PATHWAY HOME™

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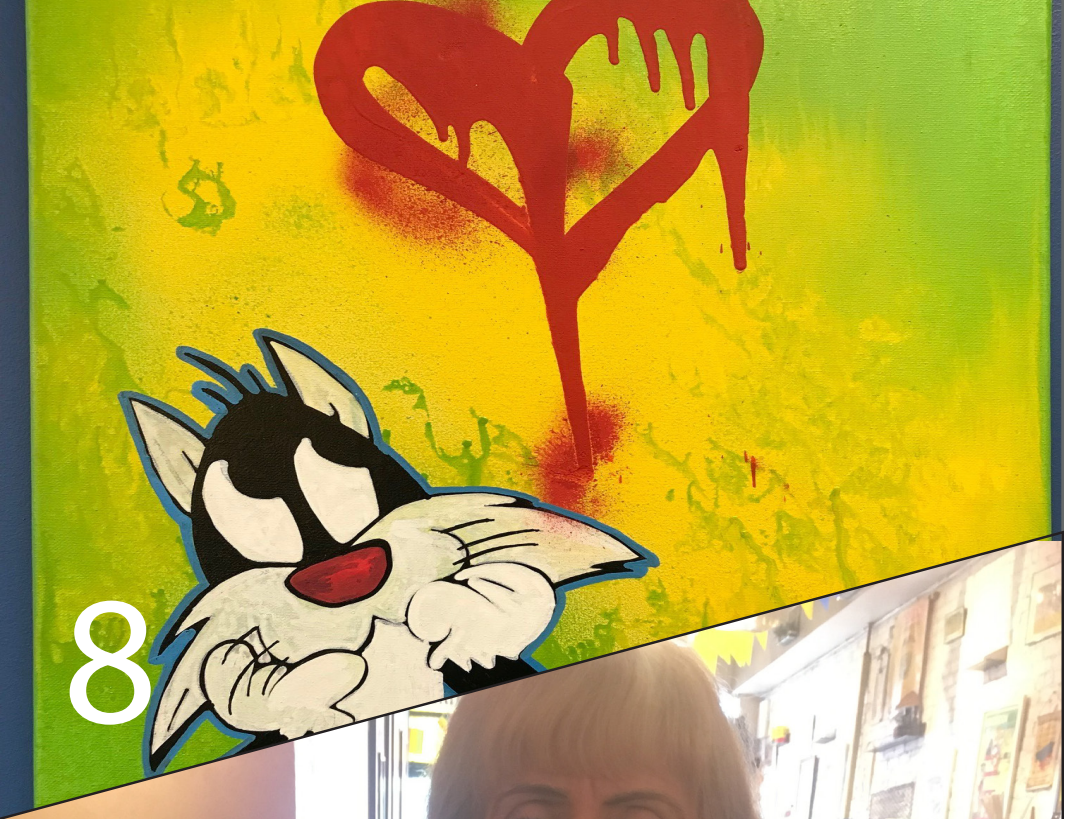
CBC PATHWAY HOME



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If You have Everything Under Control, You're Not Moving Fast Enough." - Mario Andretti

Barry Granek,
Senior Director

When training on the time-limited nature of Pathway Home™ (PH), I invariably receive the comment, "If someone needs longer services, you can extend PH, right?" or some form of this question. In this model, transition from one phase to the next is predetermined, including the final phase of Graduation. How is this accomplished? Let me explain.

For those departing a healthcare institution after treatment, when care is moved between locations like hospital to community providers, the healing and reintegration process may necessitate unaccustomed tasks. Having a healthcare provider experienced in care transitions can help coordinate tasks and facilitate connections to supports to ease the reintegration process. At Pathway Home™, there are core activities team members complete. These program-prescribed tasks, adhered to virtually like a checklist, include participation in aftercare planning, taking home on day of transition, accompaniment to initial appointments, medication reconciliation by a nurse, and travel training by a peer.

While these core activities address the innumerable modifiable barriers, other personalized and tailored goals critical for community tenure, decided by participant, are identifi d. These are the social, vocational, educational, familial, or recreational goals that sustain engagement in the community and care. This is done by "starting with what people care about" and considering what will help someone maintain community tenure. – Once again and as a prerequisite, all of these goals are decided by the participant.

Writer and Professor Elyn Saks, cleverly interpreting helping professional terminology, writes in The Center Cannot Hold: My Journey Through Madness:

"Treatment recommendations were just that - recommendations. To leave a hospital, to stay in, to take medications, to participate in group activities or not - they never forced any of it on me, and each time the decision was mine."

During goal planning, PH plays the role of advisor, while negotiating clearly the type of support PH team players will provide, the degree which PH will be participatory in aiding goal attainment, and by setting a realistic timeline. All this is because PH is a time-limited intervention, so goals that PH supports are focused. This means there are two or three chosen goals, the ones we said would be most critical to achieving community stability and tenure.

Being short-term also means identifying what bodybuilders call the Minimum Effective Dose – the smallest dose it takes to produce an ideal outcome. Anything less than your Minimum Effective Dose won't work and anything more is an unnecessary use of time, resources, and energy. By no means does this imply abandoning unelected goals or dissuading participants from pursuing other interests. Rather the PH team players are devoting their finite resources to accomplishing achievable and short-term goals. It is figuring out where you are most needed and appreciated during the transition.

Prioritizing goals is not solely a care transition principle but common in other sectors. Technology executive and author Sheryl Sandberg of Facebook and Google, coined the term

"...each time the decision was mine."

"Ruthless Prioritization", which urges focusing on those ideas that yields the most effective results, deciding on one thing and avoiding timely tasks. Sandberg says:

"I think the most important thing we've learned .... is that we have to prioritize. We talk about it as ruthless prioritization. And by that what we mean is only do the very best of the ideas. Lots of times you have very good ideas. But they're not as good as the most important thing you could be doing. And you have to make the hard choices."

In the helping profession, compassion can make it difficul to give preference or abandon a participant's ambition. Yet a path to realization dictates curbing some of the compassion – ruthless prioritization. For PH, we set out to accomplish a couple of main goals that will have the greatest impact on a successful transition. Unique to individual, each trajectory if singular, this means prioritizing the realistic versus idealistic plans. If you are compelled to choose compassion, perhaps be compassionate to let participants "take the ball and run with it" to accomplish longer-term goals? The objective is not long-term dependence on you or the system, but independence and ability to thrive in the community.

A question I receive is "What about those longer-term goals, are they not to be considered?" This is certainly not what I am advising! For any care need or goal that will go beyond the PH program timeframe, PH will outsource beginning by searching for providers who will take on the activities needed and the goals yet to be achieved. This does not stop with just a referral or suggestion, but an active process or searching, choosing, and sitting down and clearly delineating goals with the formal and informal supports.

This process is built into the PH phases. Transition and Active Linking (Phase II) is when the connections are facilitated, problems resolved, and care plans set into motion. By Practice and Transfer (Phase III), efforts are made to either transfer responsibility to participants, or transfer care to other supports – hence the phase is called Transfer. The last phase, Graduation, is when PH is observing if these supports are safely in place and assumed responsibility for ongoing care. When gaps in care occur, instead of PH teams resuming the support themselves, they step-in to hold others accountable. The Last phase is like "passing the baton" when we hopefully set up a system where if the baton is dropped, there is somebody to pick it up. Eventually, anything not yet achieved is handed off (versus extending services) with the connections to achieve them, post PH.

This short time interval means PH team members ought to speedily deliver services and interventions. This is made possible with small caseloads, to concentrate attention during the Transition and Active Linking phase. Leaning on teammates is crucial to help execute, to share ideas, divide tasks, and tap into the multi-disciplinary expertise and experience.

The focused goals are not only for the participants benefit. Since a time-limited program is unlikely to accomplish and see through those longer-term aspirations, attempts by a team member to overextend oneself to complete long-term goals during the timeframe can leave the team member over-pressured, over-promised, and under-appreciated. Realistic expectations are important to prevent stress and burnout for team members.

When done correctly, gaps in care are filled, personalized focused goal setting is set into motion, core activities vital for follow-up care obtainment are checked off, and longer-term care is outsourced – this is Pathway Home™. As services wind down, PH teams understand that baked into the program are the ingredients enabling successful reintegration during the critical time following a transition where lasting community linkages and connections are created. So, when a participant "needs" longer services, you can still celebrate the focused achievements and outsource the rest.

Hot Press

OneCity Health + Pathway Home™

NYC Health + Hospitals' Office of Behavioral Health, in partnership with OneCity Health, launched four new Pathway Home™ teams at four NYC Health + Hospitals acute care facilities. Each site will work with one Pathway Home™ team and will enroll up to 150 patients over a 15-month period. The four sites are:

NYC Health + Hospitals/Coney Island, NYC Health + Hospitals/Harlem, NYC Health + Hospitals/Lincoln, NYC Health + Hospitals/Metropolitan.

Four CBC Network CBOs will provide the Pathway Home™ services in the community. The CBOs are: Services for the UnderServed, The Jewish Board, Visiting Nurse Services of New York, and Samaritan Daytop Village.

Read the full Press Release here: http://www.cbcare.org/wp-content/uploads/2019/09/FINAL-pr-NYCHH_CBC_

OASAS

CBC is excited to partner with OASAS for the funding of a Pathway Home™ care transitions team to provide services for individuals transitioning into the community from NYC inpatient detoxification and rehabilitation settings. Read the full press release here.

The Jewish Board

"For over a 140 years, The Jewish Board has provided critical health and human services to those in need throughout all five boroughs of NYC. Through their core tenets of hope, recovery, and resilience they have provided a vast array of services addressing mental health needs to supportive housing needs and beyond. Today we are pleased to announce that their services continue to expand with the introduction of their new Pathway Home™ team. Alison Haan, LCSW at the helm the team hit the ground running. Kick off meeting with Coney Island hospital took place on 9/5/19 where both

Pathway Home™ staff and Coney Island Inpatient staff met for introductions, to discuss services, and partnership. In spirit of collaboration, Coney Island have invited Pathway Home™ Jewish Board to participate in a weekly levels of service meeting with inpatient staff on Wednesdays! Join me in welcoming this all star multidisciplinary cast as they start this new endeavor!"

Pathway Home™ Training Institute

PH Training Institute provides education and technical assistance on the successful & award winning Pathway Home™ care transition model. In addition, to care transition subject matter expertise, the Pathway Home™ training institute offers a wide array of trainings, including:

- Engagement and De-escalation
- Building Effective Relationships
- Self-care and Work/Life Balance
- Coping Skills To Empower Program Participants

September Activities:

- Training for OMH Housing Providers at Creedmoor and South Beach Psychiatric Centers
- Developing a Learning Collaborative on Gaps in Care

The topic was Person-Centered Engagement and De-escalation, and focused on how to engage and de-escalate participants in a recovery-oriented, strengths-based way. The trainings were both well-attended and well-received, and trainees expressed eagerness to attend other trainings by the PHTI. If you have any training needs, please don't hesitate to reach out to Emily Grossman, Training Manager, at egrossman@cbcare.org.

Upcoming October Trainings: Person-Centered Engagement and Crisis De-Escalation

This exciting training is being held two sessions.

- 10/17 from 10am-2:30pm - click here!
- 10/22 from 10am-2:30pm - click here!

Specialty Meetings: Be in the Know

Pathway Home™ Adult Home Plus: Monthly Check-in Meeting

A pair of Team Leaders, social workers, RN's and Case managers walk into a room with CBC staff and have an amazing Adult Home + meeting! CBC- Pathway Home Program Director, Angelo Barberio with the help of AH+/HH+ Program Manager, Teresa Hill held another "check-in" meeting with both the Postgraduate Center for Mental Health Pathway Home team and WellLife Network Pathway Home team. We talked all things AH+ settlement. We discussed barriers and obstacles as well as successes the teams have had. Both teams agreed that the major obstacles in moving class members were 1) preference in certain community locations that lacked apartments 2) wanting to live alone 3) loneliness and 4) not enough apartment viewings or apartments being in poor conditions during time of viewing. The teams also talked positives such as communications improving at certain Adult Homes and team efforts made in moving certain class members within the community. The meeting ended with talking about creative solutions (such as leaning on peer bridgers more and utilizing resources to re-connect members to what they love to do within the community), successes and even going over some case specific issues. Overall it was a very informative meeting and it was great to see everyone in one room talking shop! Thank you to both Postgrad and WellLife for all the hard work you do and the impact you have on the class members you work with!

The Latest Pulse

Pathway Home™ RN's welcome newest RN, Jorge (WellLife Network) to the team this Month (Welcome!). RN's spent the time discussing the Physical Health Assessment as well as areas surrounding health prevention like upcoming Flu season. RN's distributed flu prevention flyers with helpful tips for PH participants. They came up with a plan to provide health prevention education through the use of a flyer once per quarter. Flyers will be provided to all PH teams and Flu prevention flyers will be distributed for use from September through November. The RN's plan on having a meeting an administration staff to coordinate ongoing Health Prevention flyers for quarterly distribution. The RN's also discussed Wellth™ app and how to utilize effectively in monitoring participants with taking their medication as well as their diabetes. Discussions also included how to make Wellth™ more eff ctive with various PH populations such as Adult Home participants. RN's agreed the Wellth™ app is a good tool to use with the first 90 days of the Pathway Home™ Care Transition model in monitoring participants progress with medication. They rounded out the meeting by talking about self-care, how to deal with

Peering Out

Pathway Home's September peer meeting was just wonderful! All of the peers are devoted to the work and are invaluable to engaging Pathway Home participants. They discussed engaging individuals use substances who are in the pre-contemplative stage, and how to engage them. Another topic that was discussed was self-care. Many resources were shared amongst peers---some great examples were indoor swimming opportunities around the city and City Bike discounts for participants. The passion for the work was extremely apparent in the room throughout our meeting.

"Creativity is Contagious, Pass it On" -Albert Einstein

Guillermo has strong self- advocacy and communication skills and normally keeps his providers updated on how the medications and treatments were impacting him. When Guillermo first engaged with PH services, he had been struggling with symptoms and was experiencing interpersonal difficulties and disputes with family and friends.

PH team provided psycho-education on the importance of following treatment and learning coping skills to manage his symptoms and interpersonal issues. He now reports that he is taking his medication and attending his appointments, which are helping in his recovery. He also reports that his time working with PH has helped improve his socialization skill . He has shown improvements in his ability to write, follow housing rules, and pay his rent on time. At the start of the program, Guillermo was unsure of how to get around. After much travel training by the team and being taught about google maps, he is much more confident in his abilities. Additionally, Guillermo was educated on the benefits of a tidy living space and its impact on his mental health. Proper ways of cleaning were demonstrated and practiced until Guillermo began to get the hang of it. He is now able to keep his apartment clean and use public transportation independently.

Guillermo has been using his free time to paint and draw and uses his artistic ability to help manage his feelings around his mental health. His goal is to expand his artistic ability, and which will help with maintaining his mental health . "I am grateful for the support I received from Pathway Home™. I am ready to live by myself." Guillermo has painted portraits for program staff to show his gratitude. While a little sad about moving on, he understands and agrees that he is ready for graduation. We wish him the best!

Cooking up Sonia's Dream Pt 2

In March 2019, with the help of Pathway Home™, Sonia successfully moved into a gorgeous apartment that she could finally call her own through the Adult Home + settlement. Sonia finally "felt free". It only took a her a couple days into moving into her apartment to start living out the one thing she had been wanting to do for years, cooking. She started cooking meals for her boyfriend and family members with a new zest for life. But the initial transition from residing in the Adult Home to living independently on her own proved a little more challenging then expected.

Sonia was originally supposed to have a roommate in her apartment to hopefully counter any loneliness when family or her boyfriend wasn't around. But the room was never filled. Family stressors soon ensued when relationships with her children went a bit sour. PH SMHC Arianna soon noticed that Sonia was having some trouble. She started having difficult sleeping and soon decided to stop her medication. She started reporting depression and broke up with her boyfriend, her last social support. In the spirit of collaboration, Arianna reached out to Sonia's therapist and psychiatrist noting her behavior, but her providers brushed it off as "stress due to her move".

In April, Sonia brought herself to Brooklyn Hospital. Through advocacy and recommendations from PH team , Sonia was transferred to Brunswick Hospital in Amityville NY and the inpatient team worked on a appropriate discharge plan. Arianna drove out to Long Island each week to meet with Sonia and the inpatient team to advocate for best care and participate in aftercare planning. Arianna and PH team also made sure prior to discharge that her Medicaid surplus was paid for so that there wouldn't be a lapse in her insurance once she returned to the community. They filled her fridge with food so she could get back to her favorite activity of cooking, which was also a therapeutic coping skill for her. After a medication change and an improvement in mood Sonia was back in her apartment. Through intensive multiple weekly visits with Arianna and the team she was able to get back on track. They went over coping skills like cooking as well as getting connected to social support within the community.

Sonia accepted the help of her mental health team and PH team and was able to navigate through the first rough month back. Fast forward 6 months later and Sonia is the first PGCMH PH participant to successfully graduate! Since working intensely with PH, Sonia has been able to secure an MLTC, obtain a Home Health Aide (which happens to be her boyfriend Jose) through the CDPAP, solve her Medicaid surplus issue, develop habit of taking medication, get SNAP benefits, connect to Health Home Care coordination, and more importantly remain stably housed in the community. While PH will be sad to see Sonia graduate, we are honored to have watched her transformation and wish her the best luck in the future.

L to R: Sonia R, TL Kathy D & SMHC Arianna M posing during her PH graudattion lunch

L to R: SMHC Arianna M & Sonia R

Your Wellth™ = Success


SMHC Jessica Myers

Madriead is a 22 year old who often compares herself to others as most do at age 22. She reported to her Pathway Home clinician Jessica that she never felt like she fit in and that her life was not going the way she had hoped it would. Prior to working with Jessica on the CCNS PH team, Mairead had been hospitalized over 10 times in the past year and a half. She was struggling with managing the symptoms of her depression, anxiety, and OCD which often led to suicidal ideation or self-harm.

When Jessica started working with Mairead, she encouraged her to step out of her comfort zone as she did not often leave her home. She also signed up for Wellth™, which she used successfully and was able to earn money in order to treat herself to things to feel more like a typical 22 year old. Mairead attended the CCNS team bowling trip in June, and since that time has also been able to use the money earned with Wellth™ to attend a concert in Central Park for the band King Gizzard & The Lizard Wizard. Mairead shared with Jessica that she would not have been able to attend this concert without Wellth™.

Mairead continues to work on managing her symptoms and to date has not been hospitalized since working with the team. She also has been making more plans to get out of the house which will hopefully allow her the opportunity to continue to connect with her peers in the community.

Goals, Endurance & Dreams

Often times, we may experience anxiety or feel down, and these feelings get in the way of completing certain tasks. For some people, these feelings are amplified and completely hinders any progress in their lives. Alexia is someone who faces this constantly, but this isn't all of who Alexia is. Alexia is also very creative, she draws, writes poems and she plays musical instruments (piano, guitar and bass).

Alexis has struggled with anxiety, recurrent major depressive disorder and a history of self-harm. These challenges resulted in inpatient hospitalization. At that time, Alexia joined the Pathway Home™ program. Octavia (SUS PH Case Manager) and Alexia have discussed many coping methods such as meditation and breathing exercises when she starts to feel overwhelmed. They've been able to practice these techniques together to help Alexia prepare for this new endeavor. Alexia really enjoys meditating and writing poetry, which has helped her a lot with her anxiety and being able to express her emotions in a healthy way. Alexia also attends treatment at Payne Whitney Day program, where she learns additional skills to manage stress and regulate emotion with increased self-esteem and future oriented goals.

Alexis has recently taken steps on her own to obtain her GED, and to become more organized at home. She has passed her placement exam for the GED and started classes in September. She expressed how nervous she was about adjusting her schedule to incorporate the GED classes with her Payne Whitney Program. Alexia was able to work with Octavia to come up with a schedule that she felt she could manage without becoming overwhelmed.

Alexia will soon be graduating from Pathway Home™. "I believed I will be able do well" Alexis remarked, adding **"I have the support of my father and best friend Raven, and the support of my team at Payne Whitney."** On Alexis, Octavia says "I am proud of how far Alexia has come on her road to success."


SMC Octavia Moreno

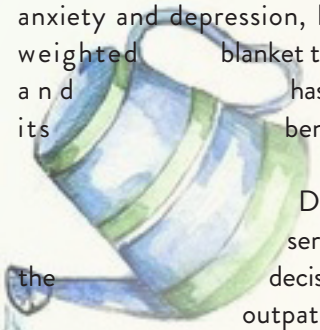
Weighing Your Options

With no entitlements, no social connection, or support groups close by her living area; Anna faced several challenges prior to her engagement with Pathway Home™. She often said that she felt alone, and she admitted herself to the hospital to find safety and social connection, as well as support from the treatment team that she lacked in the community. Anna was open to Pathway Home™ support and met with several members of the team such as the clinicians, the nurse, and Care managers when initially enrolled.

At first it seemed as though every treatment that Anna was prescribed was unsuccessful. In order to aid with her recovery, her inpatient treatment team from Long Island Jewish referred her to Electroconvulsive therapy there. Anna continued to receive ECT at LIJ despite the fact that it was difficul for her to travel to and maintain. Anna required constant escorts that appeared to be a strain on both her and her family. Though this task was difficult PH coordinated and assisted Anna, in addition to her dad, with escorting her to ECT at LIJ providing ongoing transportation.

In addition, Anna was provided with basic needs such as groceries along with accompaniment and assistance in dealing with her pending SSI and applying for SNAP, cash assistance, and public assistance.

Anna had what she described as a "crisis" when she was encouraged to check into the hospital for psychiatric help due to suicidal thoughts and even wrote a suicide letter. This admission was short, with the discharge plan to continue ECT. These treatments appeared to worsen Anna's condition; the more treatment she received, the more she experienced short-term memory loss. For example, she was unable to remember goals that she had already accomplished, like entitlement appointments. To aid with her anxiety and depression, PH purchased a weighted blanket that she uses daily and has been grateful for its benefits



During the course of services, Anna made the decision to consult her outpatient providers at Kings County on her memory loss issues. She discussed extensively with PH staff that she did not feel herself improving, which led to more feelings of depression. After much discussion, Anna made the decision to stop ECT. Since then, Anna has seen more improvement with her mood. Her daily functioning, communication, memory skills, and energy seemed to have improved significantly as well

Anna completed and graduated both Partial Hospitalization Program and Intensive Outpatient Treatment program. Since her improvement, she has obtained employment on a full-time work schedule through a Temp agency, and she's done so well that the organization wants to hire her permanently. At this time, Anna has become so independent, she has limited Pathway Home™ visits to a specific day and time each week, siting "I have to work, and I'll only be able to see you during lunch." She also plans to go back for a master's in social work so that she can help others in the way that she has been helped. Anna has recently graduated from Pathway Home™ and we could not be prouder of all that she has accomplished!

Life Changing Moments

Jerry has a gift of laughter, though he was shy and spoke in a quiet toned voice when he arrived at MHC. Initially, he presented with behaviors that caused him to be placed on 1:1 on the unit. He did not speak much with staff, but gestured and made fighting statements toward peers on the unit. The Pathway Home™ MET Embedded Team visited him daily on the inpatient unit, building a connection with him and counseling him around gaining an understanding of what negative behaviors are that could lead someone to become arrested.

He shared with team, "I spend my calm time in Queens, and my rowdy time in Brooklyn" and that he knew gang members. Though he did not feel at that point the need to explain further, team suspected there was a lot of exploring they would be doing with Jerry while he was inpatient. He expressed to the Embedded PH team that he wanted to learn how to become more independent, leading with responsible behaviors that would allow people to take him seriously. Embedded team clinician and peer worked together and taught him how to use pros and cons lists, and to analyze the choices that he was making in the hospital, and outside in the community. This was helpful for him to understand the positive and negative results of his actions. After a few engagements, our team observed that he was making healthy choices that led to better social outcomes, and was officiall off of 1:1 observance on the unit.

On the unit, he started attending groups, and also gained the privilege of leaving the unit to

go to the gym. Jerry began opening up more. "We learned that he loves basketball," shared Pam (Peer) "so we talked about basketball allowing him to laugh at my lack of knowledge." He also shared his love of boxing and wanting to learn to become a professional boxer. At 21 years old, his main goal was to go back to school to earn his GED and be a productive member of society.

After a month inpatient, Jerry is looking at his life differently. He has even decided to focus his attention on securing housing placement for young adults. "I am happy that I am supporting this young man around new ways of thinking, doing what he thought wasn't possible" said Pam. Jerry is now looking at his mental health needs and understanding the value of medication. Pam continued "I am very happy to be able to share great sparkling moments withJerry. I was able to see this young man turn from being alone and angry to becoming a loving and caring young man."

Jerry remarked, "I understand that having mental illness is not crime and taking medication is not a punishment." Jerry has created a vision of where he would like to go in his future, and setting firm goals. Our Embedded Team is now working together with Jerry, and his treatment team to plan steps to get there once he transitions from the hospital.

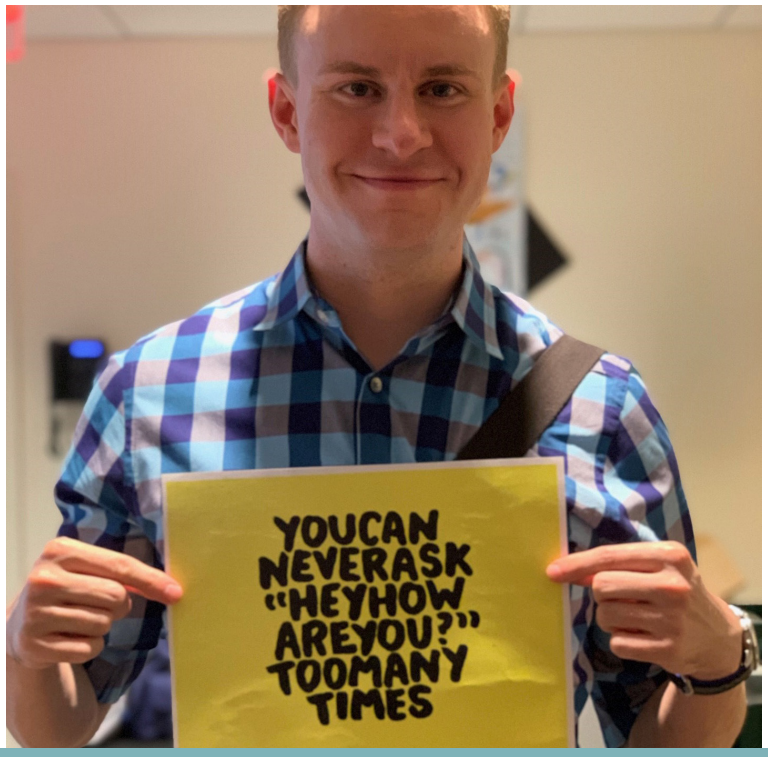
"...mental illness is not crime and taking medication is not a punishment."

L to R: Jerry and PS Pam Gerard at Metropolitan hospital

"Moving On Up!"

When I first met Cynthia, she was very happy that she was moving to supportive housing and receiving supports from community providers. Although she was not connected with Medicaid or SNAP benefits, she activated these benefits with support from Pathway Home™. Cynthia also did not have clothes for the weather but took pride in her appearance and was able to pick out her own clothing that she wanted from various thrift shops around Manhattan.

As she was independent and self-aware of her needs, Cynthia was able to advocate for necessities such as a shopping cart, which she uses to make trips to grocery stores and the laundromat to take care of her personal needs. Not having the funds, Pathway Home™ was able to use Step Down Funds to purchase a cart for her. Cynthia was connected with behavioral health treatment through the Bridge PROS program and worked with treatment providers to get to know herself and develop a treatment plan. While she faced various obstacles during her journey to recovery, she worked diligently to stay on track with her mental wellness and make steady improvements with symptom management. Cynthia struggled with motivation and self-advocacy at the beginning. She had difficulties with things such as turning on her Medicaid and buying clothing. Through continued encouragement and education, she was able to gain these skills for her everyday life. Cynthia is now able to find comfort and support in her medical, behavioral, and residential treatment team and credits Pathway Home with assisting her in a successful recovery.



Dialing Into Success

Tom is a 57-year-old man who has an infectious laugh and a continuous smile. Steven, ICL Pathway Home™ Assistant team leader, met Tom at hospital to support him on his first day moving into housing. Announcing loudly as Steven approached him, "you must be coming to try and tell me all the things you think I don't already know." Steven took this in stride and sat with the Tom while he completed his intake paperwork for housing. Tom noted how it had been a while since he'd lived in his own apartment. He had been homeless before, spending time in Rikers and several other hospitals throughout his life. That first day Steven and Tom built a respect for each other. In true Pathway Home™ fashion, Steven let Tom tell his story, took time to listen, and offer support only as needed.

Tom knew he'd been court mandated to attend treatment at a program he didn't find that enticing and knew the consequences of not going. Steven and Tom talked about how to see situations for what they are and find the good in them. Tom was agreeable to attending regularly and was encouraged to find at least one positive each time he attends to later share with Steven. Tom did this for a few weeks of attendance and eventually told Steven that he found that the program actually is helping him to gain skills for work and transitioning into independence again. As this happened, Tom became agreeable to meeting with a PCP, something he was against initially. Steven joined Tom for the first appointment, leading to Tom's high cholesterol being addressed and lowering his risk for a heart event.

The past two weeks, Steven and Tom have been working on the skill of using a cellphone. Steven harnessed Tom's wish to communicate with his old parole officer more often. He had received a Medicaid phone and would have to have Steven dial numbers for him. Tom learned how to add contacts, the basics of texting, and how to make a call. Steven once started work with 12 missed calls from Tom, who later noted he was practicing and apologized for all the 5-minute-long voicemails left. Tom eventually was able to contact his old parole officer on his own, something Steven was there to witness.

As the two men discussed the years prior, it was clear that Tom had come such a long way from where he had been. His understanding of medications, treatment, and how to live a better life had evolved. Tom told his parole officer that he was part of a new program, Pathway Home™ and that his worker, Steven was helping him to believe in himself again, just like his parole officer had once done.

BOOTS ON THE GROUND

By Angelo Barberio

Fall is around the corner and this September I got a chance to sit down with Joan Sass, Team Leader with CCNS Community Pathway Home Team working with individuals transitioning from State Psychiatric centers back into the community. We talked all things Pathway Home as well as life outside of work.

DID YOU KNOW?!?

Joan has 3 children, 2 grandchildren and 2 dogs! In 2010, she got her post masters in School Administration! (Such an overachiever!)

Strengths: "Compassionate, understanding, and loves finding the strength in people"

Weakness: "Sometimes too flexible.

Outside of work: Joan loves vacationing and traveling. She's going to Israel in a couple week (Bon voyage!) She loves the beach and BBQing with friends.

Greatest Achievement: "Starting a new program and watching it grow into something more"

Personal PH Motto: "Living with hope and embracing peoples positive traits!"

Me: So, Joan what were you doing before Pathway Home™? And How did you hear about Pathway Home™?

Joan: "I was actually working in a school for youth with developmental disabled and most of my students had an IQ below 70. I found out about PH from a simple online ad."

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

Joan: "I wanted a change from working with kids. From 1989-1998, I assisted in creating a multi-disciplinary program that worked with SUD individuals in building life skills like finding employment etc. The PH model seemed similar to that but with even more added value."

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

Joan: "I love it. I feel like I'm actually making a diffe ence again. PH provides our participants with the necessary life skills/coaching and immediate need items that help them get through the day to day struggles of life. The things we've been able to assist with run the gamut like paying for someone's LSAT exam or dental work."

Me: What do you find challenging about the work?

Joan: "People who decline services. Why wouldn't you want the services? It's confusing because we're such an added value to someone's life that it seems silly to pass on. I'm not sure if it's a "control" thing but it's difficul to engage this cohort and as a team we have to accept that people grow and change at their own time schedule."

Me: One lesson you'd give to new Pathway Home™ team leaders?

Joan: "Create a cohesive team. Make each team member feel valued, Case Managers can do clinical work, often times they have the experience to do so minus the credential. Help team members grow professionally and encourage everyone to continue to learn. Celebrate the successes and milestone life events."

WHO INSPIRED YOU THIS MONTH?

I'd like to shout out Harley (ICL team). It was cool to shadow him and seeing this work from a different angle. His nursing expertise, empathy, and patience was inspiring! - Enoch Naklen, PH intern

I would like to nominate Noemi Torres. She began Pathway Home as a quiet, observant case manager and now is vocal in addressing complicated and intense participant issues and dynamics. She is shares her opinion in meetings, takes a risk in moving participants through various phases of treatment and proves that consistency and patience is an honorable virtue. Throughout her time with us, she has grown tremendously, it is a pleasure to see her smile when she describes the interventions she has made with participants.

I am proud to call her a friend and to see how her confidence has grown. Here is to Noemi and I can't wait to watch her continued growth and development. - Joan Sass, team leader