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Capacity Building for Particpatory Health Services Research in Housing First

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Pathways to Housing PA

Center to Study Recovery in Social Contexts

Background

Pathways 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 client's reintegration into the community. The Pathways model has been remarkable successful in addressing chronic homelessness.[1]

Photo Credit: Sarah Bones

The Pathways Program started in Philadelphia in 2008 serving 132 individuals. The program maintains a 92% retention rate even amongst those individuals not considered "housing ready" by other programs

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 6/1/10 - 6/1/11
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)

Quantitative data were obtained through review of available information from clinical records. Qualitative data were obtained from individual interviews and focus groups. Study protocols were IRB approved.

Results: Demographic & Health Characteristics

Average age of clients is 50 (range 22-77), 64% are male
71% are black, 28% are white
Average time since starting in the program: 22.5 months
Axis 1 dx: Schizophrenia Spectrum Disorder (45%), Major Depressive Disorder (23%), Bipolar Disorder (11%), Other (21%)

Source of care:

86% 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

PTH Clients: Health Characteristics

	PTH All (%) n=131	PTH IC (%) n= 45	Philadelphia[c] (%)
Any chronic physical disease	77.1	88.8	
≥2 chronic diseases	59.5	77.7	--
Hypertension	43.5	57.7	35.9[a]
Diabetes	10.7	15.5	13.4[a]
Asthma	16.0	8.8	16.5[a]
COPD	11.5	11.1	--
HIV	6.1	2.2	--
Overweight//Obese	67.1 (n=83)	46.6	61.0[b]
Tobacco use	81.6 (n=98)	71.1	25.2[a]***
Substance use (excluding alcohol)	50.4 (n=115)	42.2	--

[a]Data from PHMC Community Health Database, 2010
[b]Data from BRFSS Philadelphia, 2009
[c]Comparisons made between the Pathways total sample and Philadelphia normative sample.
****p* <.001

Results

PTH Clients: Quality Assurance Measures

NASMHPD Assessments (baseline)	PTH All (%) (n=131)	PTH IC (%) (n=45)	HEDIS Medicaid, 2009[d,e] (%)
BMI	63.4	73.3	35***
BP	73.3	97.8	
Fasting Glucose/ HgA1C	32.1	71.1	
Fasting Lipid Panel	26.7	62.2	
PersonalHx DM,HTN, CVD	74.8	86.7	
Family Hx DM,HTN, CVD	61.1	73.3	
Tobacco Use Hx	74.8	84.4	
Substance Use Hx	87.8	91.1	
Medication List	74.8	86.7	
HEDIS metrics (past year)			
HTN- BP <140/90	54.3 (n=35)	57.1 (n=21)	55
DM- HgA1C screening	61.5 (n=13)	85.7 (n=7)	81
DM-LDL measured	38.5 (n=13)	71.4 (n=7)	74
Asthma-Controller medication	23.8 (n=21)	100.0 (n=4)	88.6***

[d]Data from NCQA State of Health Care Quality 2010
[e]Comparisons made between the Pathways total sample and HEDIS 2009 normative sample.
****p* <.001

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 affects 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 homeless 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

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