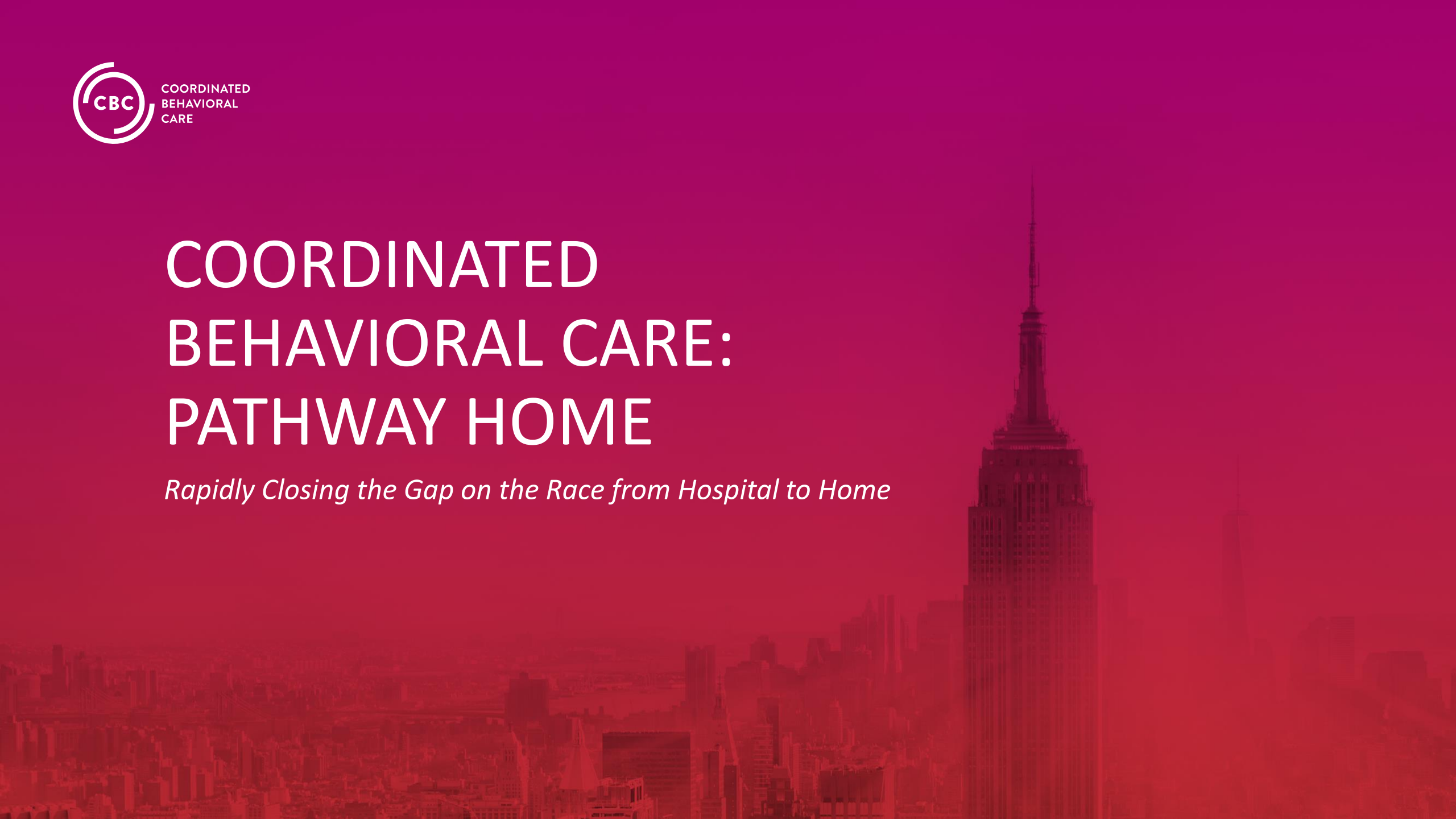
COORDINATED BEHAVIORAL CARE

COORDINATED BEHAVIORAL CARE: PATHWAY HOME

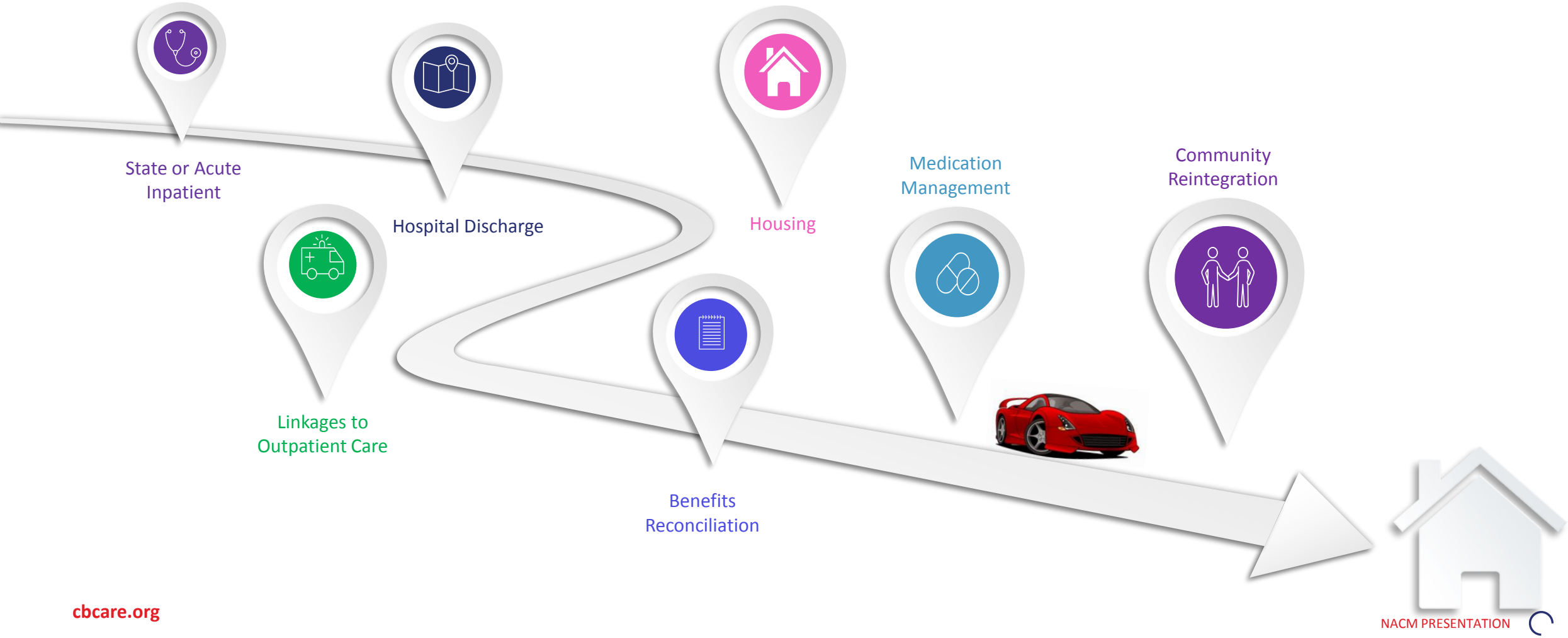
Rapidly Closing the Gap on the Race from Hospital to Home



AGENDA

1. *Welcome and Introductions*
2. *Describe the Pathway Home program as a community-based care management program.*
3. *Define the five guiding principles of Pathway Home, the benefits and how to effectively implement these principles.*
4. *Identify the key operational factors that led to positive outcomes and best practices.*

Systemic Challenges:
A Person's Journey



CBC Pathway Home is a community-based **care transitions** program that offers mobile, time limited services in NYC for adults with behavioral health needs transitioning from the hospital to the community.

*The **principle goal** of Pathway Home is to **ensure** successful transitions and **prevent** re-institutionalization, recurrent homelessness and other adverse outcomes during the period following placement into the community from shelters, hospitals, correctional facilities and other institutions.*

Pathway Home Phased Model[1]

PRE-CTI

- Develop relationships with providers, hospital staff, and collaterals
- Engage individuals in Pathway Home program
- Participate in discharge planning process

Relationship Building

01

0-3 months

- Provide support & begin to connect individuals to people and agencies that will assume the primary role of support
- Problem-solving obstacles preventing engagement in outpatient services

Transition to Community

02

3-6 months

- Observe operation and strengthen of support network and skills, modifying care plan or network accordingly
- Encourage increased responsibility

Trying Out

03

6-9 months

- Terminate CTI services with support network safely in place
- Step back to ensure supports can function independently
- Hold meeting with supports marking transfer of care

Transfer of Care

[1]Daniel Herman, Sarah Conover. Alan Felix, Aman Nakagawa, Danika Mills, "Critical Time Intervention: An Empirically Supported Model for Preventing Homelessness in High Risk Groups" (2007).

PATHWAY HOME DIFFERS FROM TRADITIONAL CASE MANAGEMENT

Time limited

Focused

Phased

CONTINUITY OF CARE:

The assurance of providing uninterrupted and coordinated mental and physical health services over time services will endure past the (PH) intervention bridging the gaps between hospital-based and community-based treatment services

splinting, trouble shooting, and client transitions, creating flexibility, speeding the system up, and contextualization" (Norma Ware)

Pathway Home System Impact

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Populations Served

Pathway Home Team Operations

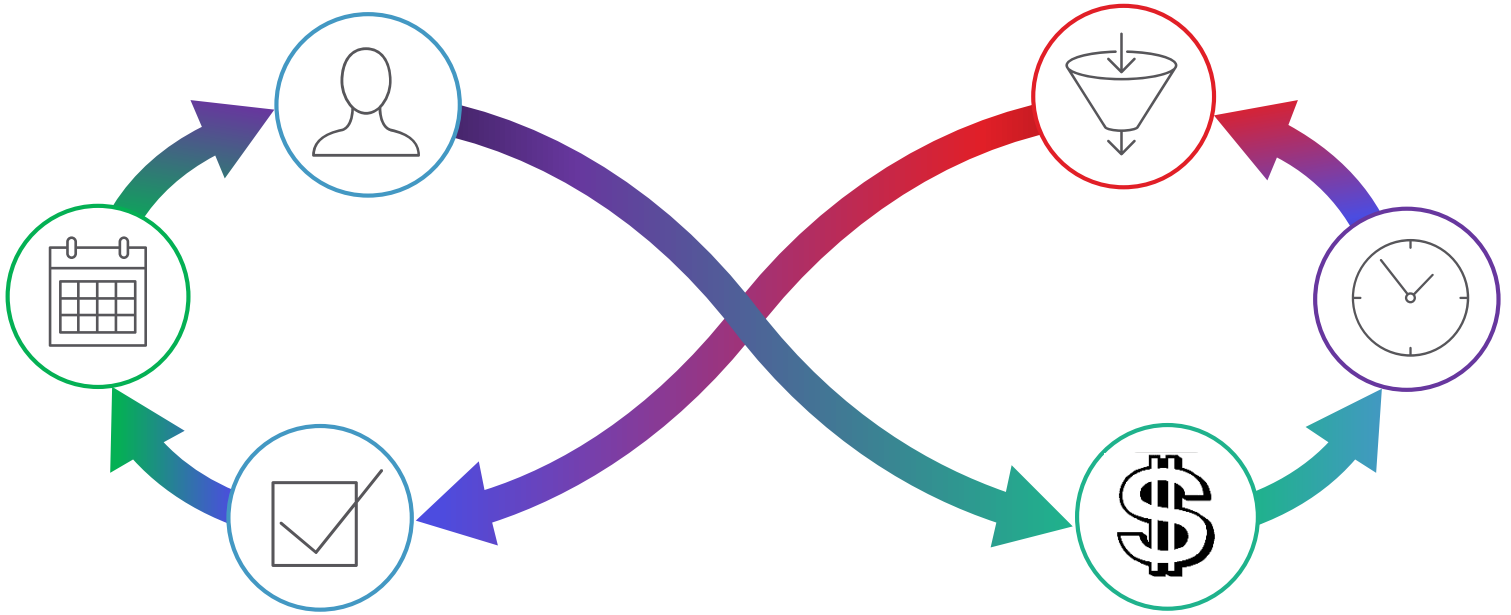
CBC COORDINATED BEHAVIORAL CARE

Team Composition

Multidisciplinary team approach

Workflow

Speedy referral and enrollment process (approximately 2 days)



Mobile and Flexible

Community Based

Hospital Engagement

Engagement begins during the hospital stay

Small Caseload

Focuses the intensive services on most critical

Wrap-Around Dollars

Funding Immediate Needs and Innovative Recovery Promoting Expenses

RAPID REFERRAL AND QUICK ENROLLMENT

Simple

Easy Referral Process

Today

Same Day Response to Referrals

24-48 Hrs

Quick Screening and Disposition

Guiding Principles of Pathway Home

COORDINATED BEHAVIORAL CARE

1

Pre-Discharge Engagement and Discharge Planning

2

Engaging in Meaningful Activities, Family, Social Networks

3

Accompaniment Home and to Initial and Follow-up BH and PCP Appointments

4

Linkages to Community Providers and Natural Support Systems

5

Fostering Self-Efficacy

INNOVATIVE TECHNOLOGY

Smart Phone

Improve connectivity and engagement by supplementing and offering support in between visits.

Medication Reminder Machine

Electronic medication reminder & dispenser machines as a tool and reminder that addresses adherence.

Telehealth

Video-conferencing to deliver a live, interactive communication and visual assessment/intervention.

Behavioral Economics

Behavioral economics in habit formation to achieve better adherence, engagement, and health.

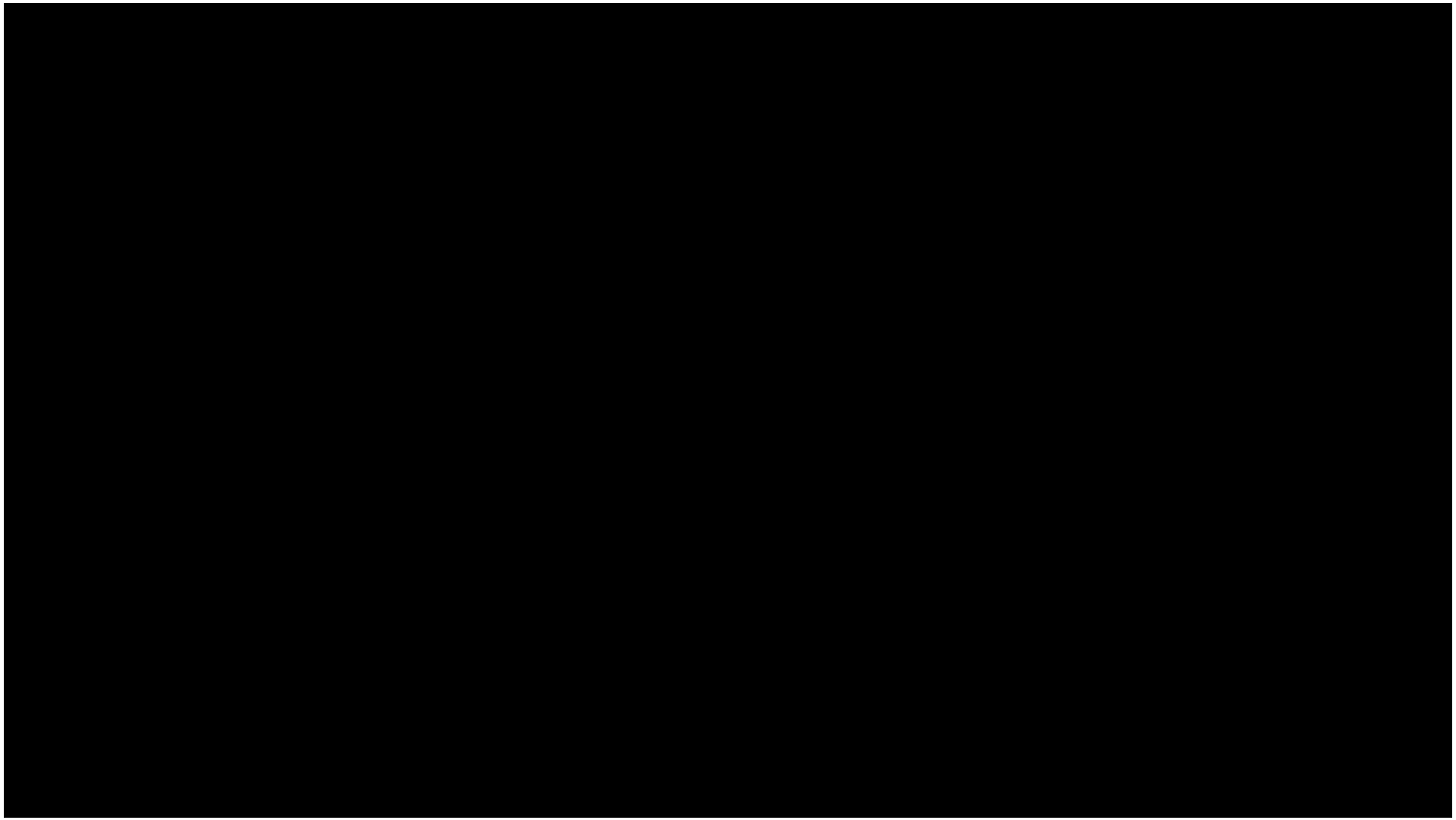
Texting

A secure texting engagement platform that sends medication and appointment reminders as well as education on healthy living habits.

Uber Health

Increasing initial medical and behavioral health appointments.

Video Testimonial



CBC PATHWAY HOME: OUTCOME DATA

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Discharge

Of 750 individuals enrolled since April 2016, 575 completed the program

Forensic Diversion

90 Individuals received Hospital Embedded Team Services at Metropolitan Hospital Center

Served

Approximately 250 individuals served at any one time

People Enrolled

1200 Individuals Enrolled in Pathway Home

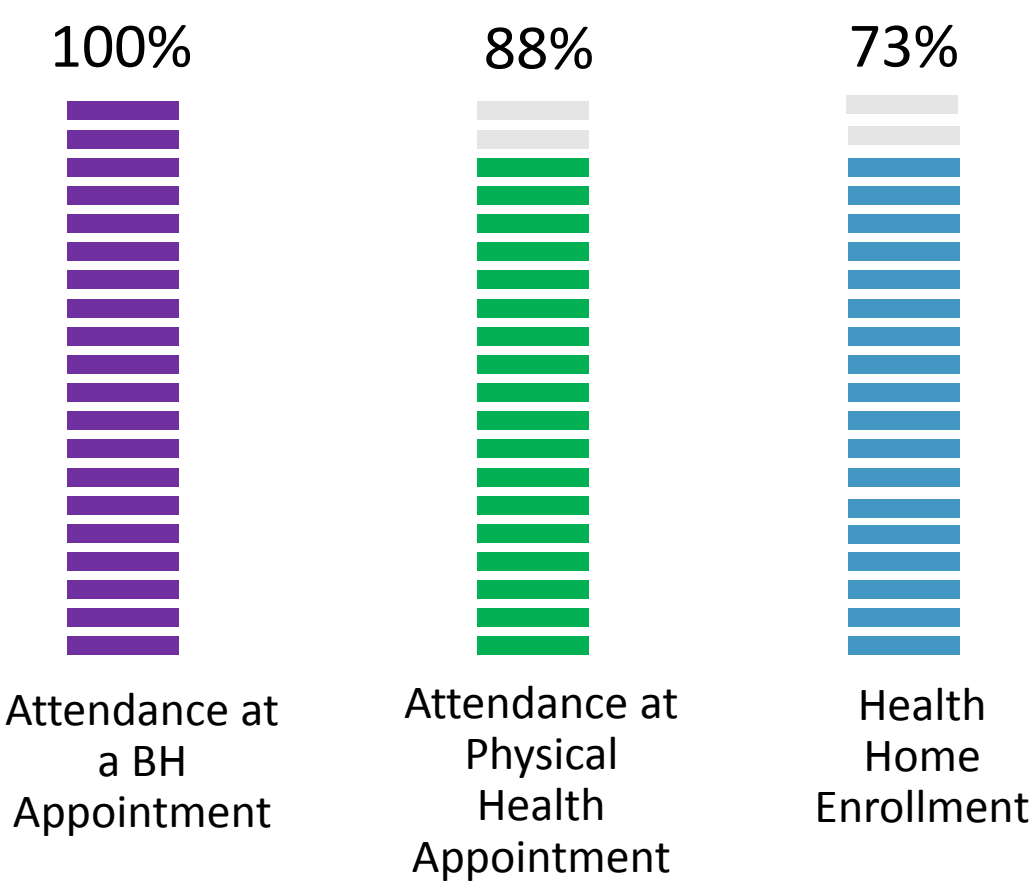
State Hospital Embedded Team

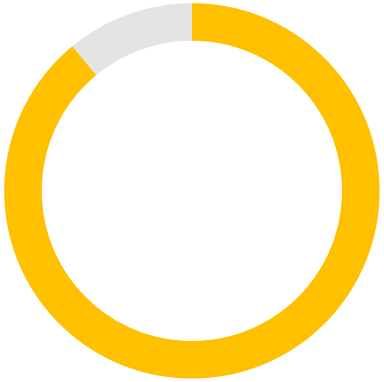
55 Individuals received Hospital Embedded Team Services at Bronx Psychiatric Center

PATHWAY HOME: PROGRAM OUTCOMES[1]

CBC COORDINATED BEHAVIORAL CARE

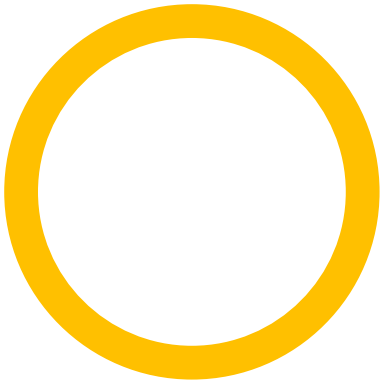
METRICS DEMONSTRATE CONNECTION TO CARE AND REDUCTION IN COSTS DURING THE INTERVENTION. OF 153 MEMBERS WHO GRADUATED FROM PH IN 2017:





89%

Not readmitted to hospital within 30 days of entering the community

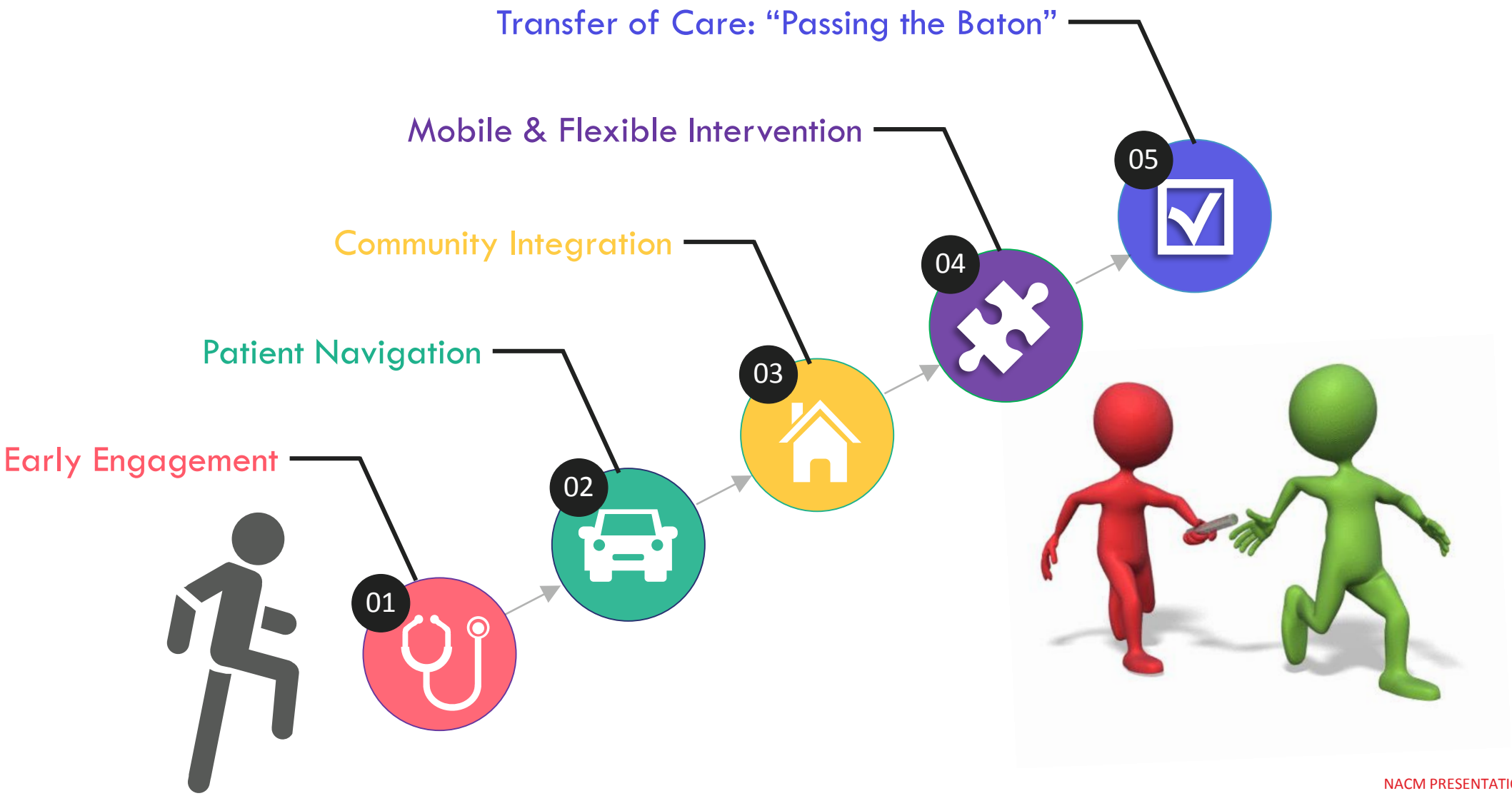


100%

Not readmitted to a State Psychiatric Center during the PH intervention

[1]Jorge R. Petit, M.D. Mark Graham, L.C.S.W. Barry Granek, L.M.H.C. (2018). Pathway Home: An Innovative Care Transition Program From Hospital to Home. *Psychiatric Services 2018; 69:942–943.*

A Person's Pathway Home Revisited



QUESTIONS?

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Frontline Reports

Pathway Home: An Innovative Care 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 severe mental illnesses who are transitioning from inpatient to outpatient 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 approach and use of critical time intervention, significantly improved community outcomes after long-term inpatient hospital stays.

Immediate response to referrals and intake within 24–48 hours are key components of the program. An intake specialist enrolls patients well in advance of their hospital discharge. By beginning engagement before discharge, the PH team develops strong therapeutic relationships with patients. Barriers to successful community transitions are identified, mitigated, and, when possible, resolved before discharge. The PH team works collaboratively with inpatient staff to develop a discharge plan that connects multiple systems of care and establishes accountability.

Another key to the PH program's success is that on the day of discharge a team member is present to ensure that discharge plans are understood, medication is filled, anxieties are addressed, and the community destination is safe and secure. The PH team's ongoing care focuses on facilitating community integration and ensuring active engagement with medical and specialty care and social services. Accompanying patients to their initial behavioral health and primary care appointments ensures that Healthcare Effectiveness Data and Information Set measures for follow-up after hospitalization for mental illness are met while improving patient outcomes. The program has a low staff-to-patient ratio (1:15), which allows the team to flexibly meet with patients several times each week, for several hours at a time, during the first few months. This allows staff to address such issues as housing, food, economic security, medication adherence, family conflict, and social isolation. Although patients have a designated case manager, all have contact with the team's clinician, nurse, and peer, who offer 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 involvement in health goals and satisfaction with the health care system.

The PH program emphasizes independent living skills and self-efficacy, whereby patients take on increased responsibility for making appointments, managing medications, and utilizing basic living skills. A recent graduate from the program stated, "He is not just a caseworker—he has been a great mentor, cheering me on, encouraging me, giving me advice, empathizing with me [during] a difficult time, and making me feel like I can overcome."

PH has served over 1,100 patients and produced robust outcomes. Metrics that demonstrate connection to care and reduction in costs are tracked during the intervention. These include attendance at behavioral health and medical appointments and hospitalizations. Of 153 patients who graduated from PH in 2017, 89% (N=136) had not been readmitted to the hospital 30 days after an inpatient discharge and 100% had not been readmitted to a state psychiatric center at the time of completion of the intervention. Within the first seven days in the community, 77% (N=117) attended a behavioral health appointment; by day 30, 88% (N=135) had attended; and at completion of the intervention, 100% of recipients had attended their follow-up appointment and 88% (N=135) had attended medical appointments. To maintain success post-intervention, ongoing case management is essential, and 73% (N=111) of patients have been enrolled in health home care coordination.

CBC's PH, a community-based care transitions intervention, is improving health outcomes and reducing avoidable costs. It is addressing treatment-related issues and social determinants of health that are drivers of preventable readmissions and emergency visits at the most critical time—the months after a hospital discharge. Most important, PH patients are thriving in their communities, connected to care, and living healthier, happier lives.

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A Women's Health Clinic for a Safety-Net Inpatient Psychiatry Unit: Project PETIT

Although individuals with serious mental illness are widely known to experience disparities in quality of health care, little attention has been given to inequities that women with serious mental illness experience in the receipt of appropriate OB/GYN services. For example, women with serious mental illness are five times less likely than the general population to have up-to-date Pap smears. Despite declining U.S. cervical cancer mortality rates, cervical cancer incidence and mortality among women with serious mental illness are several times higher than rates in the general U.S. population. Further, these women have low rates of mammography, screening and treatment for sexually transmitted infection (STI), contraceptive counseling, and peripartum care. The disparity widens for those women with additional social determinants of poor health.

Despite this population's obvious need, we are not aware of the integration of women's health services for women with serious mental illness. Our team sought to address this disparity by developing and piloting a women's health clinic on our inpatient psychiatry unit at Zuckerberg San Francisco General Hospital, a safety-net hospital. First, we formed a steering committee of stakeholders that included top leadership and champions in psychiatry and OB/GYN departments, frontline staff from multiple disciplines (registered nurses, social workers, and front desk staff), and trainees. We reviewed the strong evidence base from the literature on the need for this pilot, including local data showing that only 25% of women (ages 18–64) admitted to inpatient psychiatry over one week (September 2014) were up-to-date with cervical screenings. Given that an OB/GYN clinic was located in the same hospital, we determined it was feasible to run a satellite clinic on the inpatient unit. The steering committee met monthly to work out aspects of the pilot including admission criteria, referral processes, patient flow, staffing, service provision, documentation, follow-up, and data collection. Our primary outcome measure was the number of women successfully evaluated in the clinic.

We named the project PETIT, for inpatient **P**sychiatry women's health **E**ducation and **T**esting **I**ntegration **T**eam, and planned for a 12-week pilot. The OB/GYN team, primarily residents who were interested in safety-net populations, offered Pap smears; breast and pelvic exams; STI testing; contraceptive counseling, placement, and removal; and pregnancy care. The clinic took place one half-day per week with four potential appointment slots. We found dedicated treatment room space and ordered appropriate supplies such as speculums, culture swabs, sterile syringes, and a privacy curtain. Any admitted woman, regardless of age, could be referred, but the inpatient psychiatric team assessed appropriateness for clinic referral by taking into account the patient's mental status, capacity to provide consent, and ability to tolerate the visit. We worked with billing and pharmacy departments to ensure that supplies, such as implantable contraceptives, were stocked and accessible.

The pilot program ran from February through May 2015. Our first patient was a 34-year-old woman with a history of abnormal Pap smears who had not received women's health care for more than five years. After receiving a Pap smear, STI testing, and contraceptives, she noted, "This is such a great service."

Over this pilot period, 10 clinics were attended by 15 women, with an average of 1.5 women per week (range= 0–4). All patients received general preventive health education; seven received Pap smears; seven were screened and tested for STIs; six received contraceptive counseling, placement, or removal; four received manual breast exams; and two received pregnancy care. At the end of 12 weeks, the departments determined the PETIT clinic would continue because of high interest among patients and educational merit for the residents. In the following three months, another 12 women received services. Although some patients refused services, most of the women who attended voiced their deep appreciation.

The challenges to project implementation included billing, tracking abnormal test results, patient follow-up, launch date delays due to problems with supplies or with resident scheduling, adopting PETIT into the footprint of the inpatient psychiatry and OB/GYN workflow, patient refusal, and high turnover of psychiatric beds. Despite these challenges, Project PETIT proved to be highly sustainable and continues to meet the needs of the most vulnerable women with serious mental illness. Now in operation for more than two years, PETIT sees approximately one to two referred women weekly.

We believe our program to improve women's health in this vulnerable population could be integrated into other programs, particularly in academic centers that value the training aspect. Whereas our group was particularly interested in access to women's health care, similar programs could be created to address a variety of health care needs for persons with serious mental illness.

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Stopping the Hospital Revolving Door: A Pathway Home to Stable Community Life

By Danika Mills, LCSW, LCAT, and Barry Granek, LMHC
Coordinated Behavioral Care

A not-for-profit organization formed by behavioral health (BH) community agencies, Coordinated Behavioral Care (CBC) operates one of NYS's largest Health Homes (HH) and has formed an IPA to deliver integrated outcomes-oriented care. The many care managers who work with our HH members often face insurmountable challenges to support individuals after they are discharged from a long episode of inpatient care. There simply are not dedicated, flexible, time-limited services available in NYC to provide inpatient to community care transitions services.

In 2014, CBC created Pathway Home (PH), a care transitions program funded by the New York State Office of Mental Health, to fill this service gap. Operating in Brooklyn, the Bronx, Manhattan and Queens, three multidisciplinary teams comprised of licensed mental health clinicians, case managers, nurses and peers offer community-based time-limited services (average six months) for adults with serious mental illness who have experienced long-stays in psychiatric inpatient care. PH staff address a host of issues—

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Barry Granek, LMHC

housing, food, economic security, medication adherence, linkage with outpatient providers, family conflict, and social isolation--faced by individuals transitioning to the community.

PH uses the evidenced-based Critical Time Intervention (CTI) model, providing intense services beginning shortly before hospital discharge to build trust and continues with the individual into the community after hospital discharge. The intensity, type and duration of services vary depending on the individual's needs. By the time a PH participant is ready for "discharge," they have engaged with appropriate outpatient providers and are following prescribed treatment. They are stably housed with benefits and adequate food, and have reconnected with family/friends and/or started to develop new social networks. Many have formed a trusting relationship with a HH care manager.

Literally, CBC's Pathway Home bridges the divide between the 3 to 9-month post-discharge period when individuals are both vulnerable and face gargantuan challenges until they engage with community services. The program's target population are adults with serious mental illness, many of whom are being discharged from State Psychiatric Centers. This group is at an extraordinary disadvantage navigating the complex and fragmented community care system. Fundamental independent living skills required to take care of basic needs may be lost or eroded during a long hospital stay. Yet how can a person survive, much less thrive, without the skills to use public transportation, buy food on a budget, prepare nutritious meals and maintain new housing? Additionally, the social determinants of health, if not adequately addressed, result in poor outcomes, avoidable readmissions and emergency department visits. Consistent and meaningful mental health treatment, along with adequate case management, is important to stabilization post-hospitalization.

The CBC Pathway Home model achieves positive outcomes by addressing four key areas:

1. Pre-Discharge Engagement/Planning:

see Pathway on page 35

Pathway from page 29

Early engagement is important to increase participation and build a therapeutic rapport. Many of the barriers and challenges that impact success at discharge can be identified, mitigated and resolved during the inpatient stay. As well, potential pitfalls and problematic issues can be preemptively addressed before they can undermine the individual after discharge. The CBC team begins developing a relationship before discharge that is critical to the success of the intervention. Simultaneously, the team collaborates with the care team (e.g. hospital, housing and support staff) to develop a discharge plan that connects multiple systems of care and establishes accountability. With input, the Care Plan better reflects the unique personality and immediate needs of each individual. If family is involved, CBC will engage them as a support during the transition.

Early engagement helps forestall some typical causes of community instability during the care transition. During the transition, unexpected and unanticipated challenges or barriers to community stability can occur. For example, appointments with clinics or doctors may not be scheduled by the inpatient discharge staff, or they may be made so far in the future that medication will be depleted. Pathway Home staff can problem-solve during the discharge process or advocate directly with the outpatient provider to address any issues.

The CBC team is available to accompany the individual home upon hospital discharge, allowing an in vivo assessment and resolution of any immediate needs that may pose potential barriers to care. In the first week, the individual has an appointment at a BH clinic, which Pathway Home will facilitate by either accompanying or meeting the individual there. The team visits several times a week and at times daily immediately post-discharge, depending on the needs of the individual. Medication management and reconciliation support is provided by nurses. If transportation is needed but not arranged, Pathway Home will arrange it to ensure attendance.

2. Community Providers/Natural Supports Linkages: To prepare for long-term stability in the community, individuals are connected with various resources. Appointments are made with community providers of outpatient clinics and programs, as well as clubhouses, vocational, educational and other services that can lead to successful transitions. Pathway Home is an intense support that is meant to be temporary. A key priority is to facilitate enrollment and engagement with the CBC Health Home, so that care management services are in place after our care transition services end.

3. Community Reintegration: Successful transition is not just about making appointments and taking medication. People need to feel productive and engage in meaningful activities, such as relationships and social networks that provide friendship, love and hope. The CBC Pathway Home team accesses both community resources and State-sponsored wrap-around funds to help address issues that may negatively impact success in the community (e.g. smart pill dispensers, clothing, or transportation). Family meetings are offered to provide psycho-education and support to both the person served as well as their family members. These types of activities not only support treatment goals, but imbue purpose and meaning into an individual's life.

4. Fostering Self-Efficacy: CBC Pathway Home ensures that the time-limited nature of the intervention is made known at beginning of the relationship. Self-efficacy and self-sufficiency are fostered by encouraging participants to be accountable for their own treatment. Individuals are expected to assume responsibility by making appointments, managing medications, and becoming productive in the community. Using Motivational Interviewing, the team shares tools that support skill-development and self-reliance. Participants are better prepared to function independently after the intervention ends.

Stopping the Revolving Door: Through Medicaid system redesign, NYS is seeking to reduce avoidable inpatient admissions and emergency room presentations. CBC Pathway Home is contributing to achievement of this goal with a person-centered, skills-building care model. In two years, we have helped participants achieve better health outcomes: 93% attended a BH appointment within 30 days and 82% attended a medical appointment within 90 days of inpatient discharge; and 79% enrolled in a Health Home prior to Pathway Home discharge.

CBC Pathway Home is a Hospital to Home intervention that is stopping the revolving door by improving health outcomes and reducing avoidable costs. It successfully addressing treatment-related issues and social determinants of health that are drivers of preventable readmissions and/or emergency room visits. As important, many participants are now thriving in their communities, connected to care, and living healthier, happier lives. In 2017, CBC seeks to build on this model of care for similar vulnerable populations, including individuals who are justice involved, have medically co-morbidities and/or are long-term chronic State hospital patients.

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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 healthcare, including behavioral health. 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.

The rising need for services for those with Serious Mental Illnesses (SMI) that is accessible, less expensive, and more effective, highlights the needs for more intensive and innovative communications strategies to change health behaviors and manage chronic conditions, than our current system of weekly/monthly visits permit. Utilizing novel and innovative technology may be the only solution to reach more people. These resources can allow healthcare workers to reduce the reaction time and distance, enabling the human touch when otherwise unavailable. These tools are not meant to replace face to face visits, rather supplement, enhance, and offer added choice in how one elects to engage with their healthcare providers.

These technologies can better address treatment gaps, facilitating access and linkages to needed services, overcome geographic and transportation barriers, foster engagement by enabling anonymity as well as decreasing stigma about accessing behavioral health services. For providers there is a growing body of evidence that these technologies offer more real-time access to critical information about the patients, makes managing caseloads more efficient and effective and potentially freeing clinician time to better address patients with more intensive needs.

Coordinated Behavioral Care's Pathway Home (PH) Program draws on creative approaches to deliver community-based care, including advances in technology-assisted care. PH has started using texting, video-

Jorge R. Petit, MD

Barry Granek, LMHC

conferencing, ridesharing, and other mobile tools to support treatment adherence and to prepare staff for the changing realities of a more technologically integrated exchange between the individuals we serve and providers.

For the PH teams, meeting with individuals frequently and on an as needed basis is essential to ensure improved connectivity and ultimately engagement in services with consequent improved health outcomes. It is not uncommon for individuals in a PH Team to receive multiple weekly and at times daily visits. PH staff use phone calls or other means of communication to supplement and offer support in between more traditional visits. Nevertheless, there can remain large gaps of time between contacts where urgent matters can arise or even a small gesture of support can go a long way to minimize the loneliness that may lead to isolation and decompensation.

To further relationship building and ongoing communication, the PH Teams has started utilizing a *mobile messaging application*: a secure texting engagement platform providing assistance with reaching clinical goals, through reminders to take medication and attend appointments, as well as texts that educate on healthy living habits. PH staff schedule reminders and health education texts, either preemptively or in real time. The system can also check-in after tasks like appointments, inquiring how it went or if the appointment was made. After-hours, an automatic text responds with directions of who is on-call and how to reach on-call staff, to ensure 24/7 coverage.

One PH staff remarked "For my own clinical work, it's been monumental to break out of traditional phone calls. Not to mention, this is how most of us communicate in 2018. It makes my job a lot more convenient, authentic, and genuine." "I have seen great benefits for the individuals on our team with secure text messaging... it has really helped build relationships." another PH clinician stated.

As an example, PH used this technology with Luz, a shy 19-year-old who at first was not talkative during in person meetings or over the phone. When Luz started using the application, she would type out answers to questions about her goals and symptoms, in a way never detailed in verbal conversations. As someone who had experienced suicidal ideation and serious attempts and often described feeling "overwhelmed in life," it was helpful for PH clinician to begin seeing signs and symptoms based on responses through text messages. During a trip out of state, it proved a useful way to keep in touch and check in regularly. She is now well connected to providers, has not returned to hospital or experienced suicidal ideation, volunteers at a pet shop, and returned to school to continue her education.

Luz sums it up best; "Texting is a lot easier for me than calling. I really do not like talking on the phone but texting is simpler, quicker, and more likely to get a response from me. If you don't have time to call someone, you can find a few seconds to reply to a text."

In our work, a common theme from hospital and housing staff is medication adherence. For individuals with medication 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 three times a day. 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 no longer rely on the electronic medication and begin to take medication with increased independence, continuing adherence months later at completion of PH services.

In this ever-changing healthcare and technology world, it is imperative for behavioral health community-based agencies to remain relevant with the changing tide of new technology-assisted care. With the ubiquity of Smartphone apps, including hundreds that target mental health and substance use disorders, and inventiveness in technological tools, it is difficult to ignore this trend in healthcare. Individuals in the service delivery system in NYC with psychiatric conditions would benefit from beginning to use these and the service delivery staff should begin to become aware of the various resources that exist. If we do not embrace the innovation in healthcare and be present to shape it, we run the risk of it happening without our input. Piloting and testing technological solutions is the only way to assess usefulness, determine ability to support, and elicit buy-in from administrative and direct care staff. Behavioral healthcare professionals can be on the forefront of innovation, we simply need to have the courage to follow the virtual pathway forward.

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