# 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.

**Jorge R. Petit, M.D.**
**Mark Graham, L.C.S.W.**
**Barry Granek, L.M.H.C.**

*Dr. Petit is president and chief executive officer of Coordinated Behavioral Care, New York, where Mr. Graham is vice-president of program services and Mr. Granek is senior director of Pathway Home Programs. Send correspondence to Dr. Petit (e-mail: jpetit@cbcare.org).*

*Psychiatric Services 2018; 69:942–943; doi: 10.1176/appi.ps.69803*

## 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.

**Monique James, M.D.**
**Alissa Peterson, M.D.**
**Christina Mangurian, M.D., M.A.S.**

*Dr. James is with the Department of Psychiatry and Behavioral Sciences, Memorial Sloan Kettering Cancer Center, New York. Dr. Peterson and Dr. Mangurian are with the Department of Psychiatry, Weill Institute for Neurosciences, University of California, San Francisco. Send correspondence to Dr. James (e-mail: moniquejamesmd@gmail.com).*

*Psychiatric Services 2018; 69:943; doi: 10.1176/appi.ps.69804*