was important as AR has found resources to keep her healthy, active and engaged through a range of educational, recreational and health-related activities. As an artist, AR was able to show cased her photography and art in Fountain House's art gallery.

A turning point in AR's care occurred after a crisis when AR's wallet was stolen and her phone broken. AR was able to remember her resources, reached out to Pathway Home, and was able to calmly navigate the issues with the emotional support and assurance from Eva. Using step down funds, Pathway Home purchased a new cell phone to ensure AR would be able to communicate with service providers, family, and friends. Eva helped her to cancel all credit and debit cards to avoid potential financial entanglements. This pitfall

motivated AR to make an effort to better organize herself, impressively growing from the stressful experience.

AR enrolled as a student at NYU and has an assigned educational coordinator with Community Access. AR expressed **"The relationships I formed at Pathway Home helped me move forward in my recovery."** These days AR is working at YAI dayhab program for adults with intellectual difficulties. AR is slated to begin her Social Work studies through New York University beginning in September 2019.

Home Sweet Rakim

Receiving a 730.40 designation for trespassing, Rakim was diverted to Metropolitan Hospital. He had been evaluated after displaying disruptive, bizarre, and confused behaviors. The PH MHC Embedded team engaged Jamel as he arrived in the ER and throughout the 15-day inpatient stay, connecting him to the PH community team, explaining housing application process, submitting the HRA, ensuring a comprehensive aftercare plan, and maintaining communication with supports.

PH clinician Shannon describes Rakim as a "soft -spoken, quiet man, who was nice and very determined to better himself." Rakim was proactive to become more independent, reinstating food stamps and beginning to look for work on a construction site. A housing interview was obtained with Communilife, and team prepped Rakim for the interview. Rakim was ecstatic when he found out he was accepted to housing.

"...very determined to better himself."

Shortly after his housing interview, the team started to have trouble getting in contact with Rakim. Unable to reach Rakim, Octavia and Peer Specialist Gerald, went to visit him at Wards Island Men`s shelter without any luck.

Unfortunately, Rakim had relapsed and was back inpatient twice at MHC as he's awaiting housing placement. During visits with Case Manager Octavia, Rakim expressed motivation to remain in community and be independent and stable and start a life without the stress of shelter living. The team felt housing was key to achieving stability, so efforts were made for housing placement quickly, even as Rakim was placed in a shelter. In meantime, team helped Rakim stay at a respite which offered a more comfortable and safe option and allowed Rakim to focus on his mental health.

During third hospitalization, The PH Embedded and community team collaborated on how to ensure Rakim's next discharge would be his last. Communilife was contacted and informed of Rakim's situation. Pathway Home and Communilife worked together to make sure Rakim's apartment was ready when he was discharged from MHC. Thanks to the collaboration of providers, Rakim was discharged to his mother's house for one night, before his official move in with Communilife.

Rakim is now stably housed. When visited recently, Rakim's mother shared "I am grateful for the help and services provided for my son." Mirroring those sentiments, Rakim told Octavia that he feels "I can finally rest and have peace." Rakim continues to attribute his success to the help and persistence of Pathway Home.

Filling the Social Determinants of Health Gaps: Santana's Style

Awaiting permanent housing placement, Victor Santana was re-referred to Pathway Home from MPC-TLR. During his first PH intervention, Santana seemed disinterested to attend treatment opportunities away from "the Island." This time around, Santana appeared more confident in wanting to remain in the community for good.

As a veteran honorably discharged from the Iraq war, Santana's mental illness diagnoses of schizophrenia and PTSD began impacting his life and leading to several lengthy hospitalizations over the years. Santana continued expressed eagerness to remain adherent to treatment, substance free and motivated to continue his postponed education. Santana seek assistance from the PH case manager Carmelina in providing a laptop for his academic needs as he successfully enrolled himself back at CUNY LaGuardia Community College.

Santana conveyed his personal gratitude to the Pathway Home team in supporting him achieve a major goal. Today, Santana continues to pursue his education career and his treatment. His ICL care coordinator states Santana remains motivated, stable and most importantly in "good spirits."

Top Three Usage for Step Down Enhancement Funds:

1. Metrocards/Ridesharing
2. Groceries/Food
3. Clothing

Reflection on first semester internship

By Leeza Camilo

When my NYU advisor asked what I was looking for in my second-year field placement I said two things: one, that the agency work with individuals diagnosed with serious mental illness and two, that the agency be innovative, and Pathway Home has been just that agency.

Looking back at my first semester interning at CBC Pathway Home I am so grateful to all the wonderful staff I have been able to meet and shadow, and all of the clients I have been able to interact with. I have had the opportunity to attend team meetings and understand through shadowing the different roles of team members (mental health clinicians, nurses, case managers, peer specialists) that make this organization so special. I have had the opportunity to visit numerous psychiatric units and TLRs all over New York and this was just in my first 4 months of being here.

In my time with CBC I think the biggest lesson I have come to realize is that there is so much more to a person's recovery and story than the referral packet. I absolutely love how Pathway Home helps fill in the gap in services and come together as a team to support the people we work with. The extra services that Pathway Home can provide like movie tickets, gym memberships, and salon appointments to name a few make this a very one-of-a-kind agency to intern for. My favorite part during intakes is when I ask the client about their interests because this tends to be the part where clients start opening about their passions and what makes the client them!

I have been able to practice my clinical skills, work with teams, attend meetings, and meet incredible people during my 4 months interning at CBC Pathway Home and I am looking forward to seeing what this next semester has in store. Thank you to everyone I have had the pleasure to meet and work with and a special shout out to my supervisor Jackie who is absolutely brilliant and wonderful mentor! ☺

Getting Fit with Pathway Home

By Elizabeth Carmen, MHC

According to research cited by the National Institute of Health, aerobic exercise has an impact on mental health by reducing anxiety, depression and negative mood by improving self-esteem and cognitive function. Exercise has also been found to alleviate symptoms of social withdrawal which are key factors in cur patient populations. Exercise is crucial in people experiencing schizophrenia since they may be especially vulnerable to obesity and additional risk of weight gain due to antipsychotic treatment. People experiencing schizophrenia who participated in a 3-month study showed significant improvement with regular exercise (defined by 30 minutes 3x/week). Aerobic exercise can be jogging, swimming, cycling, walking, gardening, dancing, or anything that gets your heart rate up.

With access to generous stepdown funds, CBC: Pathway Home is constantly looking for healthier, more creative ways to help members improve their mental and physical well-being. With many of our members struggling with mental illness and comorbid diagnoses such as high blood pressure, diabetes, and obesity, aerobic exercise can be, not only helpful, but can be lifesaving when utilized. With stepdown funds and a fantastic team, we can provide gym memberships for our members upon hospital discharge, and many of our peer specialists will even go exercise with their constituents. Not only does this increase both parties health, but there is no better way to engage someone in a genuine, real-life situation, by working out together.

The following vignette from CCNS clinician, Alison Haan, which illustrates how strong of an impact exercise can have on a person's mood and life.

John was referred to the PH team after battling cancer, anxiety, depression, and two nearly lethal suicide attempts. As always, but especially due to the acuteness of the situation, the team surrounded him with immediate support. In the beginning, he was extremely distant, quiet, and remained depressed for quite some time. While the team conferred on innovative ways to engage him in treatment, his wife and son were terrified by the idea of coming home to him having harmed himself. PH continued to successfully engaged the entire family, working together they were able to find meaningful daytime activity for him to enjoy.

Each day, the team began to take John out for walks, pushing him to spend some time outside getting fresh air. While this was forced in the beginning and his affect remained flat, the team began to observe his demeanor changing. He began to talk more about his history, his depression, and he reminisced about happier times. He started reaching out for help when he needed support and after some time, his psychiatrist lessened his appointments because the shift was so drastic.

Benefits from regular exercise include:

- Improved sleep
- Better endurance
- Stress relief
- Improvement in mood
- Increased energy and stamina
- Reduced tiredness/increased mental alertness
- Weight reduction
- Reduced cholesterol and improved cardiovascular fitness

Boots on Ground

By Angelo Barberio

This December I had the pleasure of catching up with Jessica Myers, Senior Mental Health Clinician with the CCNS Pathway Home Team and decided to pick her brain a little bit about her background, interests, and overall thoughts about the Pathway Home Program.

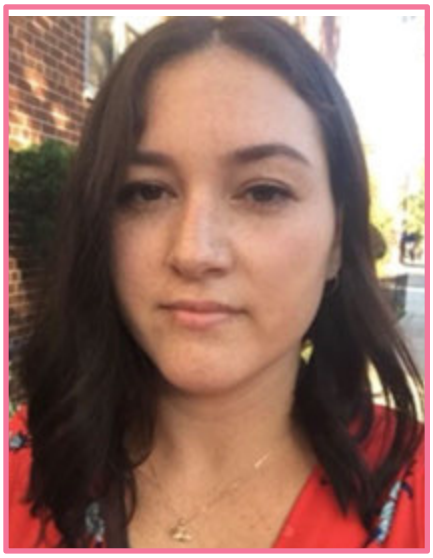
Me: So Jess, How long have you been working for CCNS? Pathway Home?
Jessica: "I've been working with CCNS since November 2015 and joined the Pathway Home team in 2016. I was the first person on the team and I still remember those first few months where I got to shadow existing PH teams with ICL and SUS. It gave me the chance to get to know the other teams and the style of the work."

Me: First person! That's awesome! So why did you decide to join the Pathway Team?
Jessica: "I was actually recommended by the Vice Presidents of Case Management to join the pathway team. I was looking for a change from care coordination and was also going back to school at the time for my LMHC so the timing worked out well."

Me: How do you like working for the Pathway Team?
Jessica: "I love it! I love my team, it's innovative, when I have ideas they are welcomed, and everyone is always interested in growing and continuing to learn. I like that the services are transitional and time limited, I feel like I get to help and touch more people that way. Shout out to my Team!"

Me: What do you find challenging working in Pathway?
Jessica: "Hitting walls. For example, Insurance companies not wanting to keep clients in the hospital when they need it or Hospital Providers not realizing clients potential or baseline and how they really are outside in the community in an everyday environment. I think it's just hard working against bigger systems like hospitals"

Me: One lesson you'd give to new pathway members like myself?
Jessica: "Take the opportunity to get to know the mental system better and how people are institutionalized. It helps us better serve our clients and help them establish roots in the community."



JESSICA MYERS

MENTAL HEALTH CLINICAN, CCNS

DID YOU KNOW?!?

Jessica has BA in Psych and 2 Masters! 1-MA in psych and 1-MA in Forensic mental health counseling. She is a LMHC-LP.

Strengths: "Dependable, good advocate for team and clients"

Weakness: "Knowing when to stop and take time for herself. Keeping it btw 9-5"

Outside of work: Jessica loves volunteering. Currently is volunteering at a yoga work study. She is also planning for a wedding! (Congrats Jess!)

Greatest Achievement: Going back to school for her LMHC.

Personal PH Motto: "Pathway Home, giving you roots!!"

Staff Spotlight

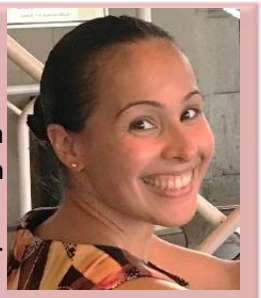
Dec 2018
Staff Appreciation
Awards

We take this opportunity to congratulate Kristen Nocerino (BPC), Justin Byous (ICL), Joan Sass (CCNS), and Sarah Lopez (SUS) recipients of this month's Staff Appreciation Award!

Kristen Nocerino
Senior Mental Health Clinician

Kristen has been a great asset to the Embedded team. Being a veteran PH staffer, Kristen brought in her PH knowledge and connections to assist with the ongoing promotion and success of the team and program. She is always willing to orient new staff members. Kristen works very diligently with her members and is always thinking of new and creative ways to engage the clients the team serves (bicycles, art, music, dance, food, etc). She embodies the creativity and out of the box thinking that PH strives to have. Kristen, your creativity and drive to help is admired. You are appreciated!! – ML*, team leader*

Sarah Lopez
Senior Case Manager



Sarah has been with the team for under a year. Upon her arrival, Sarah's main concern was understanding Pathway Home's model and serving her members. She communicates well with the other providers and is one of the firsts to take care of her client's needs. Her paperwork is extremely timely and full of content. Her dedication is shown by the great rapport she has with her caseload. Hence her nomination for employee of the month. Great Job Sarah! – *NH, assistant team leader*

Justin Byous
Senior Mental Health Clinician

Justin Byous is one of the most caring and genuine clinicians that I have had the pleasure of working with. As I have known him, Justin works hard to meet his members where they are in a person-centered way, always striving to create a safe space for processing and the development of a plan to move forward with their lives in a coherent, thoughtful manner. Justin is a firm believer in breaking the stigma associated with mental health, giving back to a forgotten population and serving them with dignity and respect. He is always willing to extend treatment and services. Justin, thank you! – AG*, team leader*

Joan Sass
Team Leader

As a lifelong LCSW in NYC, Joan has touched upon lives in schools, hospitals, home care, substance use, and private practice. A pioneer for advocacy & women's rights throughout her time in the field. After working in direct practice for many years, Joan has found a place to teach, supervise, and train workers in the field. Those fortunate to be a recipient of her knowledge will take decades worth of service with them on their journey. Joan provides a warm and genuine environment for her teammates and unafraid to give out a hug to anyone in need! Her team says "she cares for us like family." She encourages each of her team mates to be the best they can be, and it shows! Joan has created a family with the exceptional cast of characters that is the Queens Catholic Charities Team. She cares for her staff and the program's members with both real feelings and clinical expertise. She is a genuine social worker who continues to be the rock of our team Congratulations Joan! Thank you for all that you do! – *SA, director*

Celebrating you!!!!

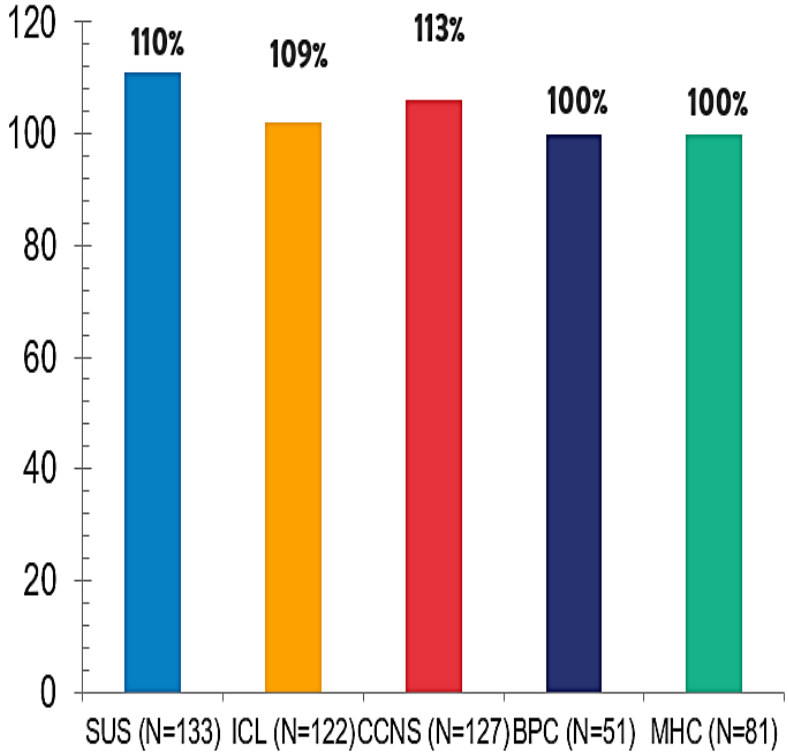
Annual Program Goals

ALL 2018 GOALS HAVE BEEN SUCCESSFULLY ACHIEVED	Completed By
Successful creation of "New" Recipient checklist	SUS-Sylvia
Creation of a streamlined transfer policy and checklist for use of PH teams when transferring cases	CCNS-Joan
80% of enrolled clients attended initial PCP appt within 90 days!	ICL-Alethea
Strived to enroll approx. 6 members a month and had 10 graduations for the year	BPC/MET-Monisa
Expanded community integration through PH presentations to a # of housing providers and organizations, created a CBC IPA networking series, and championed the launch of Healthify	Aja, Director
Solidified business partnerships with Vendors like Partner in Care, Verizon, Just Interpretations, UBER Health wellth	Enmy, PA
Conducted numerous presentations at hospitals (Elmhurst, NYU, NYPH Housing Marketplace) and community providers & residences (ACMH, CUCS, PGCMH, CPC care coordination). Contributed to increase of referrals ensuring meeting deliverables. Published research and writings for the PH monthly newsletter	Jackie, MES

2019 GOALS	To Be Completed By:
Improve medication education for by utilizing team nurses	SUS
85% of enrolled individuals will attend initial PCP appointment within 90 days	CCNS
Create a "member map" to improve staff catchment area and decrease staff travel 5% increase in completion/graduation	ICL
Register 20 members to Wellth and increase discharges from BPC campus	BPC/MET
Enhance reporting output for external & internal providers and improve efficacy for data reconciliation	CBC Program Admin
Create a more structured CBC internship program Increase knowledge of resources available in the community among PH teams	CBC MES
Aja - Implementing a quality tool to track and report clinical management and documentation outcomes to improve rate of accurate and complete documentation. Sarah - Create a staff satisfaction survey Angelo – Launch two fully staffed AH+ PH teams that work collaboratively with external peer supports	Directors

PATHWAY HOME ANNUAL ENROLLMENT

Over 700 Individuals Served & 500 Newly Enrolled in 2018



SUS Services for the Underserved
Target: Enroll an additional 100 – 120 Individuals

ICL Institute for Community Living
Target: Enroll an additional 100 – 120 Individuals

CCNS Catholic Charities Neighborhood Services
Target: Enroll an additional 100 – 120 Individuals

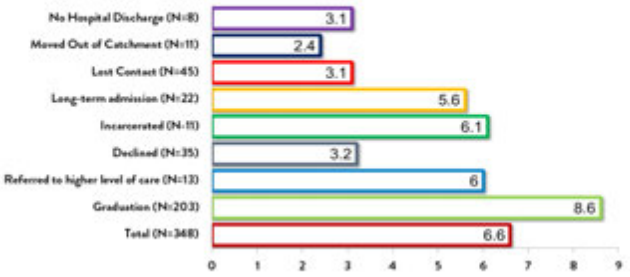
BPC Bronx Psychiatric Center Embedded (SUS)
Target: Enroll 25% of BPC Hospital and SOCR Discharges

MHC Metropolitan Hospital Center Embedded (SUS)
Target: Enroll all 730.40 Designations

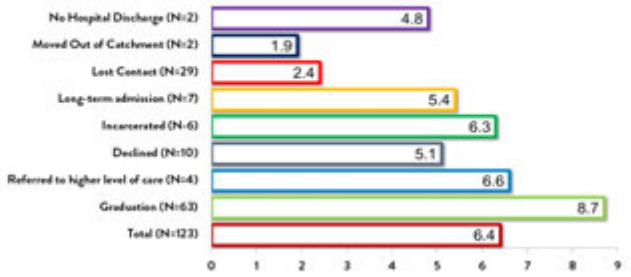
Pathway Home is a time limited, six (6) to nine (9) month model. To better understand the actual length of the PH program, a case study was performed using 2018 discharge reason data. Average length of PH enrollment looks at how long participants are enrolled in PH based on the reason for discharge. This can inform on what the expected length of the PH intervention is. For those who "graduated" in 2018 (N=203, 58.3% of total discharges), the average length of PH intervention was 8.6 months total and 8 months in community.

The results of this case study are represented with full data below:

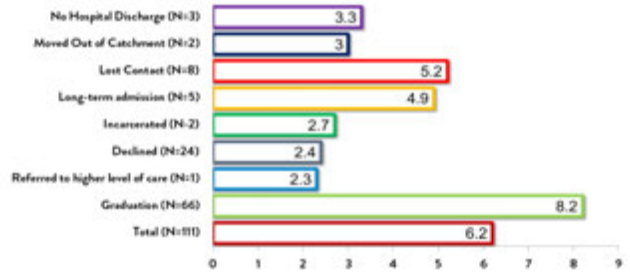
AVERAGE LENGTH OF PH ENROLLMENT (Months)
All 2018 PH Program Discharges (N=348)



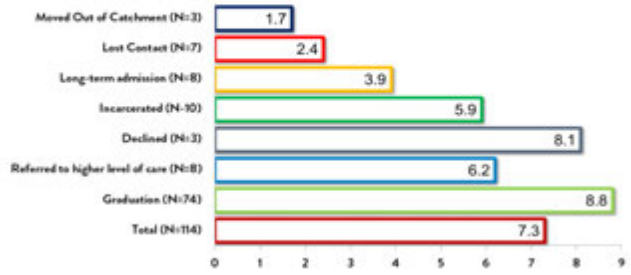
AVERAGE LENGTH OF ENROLLMENT (Months)
SUS PH 2018 Program Discharges (N=123)



AVERAGE LENGTH OF ENROLLMENT (Months)
CCNS PH 2018 Program Discharges (N=111)



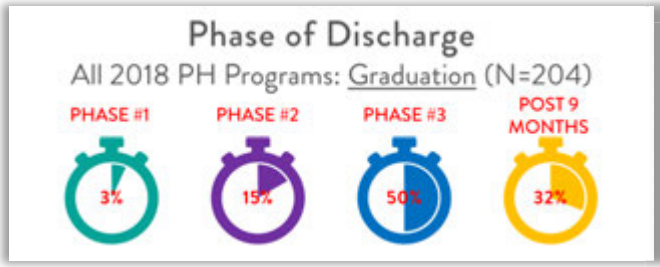
AVERAGE LENGTH OF ENROLLMENT (Months)
ICL PH 2018 Program Discharges (N=123)

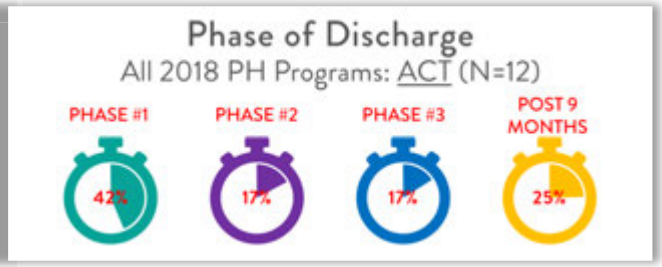


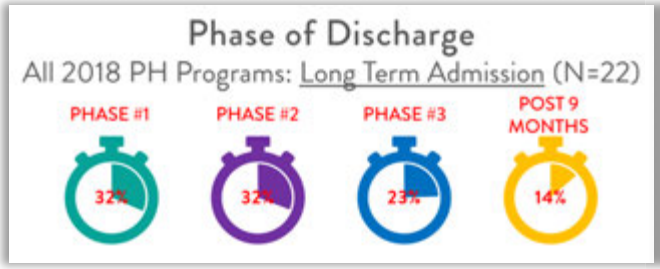
Total	Days	Months	N	Percent
Average days of enrollment Total	199.37	6.6	350	100.0%
Average days of enrollment: Graduation	258.04	8.6	204	58.3%
Average days of enrollment: Declined	95.26	3.2	36	10.3%
Average days of enrollment: Incarcerated	184.27	6.1	11	3.1%
Average days of enrollment: Long-term admission	167.48	5.6	22	6.3%
Average days of enrollment: Lost Contact	94.24	3.1	45	12.9%
Average days of enrollment: Moved out of catchment	72.18	2.4	11	3.1%
Averge days of enrollment: No Hospital D/C date	92.38	3.1	8	2.3%
Average days of enrollment: Referred to higher level of care	179.69	6	13	3.7%

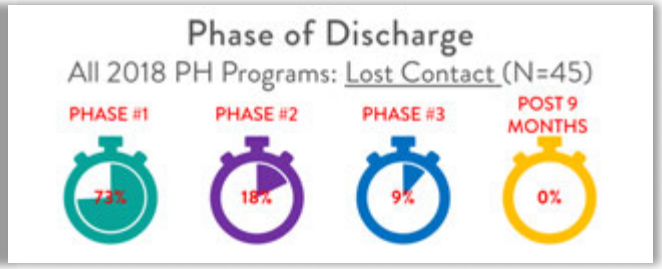
Post Community Entry (Hospital Discharge)	Days	Months	Stage	N	Percent
Average days of enrollment: Total	187.28	6.2	3	338	100.0%
Average days of enrollment: Graduation	239.36	8	3	204	60.4%
Average days of enrollment: Declined	92	3.1	2	33	9.8%
Average days of enrollment: Incarcerated	175.18	5.8	2	11	3.3%
Average days of enrollment: Long-term admission	150.36	5	2	22	6.5%
Average days of enrollment: Lost Contact	78.22	2.6	1	45	13.3%
Average days of enrollment: Moved out of catchment	62.45	2.1	1	11	3.3%
Average days of enrollment: Referred to higher level of care	167.33	5.6	2	12	3.6%

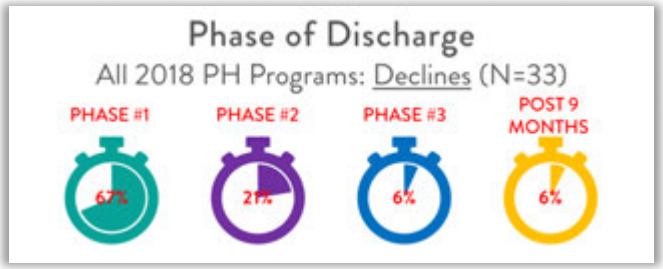
PHASE OF PH DISCHARGE STUDY: The study below looks at what percentage of discharges by "reason for discharge" occurred in which phase of the Pathway Home model. For example, 50% of graduations occurred in Phase #3. Full data below.











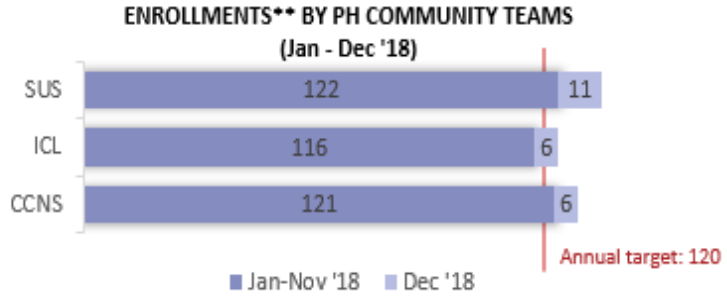
Total Discharges from time of enrollement: Phase of Dicharge (months)	Phase #1 (0-3 Months)	Phase #2 (4-6 Months)	Phase #3 (7-9 Months)	10+ Months	Avg length of stay over 10 Months	N
Graduation	5	26	91	82	10.9 months	204
Declined	23	8	3	2	10.3 months	36
Incarcerated	2	4	2	3	11.2 months	11
Long Term Admission	4	6	9	3	9.7 months	22
Lost Contact	28	12	4	1	10.0 months	45
Moved out of Catchment	8	2	1	0	N/A	11
No Hospital D/C Date	4	3	1	0	N/A	8
Referred to Higher Level of Care	3	4	1	5	10.1 months	13
Total	77	65	112	96	10.8 months	350
Percent	22.0%	18.6%	32.0%	27.4%		

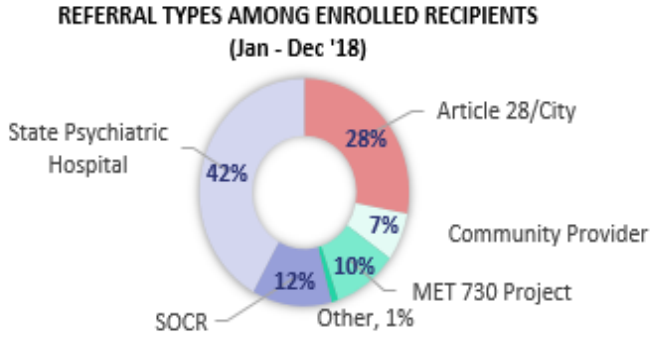
Total Discharges from time of community entry: Phase of Dicharge (months)	Phase #1 (0-3 Months)	Phase #2 (4-6 Months)	Phase #3 (7-9 Months)	10+ Months	Avg length of stay over 10 Months	N
Graduation	7	31	101	65	10.7 months	204
Declined	22	7	2	2	9.8 months	33
Incarcerated	4	2	2	3	10.9 months	11
Long Term Admission	7	7	5	3	9.6 months	22
Lost Contact	33	8	4	0	N/A	45
Moved out of Catchment	9	1	1	0	N/A	11
Referred to Higher Level of Care	5	2	2	3	10.4 months	12
Total	87	58	117	76	10.6 months	338
Percent	25.7%	17.2%	34.6%	22.5%		

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

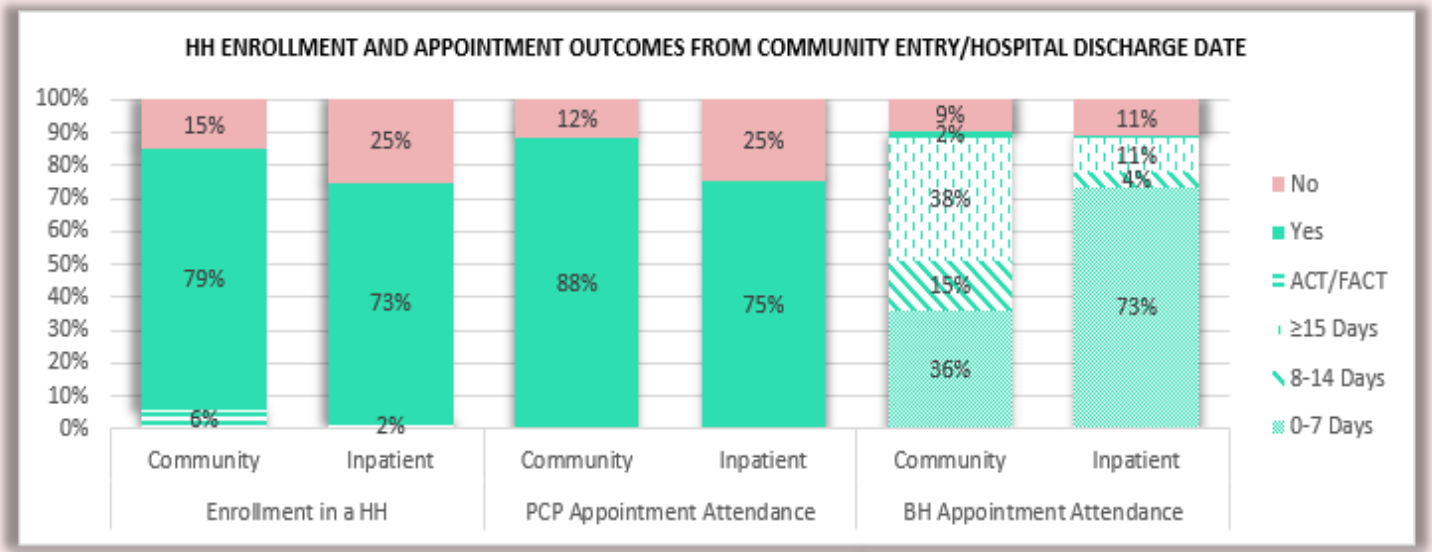
Community Teams

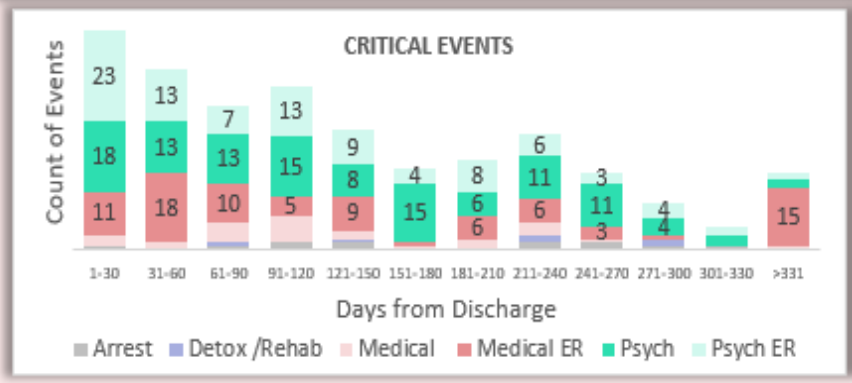
2018 Demographic Data *(Recipients Served n = 561)*	PH Program Data (Jan 2018 – Dec 2018)
Age: 25-44 (47%), 45-64 (36%)	**561 Served*** (SUS: **196**, ICL: **189**, CCNS: **176**)
Gender: Male (66%) Female (34%) Transgender (0.35%)	**16,380:** Total Services Provided
County: Queens (32%) & Bronx (25%)	**2.57:** Average # of days between referral and enrollment
	350: Recipients discharged

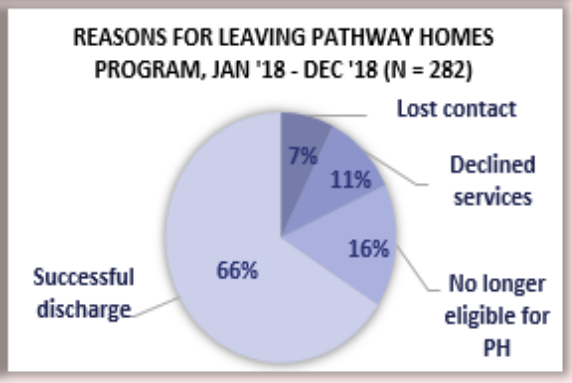




OUTCOMES AMONG THOSE DISCHARGED FROM PATHWAY HOMES JAN '18 – DEC '18 (n=282)***





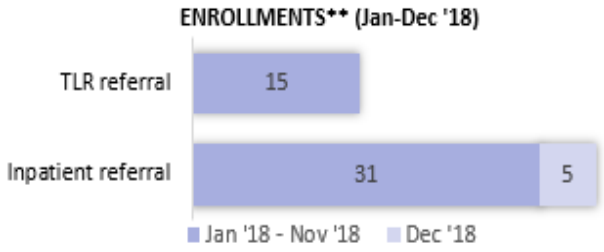


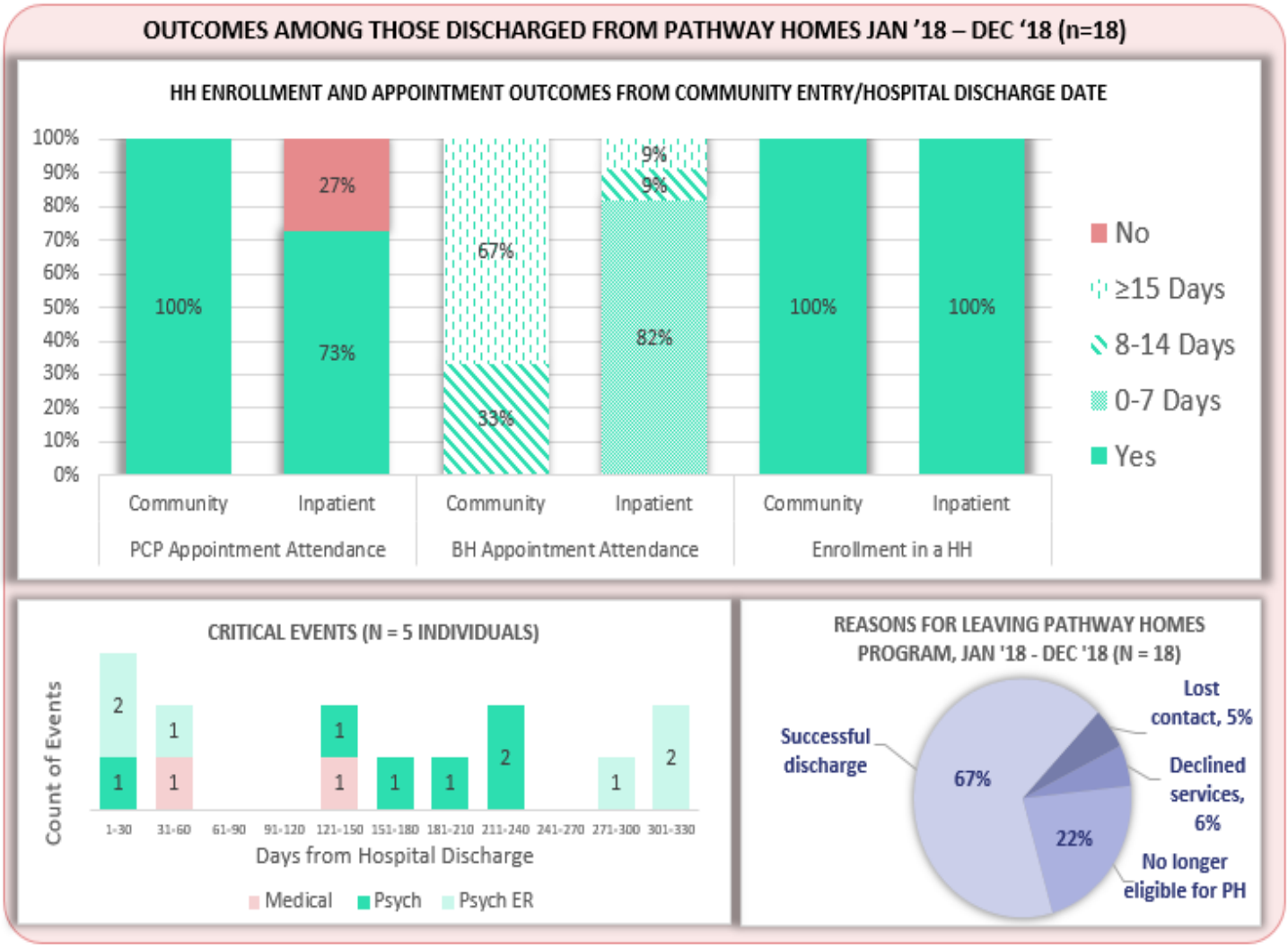
*SERVED = PATIENTS WHO RECEIVED 1 OR MORE SERVICES THROUGH THE PATHWAY HOMES PROGRAM AFTER ENROLLMENT
**ENROLLED = NEWLY ENROLLED IN THE PATHWAY HOMES PROGRAM
***EXCLUDES RECIPIENTS IN MET POPULATION

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

BPC Embedded Team

2018 Demographic Data *(Recipients Served n = 67)*	PH Program Data (Jan 2018 – Dec 2018)
Age: 45-65 (46%), 25-44 (42%)	**67:** Total served*
Gender: Male (75%) Female (25%)	**3,307:** Total Services Provided
County: Bronx (95%) Manhattan (5%)	**4.34:** Average # of days between referral and enrollment
	19: Recipients discharged



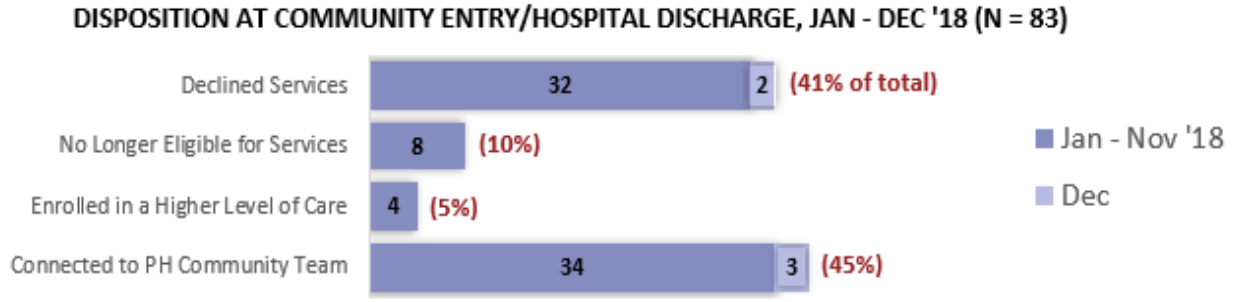


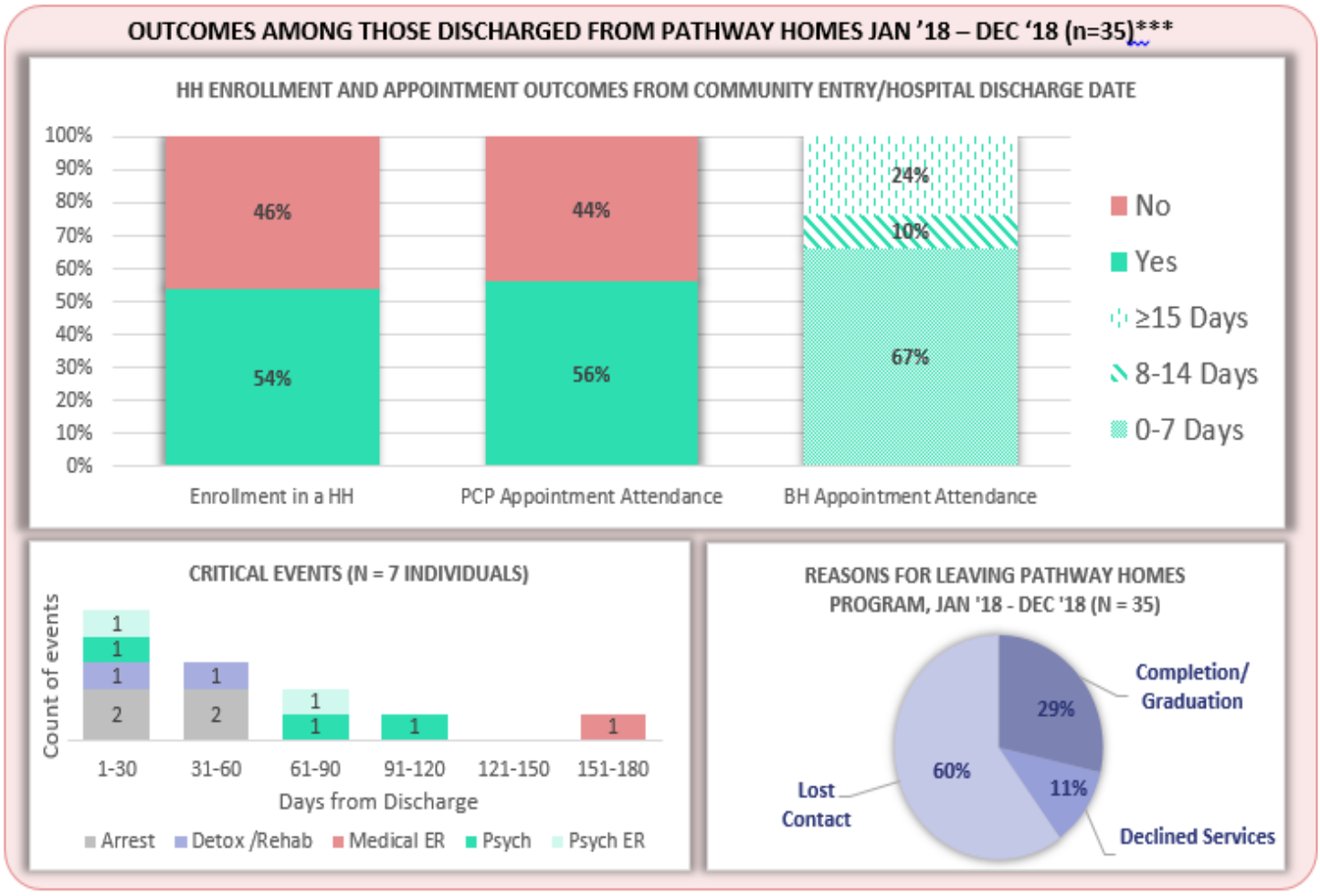
*SERVED = PATIENTS WHO RECEIVED 1 OR MORE SERVICES THROUGH THE PATHWAY HOMES PROGRAM AFTER ENROLLMENT
**ENROLLED = NEWLY ENROLLED IN THE PATHWAY HOMES PROGRAM

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

MET Embedded Team

2018 Demographic Data *(Recipients Served n = 112)*	PH Program Data (Jan 2018 – Dec 2018)
Age: 25-44 (51%), 45-64 (36%)	**112** Served, **568** Total Services Provided
Gender: Male (82%) Female (18%)	**≤1:** Avg. days to enroll
County: Brooklyn (32%) Manhattan (29%)	**10:** Average days inpatient stay
Housing: w/ Family (38%), Temp Housing/Shelter (31%)	**35:** Individuals discharged by PH Community Team





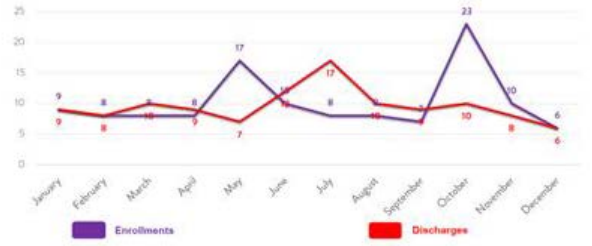
*SERVED = PATIENTS WHO RECEIVED 1 OR MORE SERVICES THROUGH THE PATHWAY HOMES PROGRAM AFTER ENROLLMENT
**ENROLLED = NEWLY ENROLLED IN THE PATHWAY HOMES PROGRAM
***INCLUDES RECIPIENTS CONNETED TO PH COMMUNITY TEAM

PH 2018 ANNUAL ENROLLMENT AND DISCHARGES

Total 433 Enrollments & 368 Discharges

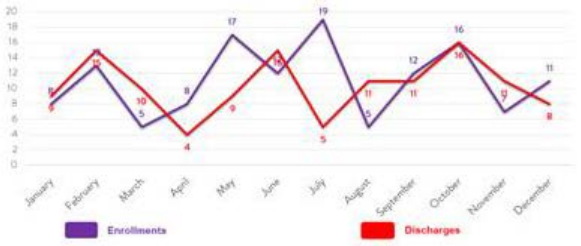
ICL 2018 ANNUAL ENROLLMENT AND DISCHARGES

Total 122 Enrollments & 115 Discharges



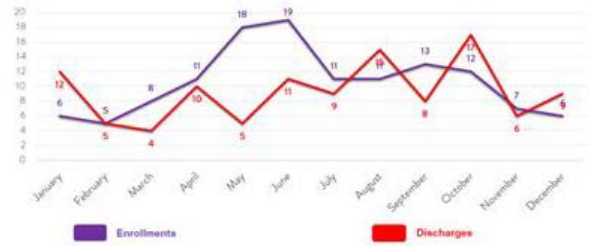
SUS 2018 ANNUAL ENROLLMENT AND DISCHARGE

Total 133 Enrollments & 124 Discharges



CCNS 2018 ANNUAL ENROLLMENT AND DISCHARGES

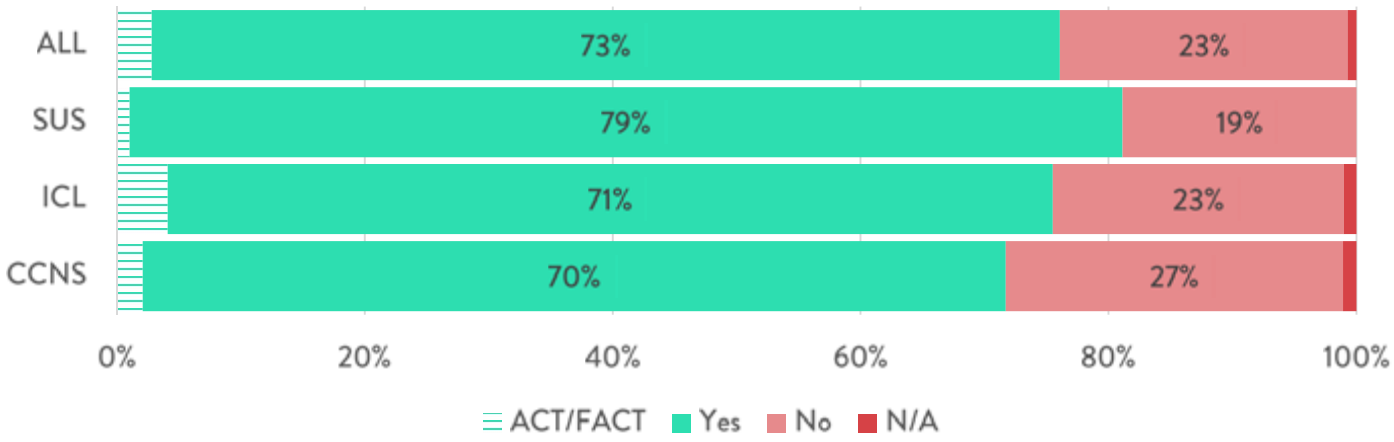
Total 127 Enrollments & 111 Discharges



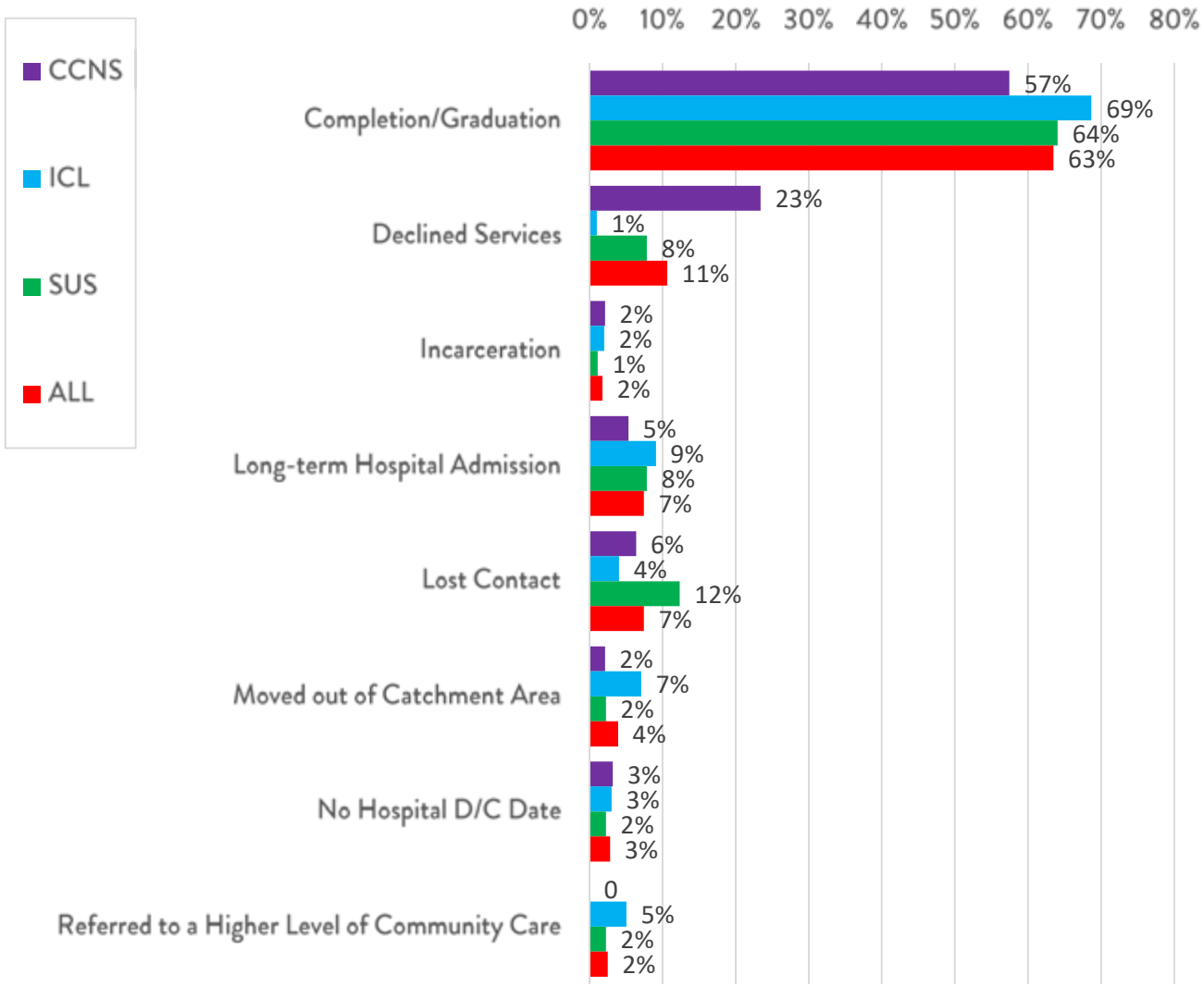
BPC 2018 ANNUAL ENROLLMENT AND DISCHARGE

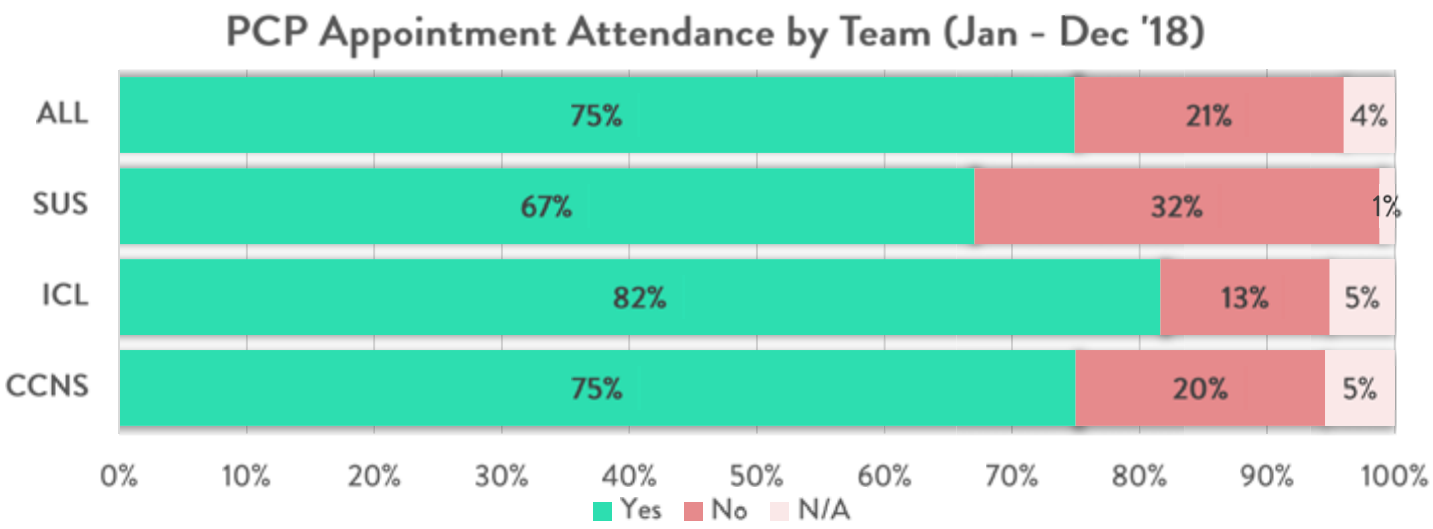
Total 51 Enrollments & 18 Discharges

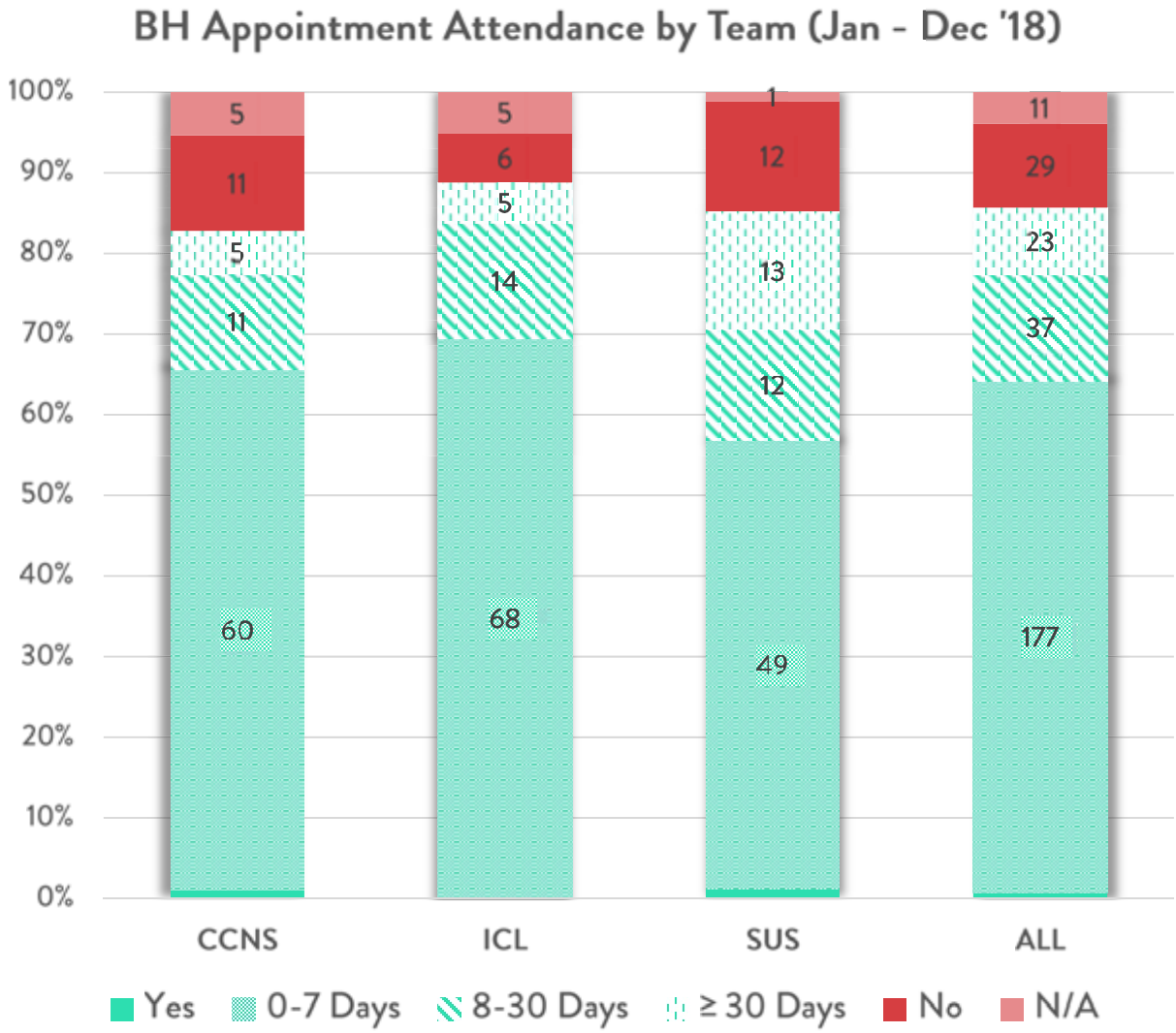
Enrollment in a Health Home by Team (Jan - Dec '18)



Reason for Discharge by Team (Jan - Dec '18)




PCP Appointment Attendance by Team (Jan - Dec '18)
ALL
SUS
ICL
CCNS
75%
21%
4%
67%
32%
1%
82%
13%
5%
75%
20%
5%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes
No
N/A


BH Appointment Attendance by Team (Jan - Dec '18)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
5
11
5
11
60
5
6
5
14
68
1
12
13
12
49
11
29
23
37
177
CCNS
ICL
SUS
ALL
Yes
0-7 Days
8-30 Days
≥ 30 Days
No
N/A