INSIDE: ASSOCIATION NEWS PAGE 28

ISSUE 5 | 2019

CMSA today™

WWW.CMSA.ORG

THE OFFICIAL VOICE OF THE CASE MANAGEMENT SOCIETY OF AMERICA

CMSA AWARD-WINNING PROGRAM
PAGE 10

MY KIDNEY TRANSPLANT STORY

THE CASE MANAGER'S ROLE IN IMPROVING ESRD PATIENT OUTCOMES

END-STAGE RENAL DISEASE

FOKUSGOOD/SHUTTERSTOCK.COM

2019 CASE MANAGEMENT PRACTICE IMPROVEMENT AWARD RECIPIENT: PATHWAY HOME™ PROGRAM

BY BARRY GRANEK, LMHC, AND JESSICA FRISCO, RN, BSN, MPH

The Pathway Home™ Program was awarded the 2019 Case Management Practice Improvement Award, sponsored by the CMSA Foundation. The CMSA Foundation presented the award on June 13, 2019, during the 2019 CMSA Annual Conference in Las Vegas. CBC Senior Director Barry Granek accepted the award on behalf of the Pathway Home programs and gave the acceptance speech to approximately 2,000 conference attendees.

Individuals with severe mental illnesses (SMI) who undergo extended stays in psychiatric hospitals or long-term facilities face enormous challenges when transitioning back to independent community living and subsequently suffer high rates of homelessness, suicide, rehospitalization, reincarceration and violence against others.[1] Pathway Home (PH) has revamped traditional care management strategies during these care transitions and has been nationally recognized for its success in improving outcomes for highly complex adult populations. The PH program aims to improve the quality and scope of services provided to participants following a long-term institutional stay when they are most vulnerable and face significant challenges engaging with community-based services.[2]

Pathway Home is operated by Coordinated Behavioral Care (CBC), a member-led nonprofit organization based in New York City, which oversees delivery of direct services by community-based health and human

services agencies that are part of the CBC Network. Pathway Home has been funded by the NY State Office of Mental Health since 2016.

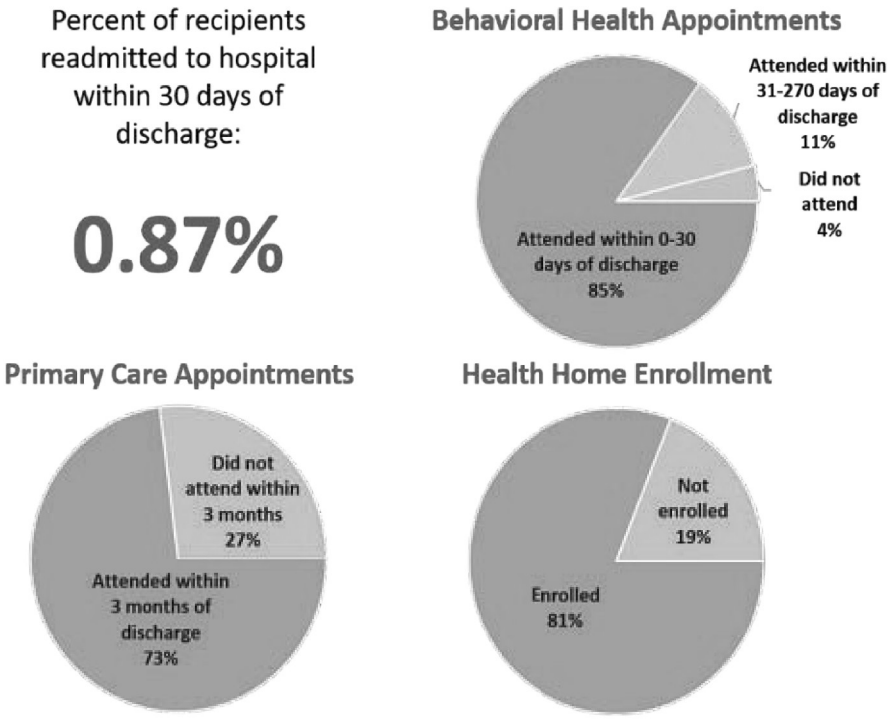
A PHASED MODEL PROMOTES INCREASING RESPONSIBILITY AND INDEPENDENCE FOR PARTICIPANTS IN TRANSITION

The Pathway Home program is an adaptation of the Critical Time Intervention (CTI) model,[3] an evidenced-based and time-limited intervention where multidisciplinary teams provide intensive services beginning shortly before participant's hospital discharge. Services continue through a series of 4 phases lasting a total of 6-9 months, gradually transitioning the participant to community living.

The initial Pathway Home phase, **Planning and Relationship Building**, begins anywhere from one week to one month before the transition from hospital to community. PH staff engage participants during this time to begin planning for post-discharge and identify potential gaps in the transition plan. Staff also collaborate with the participant's inpatient team, family, community providers, and others involved in the care, making connections with appropriate resources. Skills-building is offered for participants to learn the skills necessary to be successful in community.

During **Phase II: Transition and Active Linking**, which spans the first 3 months post-discharge, the PH Team conducts initial assessments and develops a Care Plan. The team provides support during transition by resolving immediate needs and problem-solving obstacles that prevent participant's access and engagement in outpatient services. Most importantly, the team works to build relationships and connect participants to people and agencies that will eventually assume the primary role of support.

Over the next 3 months during **Phase III: Practice and Transfer** participants are expected to be practicing and perfecting life skills so PH services can be stepped back. This allows participants greater independence and reliance on both themselves and their support systems. The PH Team continues to make appropriate linkages, ensures the transition plan is on track and resolves any unexpected complications. Services delivered are incrementally stepped back as participants begin to take on more independence and responsibility for their care needs.



SOURCE: PATHWAY HOME

During the final **Graduation** phase in months 7-9, PH ensures the support network is safely in place and begins to fully step back its services. The team shifts from in-person contact with participants to telephonic visits and text messages and increases communication with the participant's collateral and established care team. Staff solidify the long-term plan and goals with the participant and their support networks, and address any lingering gaps in care. Finally, a graduation date is determined, and a meeting is held with the participant and their supports to both mark the final transfer of care and celebrate success. Upon graduating from the program, participants are expected to have formed lasting ties to provider and community resources, be receiving care management if needed and/or eligible and be equipped with the skills to succeed independently in the community.

The Pathway Home multidisciplinary team is composed of a clinician team leader, licensed mental health clinicians, case managers, nurses and peers who care holistically for the participant with a focus on social determinants of health like food, economic security, and housing. Teams are involved in a wide variety of activities that support long-term success in the community, ranging from developing a plan for community reintegration, joining participants for appointments, and facilitating warm hand-offs to clinical providers and long-term case management. Teams may also assist with obtaining vocational and educational services, appropriate housing, or even a bank account. This high-touch service fosters a relationship where participants feel invested in and become more engaged in treatment as a result.

CREATIVITY, FLEXIBILITY AND INNOVATION ARE CORE COMPONENTS OF THE PROGRAM

Pathway Home aims to provide creative and recovery-promoting interventions that support participant's goals and encourage them to remain in the community. Since achieving overall wellness requires participation in both healthcare as well as meaningful life activities, PH teams work to identify participant's hobbies, creative endeavors and personal interests and engage them in

"Pathway Home was an essential part of my new beginning getting back to normal home life after the hospital. Without the team, I don't know if I would have made it through this tough time."

ways that provide a sense of purpose and motivation. For example, participants have been connected to social and dating apps, enrolled in career workshops, and received funds to purchase gym memberships or tickets to the movie theater depending on their interests. Activities outside the traditional realm of health can still be incredibly therapeutic, and it is not unusual for Pathway Home to use dance, art, writing, animal companionship, gardening and more to facilitate engagement in social and pleasurable pursuits.

The program also provides flexibility in services to meet the diverse needs of its participants. Visits are held in locations that are most convenient and appropriate, anywhere from a participant's home to a coffee shop to a hair salon. PH staff are given autonomy to determine frequency and duration of visits, sometimes as often as multiple times a week for several hours. The use of texting and video conferencing has facilitated personalized and more frequent communication between staff and participants which has increased engagement, trust, and quality of care. Participants without cellphones are provided one so that whether in crisis, experiencing an urgent need or simply seeking support, they have easy and immediate access to staff.

Pathway Home has also invested in technology-delivered interventions,[4] contracting with several tech startups to provide the most innovative and effective solutions. For example, the use of an app called Wellth employs behavioral economics to build the habit of taking medication. Ridesharing through Uber Health is used to transport individuals with any mobility issues to appointments while the PH team work on setting up more permanent Medicaid Assisted Transportation.

PROMISING OUTCOMES FOR PARTICIPANTS

The Pathway Home program has achieved positive outcomes for nearly 400 individuals who successfully completed the program from April 2016 to December 2018 (Figure 1), specifically regarding case management enrollment, hospital readmission rates, and appointment attendance. The PH program also shows promise for improved care utilization and potential cost savings. Comparing pre- and post-program Medicaid claims for a small sample of participants who successfully completed Pathway Home between 2016-2017,[5] 58% experienced a decrease in inpatient hospitalization or emergency department visits and 17% had no change. There was also a 508% increase in medication claims, a 406% increase in outpatient behavioral health appointment claims and a 240% increase in outpatient medical claims after completion of the PH program compared with before the program, all of which are associated with positive health outcomes and reduced net costs over time.[6-8]

Most crucially, the Pathway Home program has received extensive positive feedback from its most important stakeholders — the participants. Those who completed the program have shared testimonies expressing optimism, motivation and gratitude:

- *"Pathway Home was an essential part of my new beginning getting back to normal home life after the hospital. Without the team, I don't know if I would have made it through this tough time."*
- *"I like that [Pathway Home] picks me up for appointments to show me the destination. It's good to have someone accompany you when you're new to the neighborhood."*
- *"I have amazing opportunities ahead of me and so much potential. Pathway Home team has helped me realized this in my dull moments."*

Pathway Home is a proven model that has demonstrated improved outcomes for adults with SMI and is being expanded to focus on participants with substance use disorders, chronic comorbid physical health conditions, homelessness and those with criminal justice involvement. PH has garnered interest across different sectors of the healthcare delivery system. CBC intends to continue building on its success by securing further sustainable funding from various payers including government agencies and managed care organizations and expanding to reach larger and more diverse populations in need of effective care transition services. ■

REFERENCES

1. Herman, D. & Mandiberg, J. M. (2010). Critical Time Intervention: Model Description and Implications for the Significance of Timing in Social Work Interventions. Research on Social Work Practice, 20(5), pp. 502-508. **https://journals.sagepub.com/doi/10.1177/1049731509360667**

2. Petit, J. R., Graham, M. & Granek, B. (2018). Pathway Home: An Innovative Care Transition Program from Hospital to Home. Psychiatric Services, 69(8), pp. 942-943 **https://www.ncbi.nlm.nih.gov/pubmed/30066615**

3. Herman, D. & Mandiberg, J. M. (2010)

4. Petit, J. R. & Granek, B. (2018). Virtual Pathway to Technology-Assisted Care Models: Keeping Up with New Technology in Behavioral Health Care. Behavioral Health News, 5(4), pp. 22 **http://www.mhnews.org/back_issues/BHN-Summer2018.pdf**

5. 12 participants who had been referred from an acute inpatient hospital setting, successfully completed the program, and had accessible Medicaid claims data.

6. Villemoes, M. K., Aagaard, J., Vaggemose, U., & Sogaard, R. (2018). Cost Analysis of Community Based Family Support of Patients with Severe Mental Illness. Community Mental Health Journal, (54), 625-633. **https://www.ncbi.nlm.nih.gov/pubmed/29177724**

7. Patterson, J. A., Holdford, D. A., and Saxena, K. (2016) Cost-Benefit of Appointment-Based Medication Synchronization in Community Pharmacies. The American Journal of Managed Care. **https://www.ajmc.com/journals/issue/2016/2016-vol22-n9/cost-benefit-of-appointment-based-medication-synchronization-in-community-pharmacies**

8. Cutler, R. L., Fernandez-Llimos, F., Frommer, M., Benrimoj, C., & Garcia-Cardenas, V. (2018). Economic impact of medication non-adherence by disease groups: a systematic review. BMJ open, 8(1), **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5780689/**

Barry Granek, LMHC, *is the senior director for Pathway Home and has overseen the development and implementation of the program since 2015. He holds a master's degree in clinical community counseling and post master's degree in counseling at risk youth from Johns Hopkins University. He is a licensed mental health counselor in New York State.*

Jessica Frisco, RN, BSN, MPH, *is a quality improvement specialist at Coordinated Behavioral Care managing quality assurance and reporting for the Pathway Home program. She received her master's in public health at Columbia University and is a licensed registered nurse in New York State.*