PATHWAY HOME

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CBC PATHWAY HOME

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Inside This Issue

Letting The Outside In

Barry Granek,
Senior Program
Director

Wyatt has these memorable peculiarities. Like when he would insist someone was in his closet. When we would check and find no one there, Wyatt would casually conclude that the person simply departed temporarily. Most would label this as delusional, though we would share a glance that implied a shared understanding.

Despite being homeless and untreated for mental health conditions for a duration, Wyatt had a good spirit and was affable. My visits started after he obtained an apartment and began treatment.

One day I talked to Wyatt about the idea of opening his own bank account. Up to now he had a representative payee, so an account would offer increased autonomy and access to his own money.

After careful planning and some education, we met with a bank representative to complete the paperwork. Wyatt enthusiastically walked out of the bank with an account and his very own checkbook.

We reviewed how to pay bills, including rent and utilities. While encouraging to observe Wyatt self-reliant, he struggled with writing checks, remembering how to withdraw cash, and would often request my assistance.

A few months later, Wyatt asked if I would join him as he was on his way out to the bank. Curious to see how this was going, I agreed.

As we walked through the bank door, someone calls out "Wyatt". I turn and see a suited gentleman, a bank employee, waving to Wyatt from his office. He walks over and with a big smile says "hiya Wyatt, I am with a customer, take a seat here and I will be with you in two minutes".

I was stunned. Amazingly, a financial manager in a suit and tie knew Wyatt by name. He made the effort to flag Wyatt down and then helped Wyatt pay his bills and withdraw cash.

I learned that the bankers were taking care of Wyatt. Noticing him struggling with figuring out how to navigate the bank services, they took an interest and helped him out.

It dawned on me how it is advantageous even for a high touch program like ours to rely on community supports.

In Wyatt's situation, because the financial manager was at the bank every day, he was there when Wyatt needed him. My schedule, however, did not always coincide with Wyatt's momentary need.

One's recovery journey can be supported though an ecosystem of what Dan Herman calls the formal and informal supports. Herman indicates informal supports as family and friends. As Wyatt's story demonstrates, it doesn't need to end with the obvious collaterals. Informal supports are found in all sorts of social, retail, medical, and unexpected settings.

I have observed pharmacies waive a copay to ensure medication is filled. Bodegas give credit for a sandwich and light groceries the day before food stamps are loaded. A local restaurant who will walk upstairs to deliver a meal. Neighbors checking in so one doesn't feel lonely. The list would go on because the possibilities are vast.

We all benefit from feedback and assistance from the outside world, especially during a transition.

This is why it is critical that case managers meet participants in community locations, outside the office and outside the home. By scheduling meetings in community locations, connections can be fostered that create a sense of belonging and cultivate ties to a community.

As one is market-testing their recovery plan, discerning who, how, and when supports are most needed can be determined and appreciated in real time with experience – if done in the community. This is how the support that will have the maximum impact will be initiated, to achieve true community integration, by letting the outside in.

Hot Press

L to R: SCM Stephanie Lucianco, TL Nikenya HAll & ATL Leslie Chamorro

CBC in partnership with SUS has launched a new Pathway Home team. In collaboration with OASAS and BronxCare, the team will focus on serving individuals transitioning from inpatient Detox and Rehab. The team officially launched on July 29th and held a kickoff event with staff at BronxCare. Nikenya Hall, the Team Leader from Pathway Home SUS Team will be heading the team. She is joined by Leslie Chammaro who was promoted to Clinician/Assistant Team Leader and Stephanie Luciano and James Bradly, who joins the team in the role of Case Management/CASAC.

Specialty Meetings

On June 23, the Peers joined Sarah Abramson for their monthly Peer Specialist meeting. As an integral part of each team, the Peers use their knowledge and experience in relating to participants. Therefore, over pastries and coffee, they met to discuss a topic that is relevant to a number of participants: Supporting an Inclusive LGBTQIA+ Narrative. The group shared their experiences as well as concerns, noting that oftentimes it is difficult to know how to properly support the LGBTQIA+ community. After discussing the various titles and pronouns, as well as engaging in a comprehensive activity to ensure understanding, there was a lively discussion amongst the peers about the best ways to engage with these clients in a supportive and helpful manner.

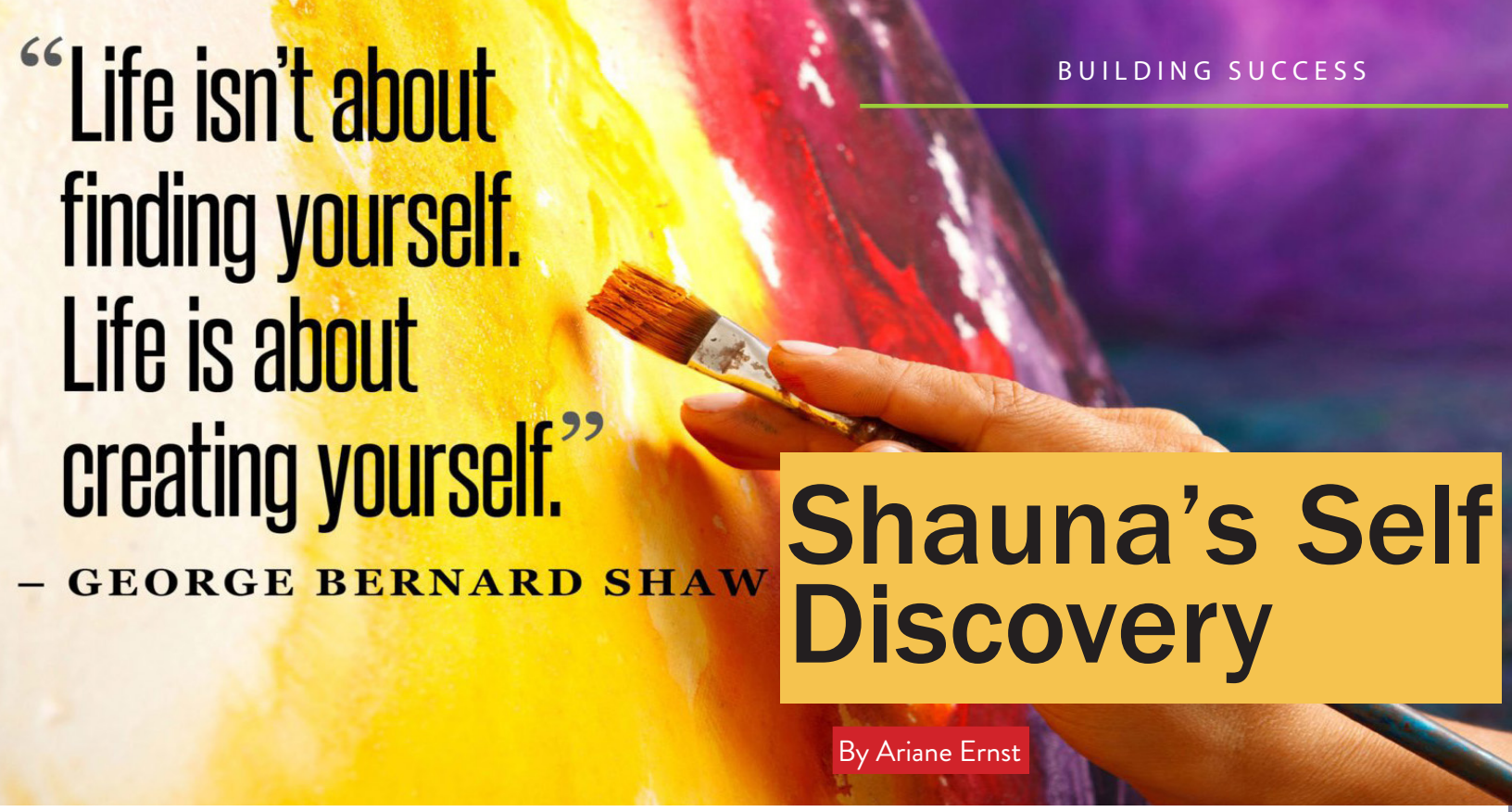
L to R: PS Dustin Grose, Pam Gerard, Edward O'Dowd & Nyasia

The Future of Norman

By Carmelina Dutan

Norman experienced visual and auditory hallucinations. He had a long history of hospitalizations due to anxiety, depression, and PTSD, all of which disrupted his day-to-day life and ability to care for himself. While initially hesitant to confide with doctors at New York Presbyterian Hospital or family, he showed improvement in his symptoms through a combination of finding the right medications and discussing his anxieties and fears.

After entering the community, Norman attended his medical and mental health appointments and learned to travel independently to appointments. He learned to take his medication and has obtained Home Attendant services. Reintegrating into the community was a key part of his recovery. With PH team, Norman explored the neighborhood to learn about his surroundings and what is accessible to him, reaching out to his brother who lives nearby, and making new acquaintances in his building. In the process of expanding his familial and friendly connections, Norman said “I feel more confident and accomplished than ever before and am thankful for all services provided by the Pathway Home team.”



Shauna's Self Discovery

By Ariane Ernst

At the young age of 17, Shauna left the Hasidic Jewish community and was suddenly on her own. She no longer had community support, and therefore found herself in a number of homeless shelters. Throughout her life, Shauna had experienced severe abuse and trauma, which had impacted her perception of herself and others. She has a diagnosis of Borderline Personality Disorder and struggled with severe and chronic suicidal ideation and self-harming behaviors. After spending several months in Rockland Psychiatric Institute, Shauna was referred to Pathway Home at the age of 20 years old.

Shauna was apprehensive about her interaction with the Pathway Home team. She had never experienced life outside of her community, and was unfamiliar with basics including grocery shopping and clothing sizes. With assistance, Shauna shopped at TJ Maxx and learned to develop her own sense of style. She became familiar with shopping and living outside of her previous community.

In addition to adjusting to her new environment, Shauna struggled with extreme emotions. Once she became comfortable with her Pathway Home team, she frequently reached out to them to discuss suicidal feelings and emotional crisis. Due to these significant needs, the Pathway Home team was able to refer her to an intensive treatment program specializing in working with people with Personality Disorders. Initially, Shauna experienced considerable discomfort in the program because she needed to address her previous trauma. However, she successfully completed the six-month program, and applied to continue for another six months.

After a lot of hard work, Shauna has succeeded in reducing the frequency of her suicidal thoughts and has learned how to cope in a much healthier way. She has started applying for jobs, and is planning on going back to school to earn her GED in the fall. She has successfully adjusted to the changes in her life, and is now thriving in her new environment.

SECOND CHANCE HOME:

BYRON STOCKHART

Byron: "Hey Pam and Shannon, I stayed at the shelter last night and I am here now- they sent me over to Brooklyn"

Shannon: "It was ok?"

Pam: "Did you like it Byron?"

Byron: "Yes I did, and I met the social worker here and finished the intake. I called the Pathway Home on-call line after intake to tell the team where I was placed and that I arrived safely. I spoke with my Care Coordinator, she told me what Shannon and you told me about not going back to my old address in Queens and getting arrested. I am not going back there."

Shannon: "Yes, Byron great progress, please remember to change your address, the team can support with this."

Byron: "I'm going to obtain a residence letter from the shelter, my Case Manager here already talked to me about this and I will get my mail here from now on"

Shannon: "Sounds like a good plan Byron"

Byron: "And Shannon, I am meeting Erika (Pathway Home Case Manager) tomorrow so I could come for my appointment at the hospital. Will I get to see you and Pam?"

Shannon: "Of course. We would enjoy seeing you."

Pam: "Byron, please call me again as soon as you arrive. We will meet you downstairs"

Byron: "Ok"

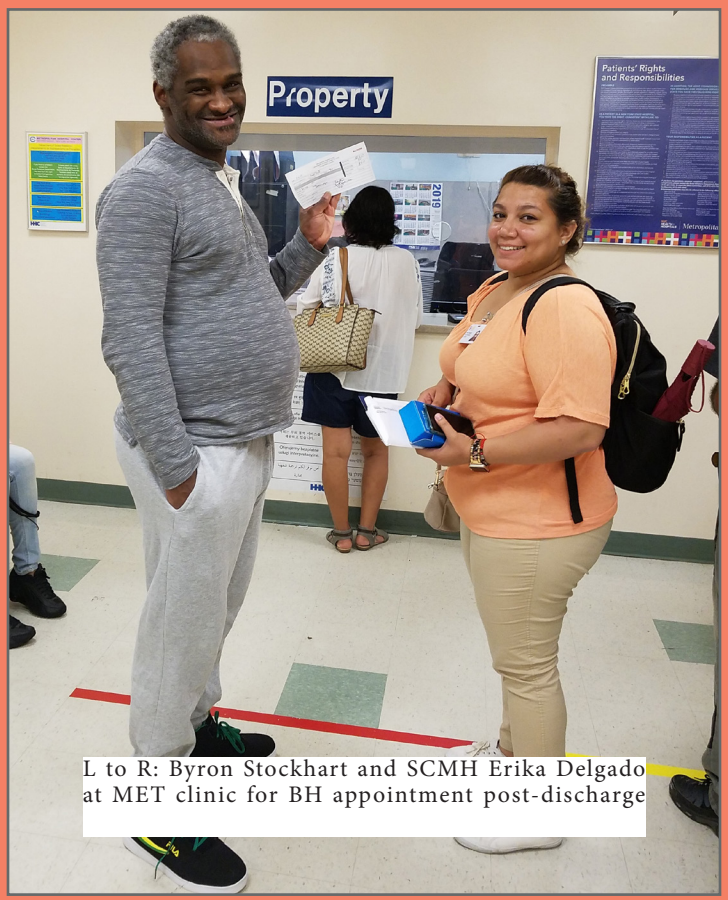
Shannon: "Byron, did you take your medications this morning?"

Byron: "I took it last night and this morning and I feel good, I'm going to keep taking it?

Pam: "Ok then, Byron we are going to see you tomorrow, have a good night and sleep well"

Byron: "Thank Shannon and Pam. I will see you tomorrow (confidently)"

Byron Stockhart had been through the doors at Metropolitan Hospital Center four times. He told Shannon, Senior Mental Health Clinician with the MHC PH Embedded Team, "I appreciate you because every time they sent me here I saw your face", they both chuckled deeply knowing how many times housing instability and not taking medication triggered substance use, arrests for trespassing, and hospitalization.



L to R: Byron Stockhart and SCMH Erika Delgado at MET clinic for BH appointment post-discharge

Byron shared that his housing instability stemmed from his family not allowing him to reside with them when he used drugs. Upon his arrival to MHC, Byron expressed he was looking for help. He shared that he was encouraged to join Pathway Home, saying" I am tired of being arrested because I did not have a safe place to sleep at night."

The PH Embedded and MHC teams worked together to educate Byron on medication treatment and its benefits. He expressed his fear of needles and that he would take his medication, asking for support obtaining his injection. Peer specialist Pam and his inpatient SW Brett, sat with Byron to help explain purpose of injection and injection schedule, he would only be receiving an injection the first week of every month. The pair spent time comforting and counseling him, Byron

"I liked Shannon and Pam working with me, they helped me make my own decisions and brought a smile. They also made sure I paid attention and taught me how to reach out to them. ..they showed me that someone will always be there for me and helped me with my medication" - Byron

L to R: PS Pam Gerard, BHA Staff Ms. Todd, Byron Stockhart and SMHC Shannon Cameron

"Byron has been reaching out with me. He is driven to make the best decisions for himself" - SCM Erika Delgado,

time comforting and counseling him, Byron agreed to take the injection in July, and now remembers his injection the 1st week of the month. This psychoeducation has motivated Byron to learn more about the diagnosis he carries and understand how his medication helps him to become more organized and to think clearer about his goals. The PH Embedded Team enrolled Byron in WELLTH to assist with his medication habit building. Byron immediately agreed to participate and began training on how to use a cell phone.

Understanding the importance of housing and not wanting to repeat his previous cycle, Byron advocated to remain in the hospital while a housing application can be completed. The inpatient team and embedded team completed and submitted a housing application. Byron was approved for housing and already attended a housing interview.

"I am really looking forward to taking the steps to making the big changes in my life" Byron said to Shannon, "I was getting tired of always getting arrested and being in the hospital." Byron is scheduled for more housing interviews. While on the inpatient unit, Byron took medication, attended groups, and engaged in healthy socialization with staff and other patients.

When team heard from Byron after discharge, it was reassuring to hear he had a good start and that he would remain in touch. Byron called when he arrived at the clinic. After four inpatient admissions at MHC, this was the first time Byron returned to the clinic.

Since entering the community, Byron went to SSA Office to change his address. He attended HRA independently and is pending benefit reactivation. Even though he is in shelter and waiting for housing placement, he has gained the ability to trust his network of supports. Byron is aware that he now has different tools he can utilize while in the community that will help him avoid re-arrest or re-hospitalization. He loves his Pathway Home provided phone and is motivated to learn more about the Wellth App.

Braking The Cycle

By Kristen Nocerino

One day when visiting Barry, I noticed a broken bike in his room. Barry explained he found it in the garbage and he used to ride bicycles as a child when he delivered newspapers. Riding the bike was exciting, as he would reminisce his childhood. “Should we fix the bike,” I suggested. The owner of a bike shop explained “there is no hope for fixing it.” Barry really wanted a bike, so we used Ph step Down Funds and purchased a new bicycle. Barry has made a relationship with the bike shop owner as he is a frequent visitor and is often requesting some new gadget. BPC staff are excited to tell me their stories of seeing Barry riding his bike around the neighborhood, ringing his bell and waving. Residence staff tell me that the bicycle is one of the main reasons that Barry has done so well in the community

We were "warned" about Barry. Honestly, I had my concerns around working with someone who had a long criminal history and who could present as threatening (due to his tall stature). Barry's need for support during his transition was apparent. When Barry first entered the community, he was difficult to engage, rarely at the residence, and often hospitalized when others found him "threatening". Most of his time was spent wandering the neighborhood.

When I first met Barry, he expressed agitation about a program checking on him and expressed "I want to live free." Being involved with the behavioral health system for decades, Barry was used to the traditional treatment and focus on appointments and medications. I needed to take a different approach.

Engaging often, with the help of Barry's favorite soda, I was able to build a rapport. I told him "I remember you talking about the soda while inpatient and how this is something you wanted but were unable to get in the hospital." I am not sure if it was the soda or that I listened and remembered it, though the therapeutic relationship started to grow that would assist Barry maintaining in the community for one of the longest durations of his life.

I coordinated closely with treatment team regarding treatment and finding the right medication for Barry to address his mood. Initially accompanying to appointments, Barry quickly learned to attend independently. We occasionally provided support, per psychiatrist requests, as he was aware of our rapport and would utilize my relationship with Barry when talking about treatment.

The team work with Barry on social skills and relating to others. With a tendency to touch people impulsively when excited about a subject, some would perceive this as threatening. Team educated Barry how this behavior could be viewed. We worked to teach de-escalation and redirection tactics, in efforts to decrease the amount

"I remember you talking about the soda while inpatient and how this is something you wanted but were unable to get in the hospital"

"I want to live free."

of emergency calls and potential hospitalizations. Any time Barry ended up in the ED, I was the first person he reached out to, all times of the day. The calls came in asking me to come to ED and advocate for him. I educated clinical teams explaining that behaviors and his imaginations were not meant to be threatening.

When Barry joined Pathway Home BPC Embedded team, there were varying levels of belief in his potential to succeed. A year and a half later, Barry is successfully living in the community. I enjoyed my work with Barry: learning about his childhood, favorite movies, and his interests in pursuing his GED.

What people misjudge is that Barry is well-meaning and caring. Throughout my time working with Barry I received numerous calls from him suggesting healthy foods I should eat, asking about my family, inviting Alexis and me to church, and championing that purchase my own bicycle. Small things like saying a little prayer before eating a street cart snack, showed Barry's true intention. With support and encouragement, Barry is flourishing. Most importantly, with collaboration and intention to change the narrative in how other providers saw him, providers took the time to understand him. I look forward to seeing Barry riding his bicycle freely and enjoying the life that he deserves.

The next step:
Pathway Home program is helping to reduce readmissions

Collaboration!

According to research, discharged mental health clients are more likely to succeed in the community if they're prepared in advance for the transition and have follow-up services in place.

The Pathway Home, a collaboration between Bronx Psychiatric Center and Coordinated Behavioral Care (CBC) of New York City, is providing such services to make the move smoother for their clients. During its first six months, the program reduced costly readmissions by 90 percent.

CBC COORDINATED BEHAVIORAL CARE

Great track record

"The idea stemmed from an OMH initiative that looked for ways to reduce the number and length of costly inpatient psychiatric hospitalizations by offering high-quality, cost-effective services within home and community-based settings," said **Barry Granek,** Senior Director of CBC's Pathway Home programs.

"In our effort to ensure individuals succeed in the community, we wanted to develop supports and connections while they're still in the hospital, so their engagement happens right at discharge," added **Anita Daniels,** MS, RN-BC, Executive Director of Bronx Psychiatric Center. "With the support of State Operations and the New York City Field Office, we were able to partner with CBC, which has a proven track record in this area."

CBC is a not-for-profit organization, started 2011 to coordinate more than 50 New York City community-based health and human services agencies providing services to adults with severe mental illness and to people with substance use and chronic health conditions. Its Pathway Home program works with long-stay individuals who've had difficulty engaging in community care. Individuals 18 years and older can be referred from a psychiatric center, a state-operated residential program, or an acute-care hospital, as a diversion to intermediate care in a psychiatric center. The program uses the evidenced-based Critical Time Intervention model, which provides intense services shortly before hospital discharge to build trust, then continues these services in the community for another six to nine months.

Steps toward Independence

Four teams made up of licensed mental health clinicians, case managers, nurses, and peers help individuals address issues such as housing, food, economic security, medication adherence, linkage with outpatient providers, family conflict, and social isolation. Two teams are located in Brooklyn, Bronx and Manhattan; a third team is in Queens; while a fourth team works with discharges from the psychiatric center and the forensic program at Metropolitan Hospital Center in East Harlem.

"Pathway Home educates the inpatient and residential teams about services available in the community," Daniels said. "In turn, staff identify people who can move on to the next level of care with the right supports and engagement."

Starting while an individual is still in the unit, Pathway Home teams are on-site every day to maximize patient engagement, conduct in-depth community needs and risk assessments, and participate in discharge planning discussions:

- Connecting them with outpatient mental health providers and primary care providers to address physical health issues that could deter them from living successfully in the community.
- Offering short-term counseling, develop their coping skills, and strengthening their confidence in making their own decisions.
- Identifying goals that can help motivate the individual.
- Determining medications and arranging for medication management.
- Accompanying individuals to their first behavioral health and me
- Offering access to crisis intervention services.
- Developing relationships and social networks that provide supp

Continued on the **next page**

Barry Granek

Anita Daniels

Continued from the **previous page**

During weekly discharge planning meetings, staff can identify potential candidates for intervention, discuss ideas on the current case load, and determine readiness for discharge.

The Pathway Home team collaborates with an inpatient team to identify which community supports will lead to a more successful discharge and determine if there is a way to manage unique, complex needs in the community, including leveraging the extensive array of community-based services offered by CBC's network.

Clients receive training in life skills through inpatient programming, such as groups or individual sessions by staff with experience in providing transitional support in the community. The team then continues teaching in hands-on situations while in the community, including travel training, shopping, cooking, and cleaning. To help prepare for discharge, Pathway Home staff educate clients on housing readiness and tenant rights, money management and budgeting, identifying obstacles in shared decision-making, and in developing solutions.

"We'd received early feedback from the inpatient and transitional residence staff that clients needed more productive activities. Especially since some weren't interested in 'programming,'" Granek said. "So we made an effort to engage individuals in activities such as hobbies, events, sports, gardening, cooking, music, and exercise."

Bronx Psychiatric Center has offered office space to the Pathway Home team, given them access to units and charts, and invited teams team to integral rounds and discharge planning meetings. "This program has helped to create a culture that facilitates regular and healthy communication between the Pathway Home and Bronx PC staff," Daniels said. "It allows sharing of information and resources in both directions."

"When we think of system change," Granek added, "there is an element that I think distinguishes Pathway Home from other traditional programs. We rely and value our relationship and partnerships with hospital systems and inpatient units. They are both our referral sources and also hold a piece of the puzzle for the ultimate success of those served, and by extension, the Pathway Home program's success."

For more information on CBC, visit: http://www.cbcare.org.

Success: Stories from Pathway Home participants

So far, the Pathway Home has served more than 900 individuals since it started in 2014, helping them to get their lives back on track. A few examples:

- **Barry Alston Jr.,** who was diagnosed with schizophrenia had a long history of multiple lengthy inpatient hospitalizations and short community stays. Upon his current discharge, the Pathway Home team provided support for Alston's transition to his new residence. Through coordination with other community providers, Pathway Home ensured that he was aware of his first outpatient behavioral health appointment and provided accompaniment for him. The Pathway Home team noticed one day that he'd found a broken bicycle in the trash. Recognizing that a working bike could, in turn, promote his goal of living a healthy lifestyle, the team used wrap-around funds to buy him a new bike and subsequent safety equipment. Alston has been successfully been living in the community for four months and rides his bike each day.
- A second man with a diagnosis of schizoaffective disorder, bipolar type, was assigned a Pathway Home embedded clinician. Through collaboration with the inpatient team, the client's goals and barriers were identified, some of which included the importance of improving family relationships and engagement with his children. He completed basic parenting skills training while an inpatient. Upon discharge, the team located additional parenting classes geared toward fathers.
- A third man had been diagnosed with diabetes, but refused to modify his diet, not worrying about how it could potentially affect him. Upon initial assessment, the Pathway Home team was concerned about his chronically high blood-sugar levels. The team's clinician began to provide basic health counseling and urged the man to be mindful of how he felt physically when he ate sugary foods or when his sugar levels were elevated. The team's nurse began to regular engage the client about healthy eating, identifying new and creative ways to assist him with improving his health and making healthier food choices. With support, client demonstration an ability to make healthier food choices and improve his management of his diabetes.
- A middle-aged woman diagnosed with schizophrenia was preparing for discharge but struggled with hoarding in her apartment. The Pathway Home team began to build rapport with her while she was an inpatient and collaborated with the inpatient team to determine an appropriate discharge plan for her. They coordinated the heavy-duty cleaning of her apartment, needed repairs to be completed by management, and the purchase of new furniture and necessary apartment Pathway Home staff worked with client on developing habits to main- of her apartment. The woman has been in her apartment for more than

Pathway House client Barry Alston Jr. said he's never felt so supported.

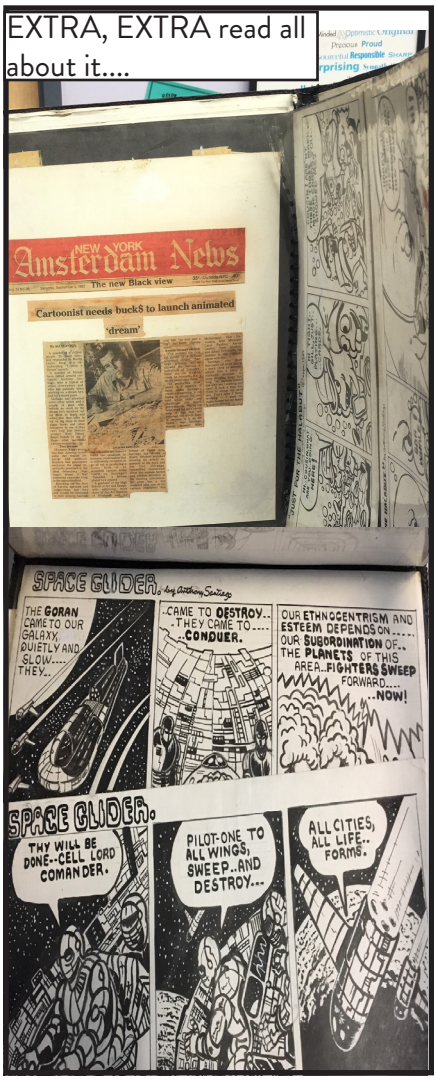
The story of Barry and his bike, was featured in the OMH May 2018 newsletter.

SMHC Kristen Nocerino and Barry catching up on the BPC campus.

State of the Art

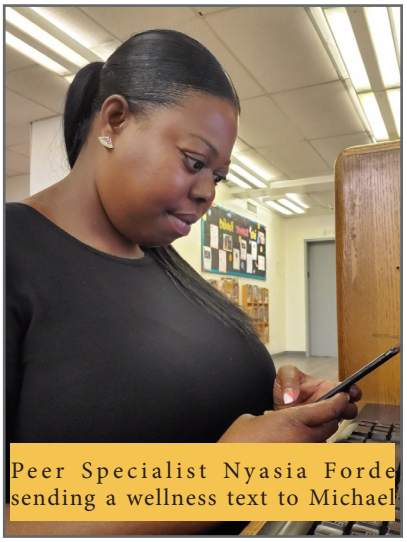
By Ashley Bleich

The idea that mental illness somehow contributes to or enhances creativity has been discussed and debated for centuries. Even the Ancient Greek philosopher Aristotle subscribed to the trope of the tortured genius, theorizing that "no great mind has ever existed without a touch of madness." For Anthony Santiago, living at Kings Adult Care Center has been torturous but his great artistic mind has been nothing short of genius. For Anthony the act of creating comic book characters serves as a form of therapeutic relief. As Anthony is an Adult Home resident, his finances are limited. Lack of budgeting and money management skills have made it tough to purchase art supplies for himself. Although there have been barriers to Anthony's transition into the community, it is clear that the continuation of utilizing art has been beneficial to not only his mental and social wellbeing, but also in working towards integration into more independent living. Through the help of Pathway Home step down funds, the Postgraduate team was able to supply Anthony with art supplies. Anthony expressed gratitude for the supplies and the solace they will bring him through his art. As seen here, Anthony has put the supplies to good use, and shared with team a live sample drawing and exhibition of his artist skills.



The talented Anthony Santiago showcasing his prize possession of artwork.

California Love


Peer Specialist Nyasia Forde sending a wellness text to Michael

Michael was initially reluctant to accept help. Due to his mandated status, Michael felt powerless in making his own decisions and declined interest in additional support. The team decided to send Peer Counselor Nyasia to meet Michael. Over time, he became comfortable with Nyasia and they formed a mutual trust. Nyasia helped Michael acclimate to services, and broadened his understanding of the mental health system, government benefits, and supportive housing. With this knowledge, Michael, who is generally a private person, began to act independently to activate benefits, as well as begin his search for supportive housing. Although Michael worked hard to secure supportive housing placement, he ultimately decided that he was uncomfortable with the decision because he was unfamiliar with the territory. He shared his desires to move back to California, where he had always felt more at home.

Over time, Michael was able to understand the importance of supportive relationships. He began breaking ties with those who casted him aside and form healthier and more significant relationships. Michael was even able to reestablish his relationship with his mother, who continues to provide support. In fact, he proudly shared his decision to move to California with his mother so that he can care for her as her health declines. Michael was also able to avoid rehospitalization and further legal interaction, thereby increasing his autonomy and ability to make decisions for himself.

Securing Paul's Future

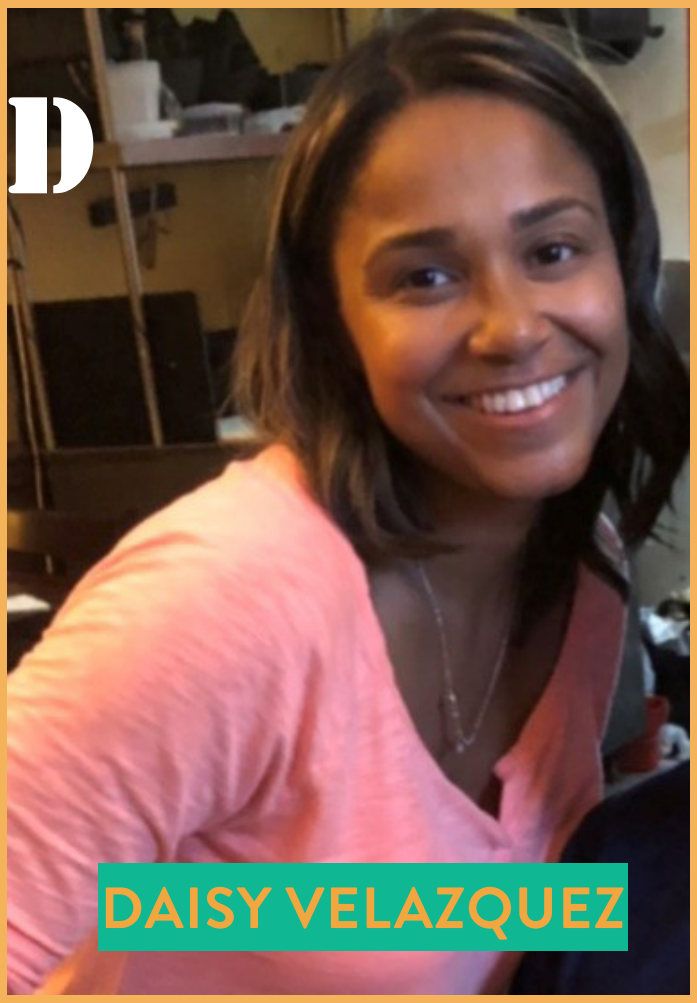
By Justin Byous

Paul determined that his main goal during his time with Pathway Home was to look for and obtain employment in the security guard field. Before achieving this goal, he had to first address his mental health and substance use, by learning coping skills and how to live independently. His treatment included recognizing those reactive behaviors that led him to an extended stay at a State Psychiatric Facility. Since transitioning to the community, through travel training and MetroCard assistance, Paul has learned to attend appointments independently, now using the train on his own. Using PH Step Down Funds, Paul obtained assistance buying groceries when his benefits were inactivated. To make his surroundings meaningful, team helped Paul acquire items for his apartment to improve the home décor.

Paul is on the path towards more independent living. He has formed a relationship with his outpatient clinic social worker, has drastically reduced his substance use, and improved the relationship with the housing provider. Paul was able to sign up for and successfully complete vocational rehabilitation services. He bought new clothing to help him feel more dignified, and has begun interviewing for jobs in his field. Paul has since graduated from the Pathway Home program, and is much more equipped to take on his new life goals in a productive way. Through the support of his team, he is much closer to achieving his goal of becoming a security guard.


SMHC Justin Byous texting with Paul

BOOTS ON THE GROUND



By Angelo Barberio

Summer is around the corner! This June I got a chance to sit down with Daisy Velazquez, Case Manager with the WellLife Network Pathway Home Team working with individuals transitioning from Adult Homes back into the community. We talked all things Pathway Home as well as life outside of work.

DID YOU KNOW?!?

Daisy has 2 sons (2 y/o & 8 y/o) and has BA in Psychology and Minor in Education from St. Francis College! She even played baseball in college.

Strengths: "Team player, good listener, and quick learner"

Weakness: "Sometimes gets too involved with members goals and take things to personally when they don't work out."

Outside of work: loves spending time with her Family & family trips! She enjoys sports like basketball, baseball, & bowling. But most of all she loves watching her son play baseball!

Greatest Achievement: "Being strong for my two sons and being able to accept help/support from family and friends when tragedy struck after my fiancé passed..."

Me: So Daisy, how long have you been working for Welllife Network? Pathway Home?

Daisy: "I've been working with WellLife Network since the inception of their Pathway Home team, so since Jan-Feb 2019."

Me: That's Incredible! So why did you decide to join the Pathway Team?

Daisy: "WellLife Network must have seen my resume online because they actually reached out to me about the position with the PH team. Prior to WellLife, I was working with the Adult Home + population for 5 years, since the beginning of the settlement. I ultimately decided to join PH because I wanted to use my expertise working with AH+ in a new initiative with a small team with a team-based approach to hopefully have a bigger impact with this population."

Me: How do you like working for the Pathway Team?

Daisy: "Love it! I love the team-based approach and support the team gives. With a quick call or text, I have help. It's a great feeling."

Me: How do you like working for the Pathway Team?

Daisy: "Working with the moving parts of the settlement like the Adult homes or the housing contractors. Collaborating and coordinating things for a participant can become complicated even if it's something as simple as requesting documents."

Me: One lesson you'd give to new pathway members?

Daisy: "Be patient and listen to the participants. They will open up and tell their story in time. Act like you're talking to a human or your grandma, not just to a patient. You wouldn't yell or be short with your grandma."

Why Call Me First Matters!

The goal is to encourage participants, their family, caregivers, or providers to know that they can call their Pathway Home team when they start showing early signs and/or symptoms exacerbation.

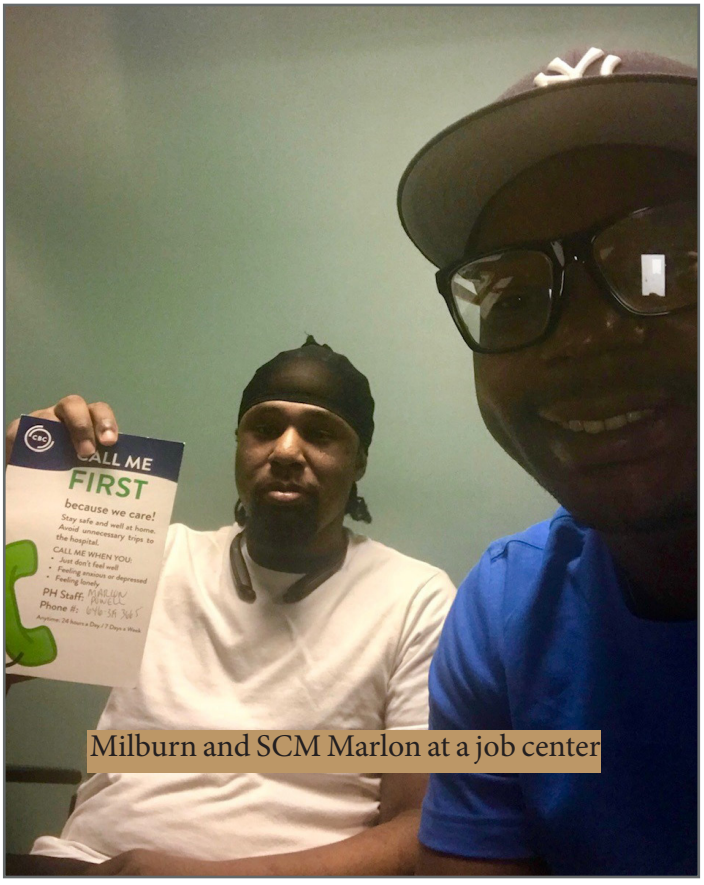
Timothy sitting on his bed

Timothy was referred to Pathway Home while residing at the Mary Brooks TLR. Timothy struggled with remembering his appointments. He was involved in a traumatic experience which led him to have TBI (traumatic brain injury). As a result of his injury, Timothy finds it difficult to remember appointments and meeting dates with his parole officer. Whenever Timothy misses his appointments he gets frustrated which can trigger his symptoms. Timothy would mention that if he runs out of medication or misses his psych appointment, he will visit the Psych ED.

Marlon (Pathway Home Senior Case Manager) provided Timothy with information and literature about Pathway Home **Call Me First** Campaign. Timothy called many times and we discussed all his upcoming appointments. When he missed an appointment, he called. Marlon was able to help him reschedule. Timothy has shown less anxiety and stress since calling Marlon whenever he feels frustrated. The availability of staff has allowed Timothy to resolve his issues with visiting the hospital or becoming symptomatic.

Milburn hadn't engaged with outpatient treatment and struggled remaining in the community. During Marlon's visits with Milburn, they talked about importance of allowing his providers to assist him with transitioning to the community. Milburn has limited community support and family members stated that they "need a break from him". This transition was Milburn's first time discharged from inpatient with a community support.

Marlon described to Milburn the Pathway Home **Call Me First** Campaign. Milburn has called Marlon numerous times. When Milton was "Calling Staff First", Milburn described feeling anxious and "worried" about living Independent in the community. Maron shared strategies of ways to manage anxiety and stress. After speaking with Marlon, Milton expressed "I feel better, my anxiety went down."



Milburn and SCM Marlon at a job center

Treat Yo' Self: The New Self-Care

By Alethea Glave

Self-Care. A phrase Pathway Home has heard me utter more times than they'd like. "How do I take care of myself? Is it selfish? What if I can't make time?" There are a sufficient number of people and things in your life that can get in the way of caring for yourself, but you don't need to be one of them. This was one of the key lessons during my Self-Care presentation at last year's annual Pathway Home retreat.

While trying to bestow tokens of wisdom, I asked staff to pick one of "50 ways to take a break" and write a letter to themselves indicating their choice and how they planned on focusing on themself. "Write anything your heart desires and wait for your time capsule to arrive." The idea was to write a meaningful message to your future self that emphasized the idea of who you are and how you could love...you! These letters were held for one year before being delivered to staffs individual homes.

The reactions were strong. Several experienced a wave of emotions as they read about their plans and love of self. The chance to share with others at this year's retreat meant more than we could have imagined. "I can't believe you kept this for a whole year." "You made me cry." "I am going to frame this." "This means so much to me, looking back."

Looking back, I am reminded of the wonderful, passionate, and inspiring people that make up Pathway Home. The care put into being there for our clients begins with self. Much like the oxygen mask on a plane, before we can help others, we must first help ourselves. ***We*** are amazing. We are beautiful. We are most important, and if we love ourselves, the rest will follow.

Here are some tips you can try: