Background

Pathways to Housing First Model

Pathways to Housing ends chronic homelessness for individuals with serious mental illness (SMI) by providing housing first, and then combining that housing with supportive treatment services in the areas of mental and physical health, substance abuse education, and employment. Housing is provided in apartments scattered throughout a community. This “scattered site” model fosters a sense of home and self-determination, and it helps speed clients’ reintegration into the community. The Pathways model has been remarkable successful in addressing chronic homelessness.¹

Integrated care

Pathways to Housing Philadelphia has developed a novel integrated care program through a unique partnership with the Department of Family and Community Medicine at Thomas Jefferson University. A primary care physician has been embedded within the transdisciplinary care team to provide direct clinical services and care coordination and functions as the medical director. In keeping with the Housing First principle of consumer choice, individuals may choose to receive individual psychiatric and/or primary care from the Pathways physicians or in the community. However, the team supports all clients in medical and behavioral healthcare coordination. Integrated care team members include staff from social work, nursing, psychiatry, primary care, community integration, substance abuse support, and peer support.² ³ Key services of the integrated care team include:

- Ongoing onsite integrated primary and behavioral health care
- Direct linkage to academic medical center and specialty care
- Direct management of hospital care transitions
- Integrated health record
- Medication management and e-prescribing
- Chronic disease registry
- Coordination of preventive care and screening
- On-site adult vaccines
- Tobacco cessation support
- Community based participatory research (CBPR) in health services and support

Research Question

What are the chronic physical disease self-management support needs of Pathways to Housing clients?

Methods:

This project consisted of 3 complementary assessments of the current Pathways population:

- 1. Epidemiologic surveillance of health characteristics from 6/17/10 - 6/17/11
- 2. Chronic disease quality assurance monitoring of the integrated care program using select recommended measures from the National Association of State Mental Health Program Directors (NASMHPD) and the Healthcare Effectiveness Data Information Set (HEDIS)
- 3. Community Based Participatory Research (CBPR) piloting onsite implementation of the Stanford Chronic Disease Self Management Program (CDSMP)

Results:

Demographic & Health Characteristics

Average age of clients is 50 (range 22-77), 64% are male 71% are black, 28% are white

Source of care:

88% of clients have a primary care provider 44% of clients receive primary care through PTH 89% of clients receive psychiatric care through PTH 36% of clients receive both psychiatric and primary care through PTH and form the Integrated Care (IC) subgroup

CDSMP Preliminary Analysis

Process evaluation:

- 25 participants took part in the pilot CDSMP session, with over half attending at least 5/6 sessions
- Staff facilitation and reminders were important in assuring attendance
- With active and specific assistance from the facilitators the action plan process improved for clients
- Some clients with significant chronic medical and psychiatric issues were unable to participate in the group process

Preliminary findings:

- Participants would welcome further inclusion of mental health issues into the program, especially depression and substance use
- Women participants would welcome further discussion of past trauma and its effects on current health
- Social isolation figures heavily in influencing self-management and dietary behaviors for many participants
- Regular group attendance and sharing was beneficial in counteracting social isolation and building relationships with other Pathways clients
- Participants reported very limited community/neighborhood integration
- Few participants would consider becoming lay leaders

Public Health Impact

Individuals with experiences of homelessness and serious mental illness represent an older population with complex co-morbidities and increasing chronic illness care needs.⁴ As advances have recently been made in ending homelessness for individuals with SMI, a significant opportunity arises to systematically integrate participatory health interventions into pre-existing systems of housing and social service support.

Initial experience at Pathways to Housing Philadelphia suggests that this integration is feasible by expanding the current infrastructure to include programs of integrated behavioral and primary care, ongoing quality assurance and consumer participation in health services planning.

Future plans

NIMH K23 proposal: CBPR for self-management support of formerly homeless people with SMI

Literature Cited


Acknowledgements

Grants Support

Dr. Weinstein’s research at Pathways to Housing is partially supported by a Health Resources and Service Administration Faculty Development Program (HRSA-HRSAH75312 PI: Howard Rubinstein). The federal funding for the faculty development program is $360,181, which is 75% of the total funding of the program. The non-governemental funding is $119,914, which is 25% of the total funding of the faculty development program.

The Center to Study Recovery in Social Contexts provided funding for the CBPR projects. The Center to Study Recovery in Social Contexts is funded by grant P20 MH073188 (PI Alexander) from the National Institute of Mental Health and is supported in part by the New York State Office of Mental Health at the Nathan S. Kline Institute for Psychiatric Research. The contents of this paper are solely the responsibility of the author and do not necessarily represent the official views of HHS or NIH

Ongoing thanks to my mentors and colleagues at the Department of Family and Community Medicine at Thomas Jefferson University, Pathways to Housing, Center in the Park, and the Center to Study Recovery in Social Contexts and especially the clients at Pathways to Housing Philadelphia.

Capacity Building for Participatory Health Services Research in Housing First

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