Pathways to a Healthy Bernalillo County Annual Report July 2009 – June 2010

Office of Community Affairs
UNM Health Sciences Center
Office of the Executive Vice President
July 30, 2010

Background

The *Pathways to a Healthy Bernalillo County Project* (Pathways Project) is the result of a more than 2-year planning effort in 2007-2008 that involved community advocates, the Bernalillo County Commission, the UNM Health Sciences Center and Hospital staff, community-based social service organizations, and numerous other partners. Its primary purpose is to find the most difficult-to-reach uninsured populations across Bernalillo County and connect these individuals to a variety of health and social services thus improving their health and well being as well as the health of the County as a whole. This is done through the skills of community health workers (Navigators) who first build trust with these hard-to-reach populations and then guide them through our complex health and social services systems resulting in positive health outcomes. In addition, the Project aims to identify, document, and resolve many of the systems barriers that surface throughout this Pathways process.

Twenty-two distinct pathways are available for Navigators to organize and coordinate care for clients. A pathway begins with an identified problem, includes several action steps to address the problem, and concludes with a meaningful outcome for the client. Pathways are designed for a multitude of different health and/or social issues that if completed, should result in better health, overall wellness, and increased self-sufficiency.

Funding for the project is made available through an agreement between Bernalillo County Government and the University of New Mexico that describes the transfer and use of a county property tax levied to support University of New Mexico Hospital. Signed in May 2008, the current agreement includes a clause that directs approximately $800,000 each year for eight years, to be used to "increase access to health care and improve the use of community resources". This funding source was the result of arduous community advocacy to gain commitment from County and University leaders to address barriers to care and provide community-based preventive and supportive assistance to vulnerable and underserved populations to improve health.

The UNM Health Sciences Center Office of Community Affairs (OCA) serves as the project hub, and oversees project management and evaluation activities. In May 2009, OCA organized a competitive process that invited community health and social service agencies to submit proposals to implement project activities, including the commitment to designate or hire a Community Health Navigator. In July 2009, contracts with ten community organizations were established; one contract funds a collaborative of five organizations that are geographically proximate and that work closely with each other. A total amount of $643,610, or over 80% of total funding for the project, goes to community contracts.

The Bernalillo County Pathways Project is part of the national Agency for Healthcare Research and Quality's (AHRQ) Health Care Innovations Exchange called the Community Care Coordination Learning Network (CCCLN). Bernalillo County's is the largest project in this network and local data is sent monthly to a national database "scorecard" developed by Westat, a consulting firm for the AHRQ. In addition, there are monthly conference calls and a face-to-face meeting that occurs once each year among the seventeen-plus Pathways partners across the country. The Bernalillo County Pathways project quality assurance manual has been requested from projects in other states as a resource for building their own programs, and soon will be made available on AHRQ's Innovations Exchange website. This fall, the OCA director will participate as a presenter on a national webinar to discuss Pathways and the care coordination model, and the program manager will participate on a panel presentation at the national AHRQ conference in September 2010.

Introduction

This is the first annual report of the *Pathways to a Healthy Bernalillo County project*, which will be received by the UNM Hospital Board of Trustees, the Pathways Community Advisory Group, and the community at large via a community meeting and the OCA web site. Note: Table 1 and figure 1 thru 4 were taken from the Bernalillo County Community Health Council's 2009 Community Health Profile.

Bernalillo County has grown rapidly in the past 20 years, requiring expansion and adjustments to health care system and other infrastructures. From 1990 to 2007, the Bernalillo County population increased from less than 500,000 to 628,292 in 2007, a 30% increase. Albuquerque's population has increased by nearly 35%; the remainder of the County by 11%. Table 1 Identifies important demographic information about the county.

Table 1 - Bernalillo County Census Quick Facts

BERNALILLO COUNTY CENSUS QUICK FACTS	Bernalillo County	New Mexico
Population, 2008 estimate	635,139	1,984,356
Population, percent change, April 1, 2000 to July 1, 2008	14.2%	9.1%
Population estimates base (April 1) 2000	556,002	1,819,041
Persons under 5 years old, percent, 2007	7.5%	7.4%
Persons under 18 years old, percent, 2007	24.7%	25.4%
Persons 65 years old and over, percent, 2007	12.1%	12.7%
White persons, percent, 2007 (a)	86.7%	84.5%
Black persons, percent, 2007 (a)	3.9%	2.8%
American Indian and Alaska Native persons, percent, 2007 (a)	4.8%	9.5%
Asian persons, percent, 2007 (a)	2.2%	1.4%
Native Hawaiian and Other Pacific Islander, percent, 2007 (a)	0.2%	0.1%
Persons reporting two or more races, percent, 2007	2.1%	1.7%
Persons of Hispanic or Latino origin, percent, 2007 (b)	45.2%	44.4%
White persons not Hispanic, percent, 2007	44.2%	42.3%
Foreign born persons, percent, 2000	8.6%	8.2%
Language other than English spoken at home, pct age 5+, 2000	29.5%	36.5%
Median value of owner-occupied housing units, 2000	$128,300	$108,100
Persons per household, 2000	2.47	2.63
Median household income, 2007	$45,147	$41,509
Land area, 2000 (square miles)	1,166.03	121,355.53
Persons per square mile, 2000	477.4	15

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.
Source: US Census Bureau State & County QuickFacts

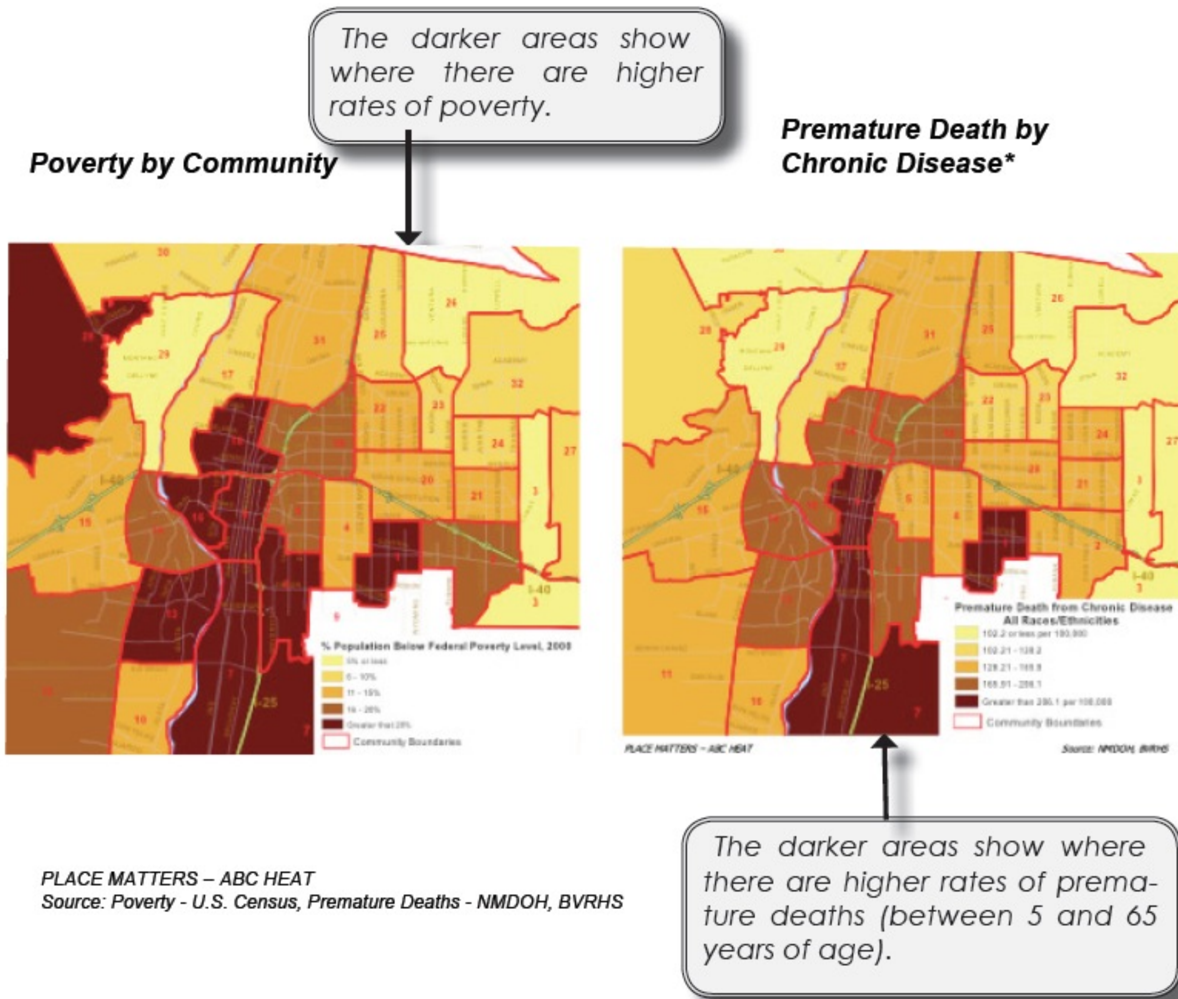
The County is linguistically and culturally diverse, requiring a variety of approaches to improving health access. Poverty and other social determinants of health vary significantly between Bernalillo County neighborhoods, resident ethnicity, and age groups.

It is important to note that according to the National Bureau of Labor Statistics website (http://www.bls.gov) the unemployment rate in the City of Albuquerque was 8 to 9% for the months of January thru May 2010, right around the time that many of the Pathways partners began to hit their stride.

Health Status

The health status of Bernalillo County residents varies greatly by neighborhood. For example, the areas of Bernalillo County that experience higher rates of poverty also experience higher rates of mortality due to chronic disease, incarceration, homicide, and teen birth rates. Figure 1 illustrates the relationship between poverty and premature death by chronic disease.

Figure 1 Poverty and Premature Deaths



It should be noted that the majority of Pathways clients reside in the darker areas of the maps noted above. See Client Zip Code chart on page 8 of this report.

Below, Figure 2 show the large number of Bernalillo County residents without health insurance (2004-06) with particular emphasis on Hispanic populations in the County. In Figure 3, the uninsured rates are directly linked to poverty in Bernalillo County (e.g. the lower the income, the higher the uninsured rates). Again, it should be noted that among the more than 480 clients actively participating in Pathways in the first year, 73% self-reported their race/ethnicity as Hispanic.

Figure 2 - Bernalillo County Residents without Health Insurance

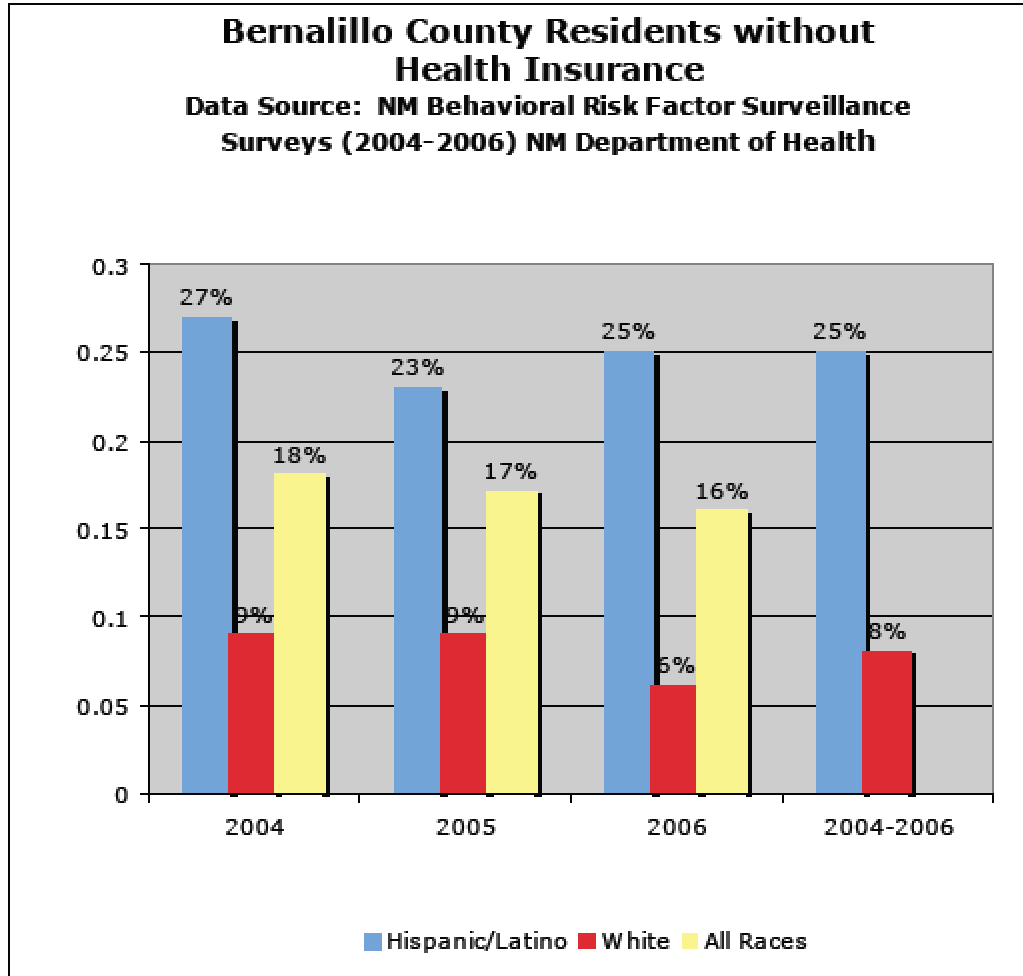
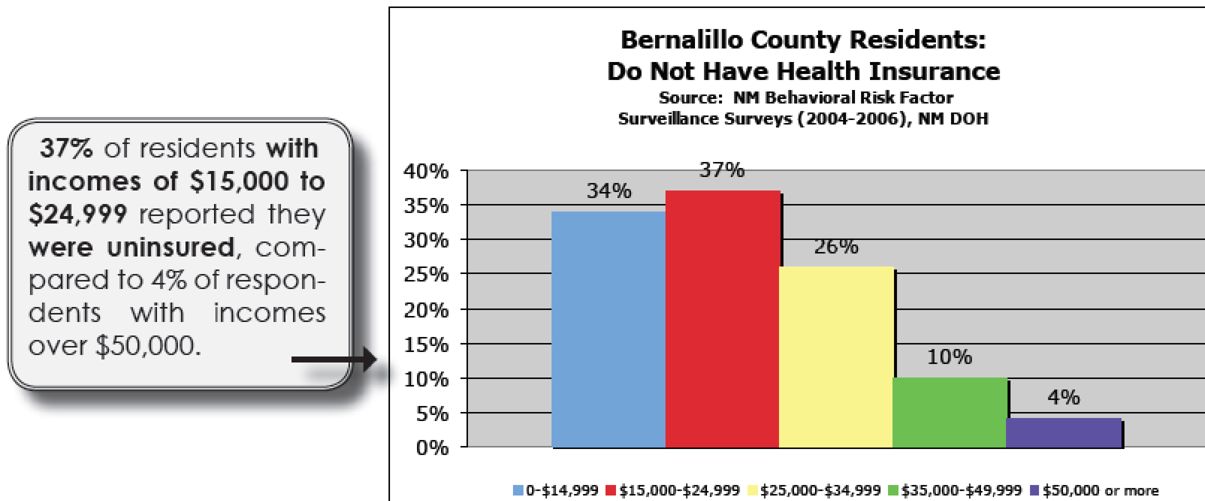


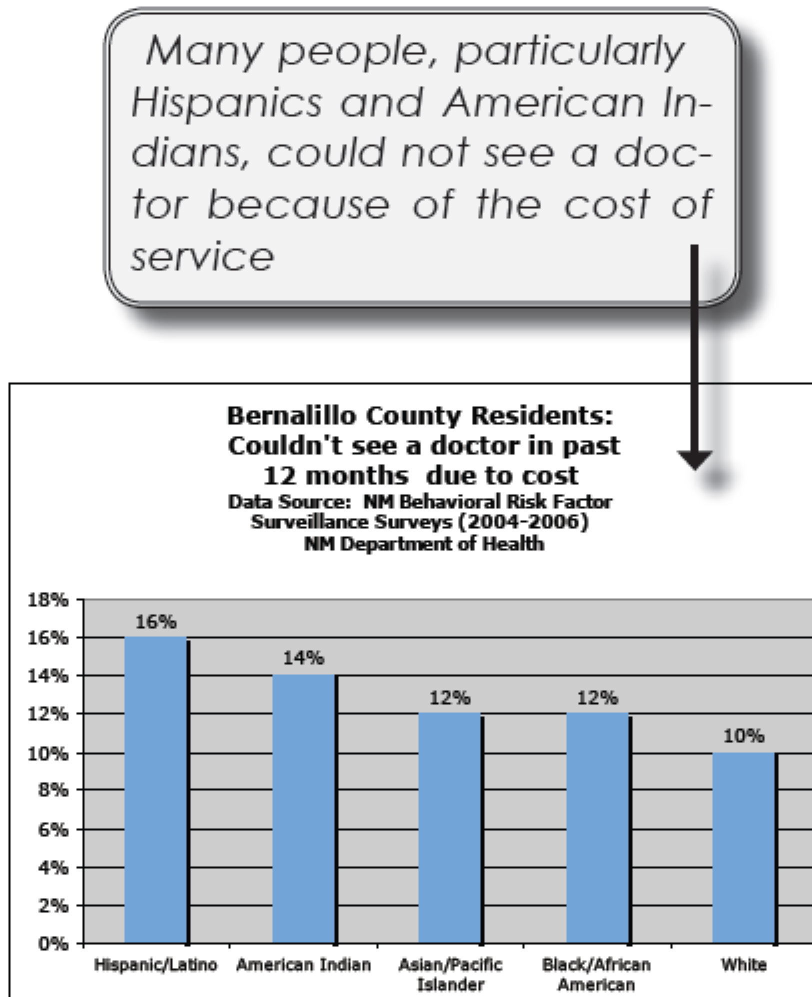
Figure 3 - Bernalillo County Resident without Health Insurance



One of the primary outcomes defined in the Pathways planning process is to ensure that every Pathways participant establish a health care home prior to completing the Project. Below, Figure 4 demonstrates the percentage of Bernalillo County residents (2004-06) who could not see a doctor in the prior 12 months due to cost. Once again, Hispanic/Latino populations in the County make up the highest percentage.

While these data are now 5+ years old, it can probably be safely assumed that with the current state of the economy and the numerous cutbacks in Medicaid and other forms of insurance that the situation has only worsened for many of Bernalillo County's poorest residents.

Figure 4



Project Activities Description

Project activities are designed to achieve four community-defined outcomes:

1. People in Bernalillo County will self-report better health
2. People in Bernalillo County will have a health care home
3. Health and social service networks in Bernalillo County will be strengthened and user friendly
4. Advocacy and collaboration will lead to improved health systems

Clients

Pathways clients that are recruited by Navigators meet criteria that include **low income, uninsured adults** who may be experiencing one or several of the following:

- Have multiple or complex unmet needs and reports feeling unhealthy
- Have had a minimum of one Emergency Room visit within the last year
- Currently homeless and not currently receiving services
- Urban off-reservation Native American not connected to or trusting of the currently existing resources in Bernalillo County
- Undocumented and/or limited-English proficient (LEP) immigrant who does not understand how to access existing resources and/or has run into barriers trying to navigate the system
- Hungry and averaging less than two full meals per day
- Any of the above who are parenting young children

By the end of June 2010, the Pathways organizations had worked with a total of five hundred and eighty eight (588) clients, broken down as follows:

Table 1

Active Clients (current)	Clients who've completed Pathways	Inactive Clients	Clients who've withdrawn from Pathways	Total number of clients
425	67	65	31	588

Approximately 83% of the clients seen over the course of the year are either still actively working on different pathways (72%) or have already successfully completed the Project (11%). In most cases, the latter means that the clients have completed at least two pathways (an exception to this is a client who needed one specific thing such as a job, and was successful in finding one).

Of the remaining 16%-plus, approximately 11% of the clients were inactivated by their Navigators, usually due to the Navigators having lost touch with them over a period of several months. There are a variety of reasons why this could have happened, such as the person moved away, their phone got disconnected, they became incarcerated, or their personal situations changed. The remaining 5% of the clients have withdrawn from the Project by their own decision, again resulting from a variety of reasons.

The gender breakdown among the clients was approximately 74% female to 26% male. The self-reported Race/Ethnicity is as follows:

Hispanic/Latino	73%
American Indian/Alaskan Native	13%
White/Anglo	9%
Black /African American	3%
Other	2%

Pathways clients fall within the 20 to 49 year range (78%) and most (61%) have less than a high school education as demonstrated in Tables 2 and 3. The Bureau of Labor Statistics (http://www.bls.gov) states that there is an approximate 15% rate of unemployment among high school dropouts nationwide.

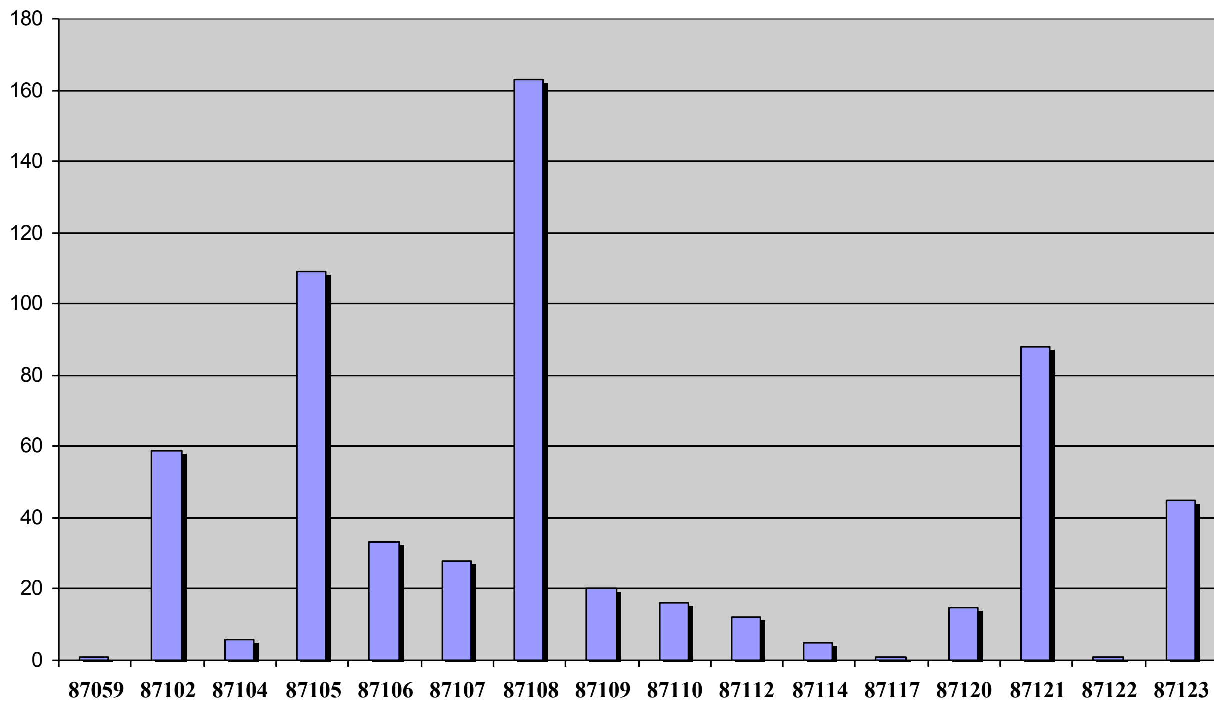
Table 2

Age of Clients	Percent of Total
Under 20	6%
20-29	26%
30-39	28%
40-49	24%
50-59	13%
60-69	3%
70-79	<1%
80 and over	<1%

Table 3

Education Level	Percent of Total
Elementary to 8th grade	35%
Some High School	26%
High School Graduate	19%
Some College	12%
GED	4%
Associate's Degree	2%
Bachelor's Degree	1%

The majority of Pathways clients live in the Southeast Heights zip code areas (87108 & 87123) followed by South Valley and Southwest Mesa zip code areas (87105 & 87121).



Common Pathways

After a Navigator identifies an individual as a potential candidate for project participation, he or she conducts a risk assessment with the individual to qualify them for project participation and to understand their personal situation. The new Pathways client and the Navigator discuss areas to work on together, and determine which of the twenty-two pathways the client will undertake. This year, the pathways that were most commonly selected by clients to work on were those of Health Care Home, Employment and Food Security.

Table 4 below further illustrates the level of activity on each Pathway:

Table 4

Pathways	# of Clients
Health Care Home	213
Employment	199
Food Security	179
Housing	137
Vision & Hearing	114
Medical Debt	109
Dental Care	95
Behavioral Health	91
Depression	90
Domestic Violence	72
Transportation	64
Legal Services	62
Pharmacy/Medications	59
Education/GED	48
Substance Use/Abuse	39
Income Support	36
Heat & Utilities	34
Child Care	32
Diabetes	27
Homelessness Prevention	17
Pregnancy	12
Child Support	4
Total Pathways	**1321**

In Year 1, Pathways clients completed a total of 498 pathways:

Table 5

Pathways	# Completed
Food Security	85
Health Care Home	58
Employment	45
Domestic Violence	40
Medical Debt	39
Behavioral Health	31
Legal Services	27
Vision & Hearing	23
Housing	19

Income Support	19
Depression	16
Transportation	14
Heat & Utilities	13
Child Care	13
Dental Care	12
Substance/Abuse	11
Diabetes	9
Pharmacy/Medications	9
Pregnancy	5
Homelessness Prevention	5
Education/GED	4
Child Support	1
Total Pathways Completed	**498**

Pathways Completion

A comparison of the number of persons completing a particular pathway with the number of persons on that pathway provides an opportunity to see which pathways seem easier to complete and to explore possible correlations to systems barriers (i.e. the lower percentage completed = fewer available resources). The average completion rate is 28% {487/1736} for all pathways combined.

It is important to note that the amount of time that the person has been on a specific pathway is not factored into these comparisons however, which could skew the results somewhat.

Level 2 Pathways [*]

Level 2 Pathway	Completed	Enrolled	Percent Completed
Dental Care	11	95	12%
Housing	19	137	14%
Pharmacy/Medications	9	59	15%
Depression	16	90	18%
Vision and Hearing	23	114	20%
Employment	45	200	23%
Health Care Home	55	213	26%
Substance Abuse/Use	10	39	26%
Homelessness Prevention	5	17	29%
Diabetes	9	27	33%
Behavioral Health	31	91	34%
Medical debt	38	110	35%
Heat and Utilities	13	34	38%
Legal Services	25	62	40%
Domestic Violence	39	72	54%
Total	**348**	**1360**	**26%**

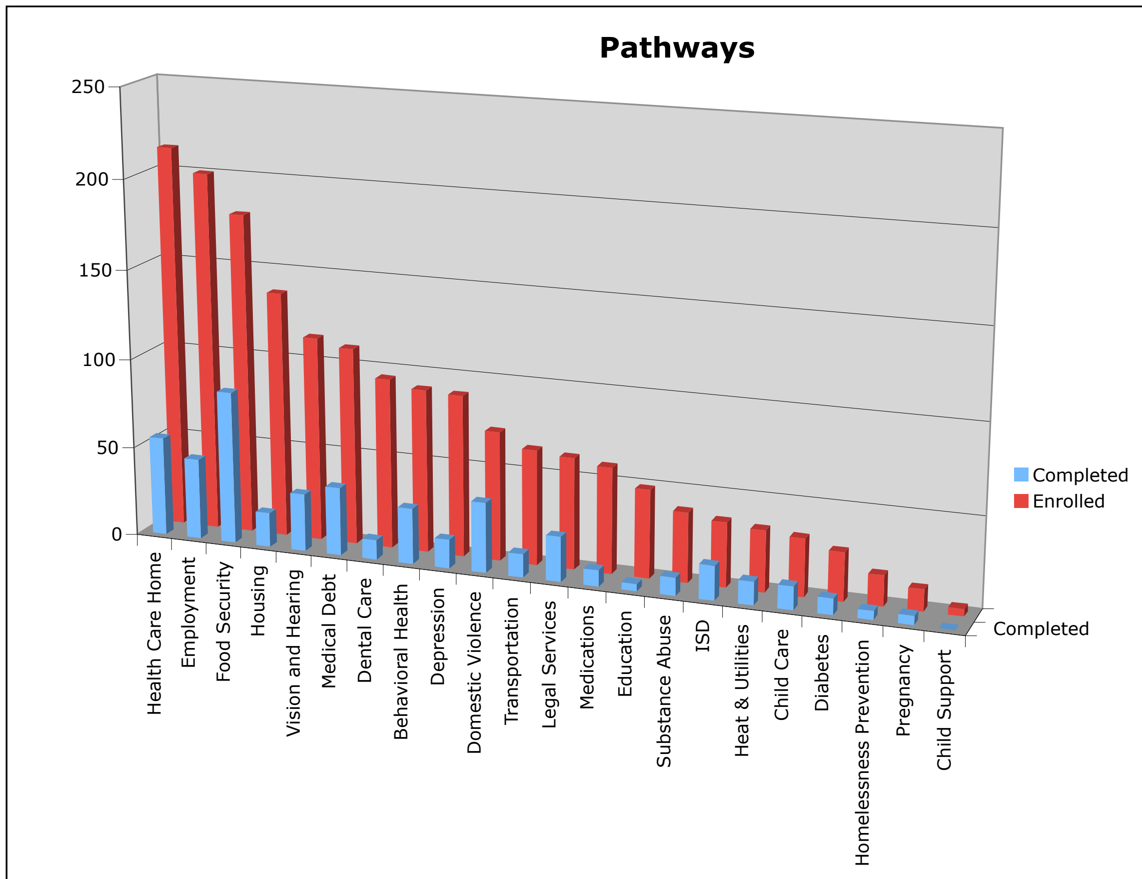
*Level 2 pathways are in general harder to accomplish, therefore it is expected to see a smaller number of completed clients. In addition, several Level 2 pathways such as Housing and Employment will take a

longer amount of time to complete than others due to a variety of reasons. For example, according to the City of Albuquerque's website (http://www.cabq.gov/housing/waitinglist), Section 8 Housing for low income residents is seeing over a two-year wait list for clients to be placed in a home.

Also, with an estimated 8 to 9% unemployment rate in Albuquerque and the fact that nearly 50% of the Pathways participants state that Spanish is their primary language, these factors can make it especially hard for the Navigators to help the client in finding a job.

Level 1 Pathways

Level 1 Pathway	Completed	Enrolled	Percent Completed
Child Support	0	4	0%
Education/GED	4	49	8%
Transportation	13	64	20%
Child Care	13	32	41%
Pregnancy	5	12	42%
Food Security	85	179	47%
Income Support	19	36	53%
Total	**139**	**376**	**37%**



Health Care Home Pathway

As mentioned earlier in this report, one of the primary goals of this Project is to ensure that every Pathways participant establish a health care home prior to completing their involvement with Pathways. The definition of a completed Health Care Home pathways reads as: "*Client has appropriate health coverage or financial assistance program in place to establish a health care home and has seen a provider a minimum of 2 times at their new health care home*". It has been somewhat difficult to determine exactly where each client's health care home is established due to a variety of factors. Bernalillo County sites identified for a health care home to date in this project are as follows:

One Hope Centro de Vida - Located onsite at East Central Ministries (one of the Pathways partners), this clinic opened in September of 2006 and is based entirely on medically-trained volunteers (including UNM HSC staff) from the greater Albuquerque community. The idea to create this clinic started from a Southeast Heights community health fair held in 2003. The community wanted to do something for their health and make health care accessible and affordable to their residents. This clinic is community run and its services are provided by volunteer doctors and dentists.

UNM sites including UNM Hospital, Family Practice clinics, and UNM Psychiatric Center: Many Pathways clients are seen at different UNM sites, including the UNMH Northeast and Southeast Heights clinics, the Family Practice building, the UNM Cancer Center, the Hospital, and others. Generally, most of these sites are not accepting new patients however, UNMH has asked its Care One Program to be the point of contact for the Pathways Project and has resulted in much easier access to care for the pathways clients, whether it be at one of the UNM facilities, or with one of its contracted clinics such as First Choice or First Nations.

First Choice - This is a Federally Qualified community Health Center system (FQHC) that was founded in 1972. First Choice has ten clinics in the area, primarily located in the South Valley, and serves 43,000 patients annually.

First Nations - This clinic is also a Federally Qualified Health Center (FQHC) serving American Indian/Alaskan Native and other populations located in Albuquerque's Southeast Heights area. It was incorporated in 1972, and is the only Title V Urban Indian Health Program in New Mexico. It should be noted that First Nations now has a substantial non-Native clientele.

Casa de Salud – This clinic is located in the heart of the South Valley and is a not for profit, locally run clinic that does not accept insurance. This clinic is focuses on holistic care and provides services such as massage and acupuncture as well as traditional medicine. The clinic broke off from a larger partnership three to four years ago and sees 15-45 patients daily.

While there are several additional health care facilities in the Bernalillo County area, a very limited number of Pathways clients access their health care outside of the sites mentioned above. One exception is the Albuquerque Health Care for the Homeless medical clinic located downtown, but since clients are only eligible for their services while homeless and become ineligible after finding housing, this is not considered a health care "home", but rather temporary access. Other sites include Presbyterian Medical Services' numerous sites around the County, the Veterans Administration Hospital, the Albuquerque Indian Hospital, Albuquerque Health Partners, and other sites.

It is important to note that one of the difficulties in determining exactly where each Pathways client is establishing their health care home is due to the partnership with the UNMH Care One Program. Since many of the clients are now being referred to Care One, their social worker/case manager makes the

determination on where each patient should be referred to, based on their condition. In many cases they are referred out to one of the First Choice clinics, but may very well end up back at UNMH if they have a chronic condition or any other condition that requires more specialized care. The Hub and the Evaluation Team are adding more features to the Pathways database in an attempt to capture this important information more effectively in Year 2.

Year One Summary

Recommendations from the Pathways Partner Organizations

A meeting with the community organizations that are implementing Pathways was held in early June 2010 to gather their feedback on progress toward the four project outcomes; the Pathways model overall, and to make recommendations for improvements.

Partners were asked to discuss and provide responses to four questions. The questions and response examples are as follows:

1. **What signs of progress can you identify for this outcome that occurred in Year 1?**
   - Clients have identified more social services for families
   - Families have learned how to advocate for services for themselves
   - The number of navigators has increased, which has resulted in more services being accessed
   - Clients enrolled in Pathways are benefiting from the services that they are accessing

2. **What has been missing?**
   - Sufficient training for the navigators
   - Not enough promotional materials in Spanish
   - We should consider having some meetings in Spanish and possibly some service announcements on Spanish TV, radio, and newspapers
   - Navigator salaries are too low

3. **What recommendations do you have to address this outcome in Year 2?**
   - Show proof that having a health care home results in better access to care
   - Increase the salaries of the navigators
   - Provide more training and offer orientation and refresher training throughout the year
   - Payment for all Pathways completed and not limited to only 2 pathways per client
   - Consider providing additional funds to organizations whose navigators can serve as mentors to the newer, less experienced ones
   - Improve the specific barrier tracking
   - The Evaluation Team needs to develop a measurement for systems change
   - Collaborate more with legal services for possible pro bono work on behalf of Pathways clients

4. **What suggestions do you have that we should consider in the design of the Request-for-Proposal (RFP) for Years 3 – 6?**
   - Address recurrent barriers and challenges by Navigators
   - Incentives to include secondary agencies' participation in pathways
   - Allow for some of the funds for the Pathways partners to be used to cover barriers at their own discretion
   - More funding needed all the way around
   - Be very specific about eligibility criteria for applicants

Partners then worked in small groups to apply these questions to each of the four community-defined outcomes for Pathways, prioritizing the outcomes that each group preferred to discuss. Groups spent most of the time discussing Outcomes #2 and #3, and examples of their feedback are provided below:

Outcome 2 - People in Bernalillo County will have a health care home

Observations:

- Clients are getting access to a HCH but seeing a doctor is still a problem
- Does getting a health care home actually result in better access?
- Mental health services should be part of the health care home pathway
- All that want a HCH should have one
- Many clients are reporting better health by pathways completion

Limitations:

- MCOs are not being held accountable for the limited number of Medicaid clients that they see
- Many Pathways clients have other problems more urgent than HCH
- Access to healthcare for adults not priority and more difficult to access
- Doctor appointments not readily available
- HCH not viewed as important and due to some of the barriers in accessing care, the client gives up and turns to the ER every time they need care
- No incentive to get clients on a HCH pathway
- No dental services available unless client is homeless (AHCH)

Recommendations:

- Care coordination through the Care One Program for a HCH is working well and should be replicated for other pathways
- Move UNMH Financial Assistance staff to sites such as First Choice and First Nations where they can be enrolled for UNM Care and other programs
- Educating clients on the importance of preventative care
- Tie healthcare in with other needs (ex. being healthy means ability to go to work)
- Implement policy changes where client education becomes billable from Medicaid.
- The Hub should make the HCH mandatory and allow billing for a 3rd pathway

Outcome 3: Health & social service networks in Bernalillo County will be strengthened and more user friendly

Observations:

- Navigators have learned more about utilizing services and understanding what documentation/specific clients will be accepted into service
- Networking within Pathways partners has improved, but more work needs to be done in reaching out to non-Pathways partners
- Monthly meeting allows us to learn about each other and other partners
- Navigator skill set has improved
- The exchange of information among navigators and the partner organizations has increased a lot in this first year
- Awareness of Pathways by the local Dept. of Health staff has increased and trust between providers has been enhanced

Limitations:

- Collaboration among non-Pathways organizations has been limited
- Non-Pathways organizations are less invested in the Pathways model and its success

Recommendations:

- Navigators need more help on how to better navigate systems, especially because the supply cannot be changed
- The Pathways Project needs to be promoted more to external partners/agencies
- Broaden the non-traditional partners of health
- We will need more support from the County once we begin to address the barriers identified
- Provide incentives to non-Pathways organizations as a means to get buy-in from them
- Simplify the mission of Pathways
- Invite non-pathways organizations to the monthly meetings to learn more about Pathways
- Educating other organizations on the benefits of working with Pathways partners

Please refer to Appendix A to review the Summary of Challenges, Barriers & Successes as documented by the Navigators in the Final Reports. This includes both barriers and successes specifically related to UNMH. There are some very compelling success stories that demonstrate examples of just how effective and resourceful the Navigators have been in improving the quality of life for so many of their clients.

Project Management Summary

Overall, a great deal was learned over the first eleven months of implementation. Examples are that client enrollment reached 88% of total expected enrollment for Year 1 (492 active or completed divided by 560 anticipated); the majority of the Pathways-funded organizations have adapted to the Pathways model and are demonstrating competence at moving clients through pathways and reaching benchmarks (as shown by the 498 completed pathways vs. only 154 in the first 7 months of implementation); and the web-based data collection system is functioning well and reported to be very user friendly by Navigators. New features are continually added to the database to improve data collection that more directly related to our four primary outcomes. The technical services contract with the database consultant will be continued in FY11 for this purpose.

Partner organizations are strongly encouraged to look at the Pathways model as unique and different from the services that they have historically provided to their clientele. This has been a challenge for a few of the Pathways organizations and the Hub continues to work with them to break down silos, trust their referral sources, and integrate the Pathways model more into their everyday activities. This attempts to address one of the primary components of this model defined during the community planning process, which is to strengthen collaboration across organizations and to cross-refer and collectively problem solve: "Health and social service networks in Bernalillo County will be strengthened and user friendly".

Two of the original Pathways organizations were unable to adapt to this new model and two additional partners have struggled over the first year. This most likely explains why the goal of working with 560 clients was not achieved over the first year of implementation. The two contracts that were terminated were with Adelante Development Center, which was terminated on March 15, 2010; and Addus Healthcare, which was terminated in April 17, 2010. Contract awards have been adjusted in Year 2 with the additional availability of funds, and the more successful organizations now have larger contracts than they had in Year 1. By the end of June 2010, there was a balance of $31,525.00.

Budget adjustment decisions were made at the end of March to assess whether each organization had spent down a minimum of 60% of their budget. Two partner organizations had under spent their budgets by March 31, 2010 and thus had their original budgets reduced. Three organizations proved to be high performers and received additional funding for the remaining contract period: A New Awakening; East Central Ministries; and the Rio Grande Community Development Corporation (RGCDC) South Valley Partnership. The process to shift funds to high-performing contracts was not completed until late April, however, and meant that the organizations that received budget increases were pressured to find more clients and spend down their additional funds in only a 2-month period. As a result this language has been changed to "by the end of February" in their FY11 Scope of Work.

There has been an unanticipated and unfortunate high turnover rate of Navigators since the Project rolled out and this has not stabilized as of this writing. The Evaluation Team is designing a series of exit interview questions that it will use in Year 2 with all of the Navigators who change their Pathways status. Anecdotally, we know that there were several cases of underperformance, but most were the result of moving on to a better paying position elsewhere. This has also led the Hub to start working on an ongoing training and orientation curricula for the new Navigators. In partnership with UNM HSC's Project ECHO, a series of Navigator trainings are scheduled to begin in early August. The Hub is working to ensure that training and support for new Navigators is timely and sufficient to sustain ongoing project activities.

Monthly Navigator meetings were held throughout the year with training and information that correspond with topics of interest to the Navigators. Speakers were frequently invited to share their expertise with Navigators. Meeting topics and speakers included the following:

- November 2009 - JulieAnn de Kok from the Human Services Department's Income Support Division (ISD) presented on the SNAP and Medicaid eligibility requirements, and Melissa Manlove, COO of First Choice Community Health presented on their services and eligibility requirements.
- December 2009 - John Brown and Julie Rosen from UNM's Project ECHO (Extension for Community Healthcare Outcomes) spoke about the many ECHO disease tracks now offered, and about their new community health worker training curriculum that they are developing and testing. At this meeting the database consultant, Mitchell Steinberg from Ruby Creek Design also attended to allow an opportunity for the Navigators to provide feedback directly to him on the user-friendliness of the database.
- January 2010 - This meeting was used as the Hub and Evaluation Team's first Report-to-the-Community at the South Broadway Cultural Center. Approximately 50 to 60 people were in attendance and the feedback from the audience was mostly positive and complimentary. It should be noted that the second Report-to-the-Community is being scheduled for mid-August.
- February 2010 – Amanda Clearwater, coordinator of the Metropolitan Homelessness Project's Community Voice Mail Program presented on their free voice mail services of which since have been heavily utilized by Pathways clients. Also, Stephen Sanchez from CNM (Central New Mexico Community College) spoke about Adult Education and GED programs offered at CNM. Finally, Dr. Doug Binder and Duly Arenivar from the UNMH Care One Program attended and were introduced to all of the Navigators.
- March 2010 - Gustavo de Unanue, Daniel Dominguez Cantu, and David Espinoza Rodriguez from the Consulado de Mexico spoke about the various programs offered at the Consulate for Mexican nationals residing in New Mexico. Note: to give some of the English-speaking Navigators a little taste of the difficulties of simultaneous interpretation, this particular presentation was done in Spanish with English interpretation.
- May 2010 - speakers from Catholic Charities (Beatrice Villegas), the Mortgage Finance Authority (Catherine Hummel), and Bernalillo County's Housing Programs (Christi Baker) spoke about the

various housing services offered, particularly the Homelessness Prevention-Rapid Re-Housing Programs funded through ARRA Stimulus Funds.

- June – Two attorneys from the NM Center on Law and Poverty (Sireesha Manne and Patricia Anders) spoke about the Public Benefits Programs offered in New Mexico and about Immigrant Rights when trying to access some of these services.

Navigators reported that the speakers have helped them understand more of the available resources out in the community and contact persons with which they can communicate. The Program Manager continues to go out and meet with local organizations that might serve as good referral sources/partners to the Pathways organizations, and slowly more and more people are becoming informed and excited about the potential of the Pathways model for residents of Bernalillo County. A number of non-Pathways organizations have expressed interest and inquired about the next RFP (scheduled for early winter).

In the partner organization's contracts for Year 2, the OCA has inserted an "Emergency Fund" line in the organization's budgets that is equivalent to approximately 3% of the total contract. This fund was created as a result of the Navigator's feedback around the difficulty to come up with some one-time funds to assist the clients with small things like buying bus tokens, an identification card, driver's license, one time co-pays on prescriptions, and other assorted minor expenses. A protocol was developed for the appropriate use of these funds and a $40 cap per client was established.

At the June pathways partner meeting, the Hub made a commitment that in Year 2, in collaboration with the Pathways Community Advisory Group (PCAG), and the navigators and their organizations, we will begin to prioritize and act on some of the barriers, both short-term and long, and of course, based on what we perceive as realistic vs. unrealistic. Discussion and problem-solving about identified barriers will also be incorporated in the monthly Navigator meetings.

Evaluation Team Summary

Project evaluation activities are coordinated through a contract with UNM Health Sciences Center Institute for Public Health. Although it is very early in the project implementation process to have conclusive evaluation data, the evaluation team offered the following discussion regarding progress toward the four project outcomes.

1. **People in Bernalillo County will self-report better health**

The Evaluation Team is embarking on assessment of persons directly receiving Pathways services. With the completion of 10 months of service operations, the numbers of persons participating in several of the specific pathways are now sufficient to permit assessments of outcomes and impacts on health and ability to navigate the health care system.

Follow up interviews for participants receiving Pathways services are being planned and will include use of (a) standardized assessment of general health, (b) re-administration of the Risk Score Assessment instrument and analysis of changes in status, and (c) determination of the extent levels of Pathway completion are maintained over time.

Skills obtained by Pathways clients may benefit others who are close to them such as family, friends, or neighbors in terms of improving access to services. The Evaluation is seeking funding to undertake the interviews needed to test this hypothesis.

It will be difficult to attribute changes of general health status in a population to a single program such as Pathways. Beyond the individuals (or families) directly engaged in Pathways, population-wide improvement in health may accrue to the extent that access to and effectiveness of the delivery system improves and the extent to which social stressors that impact individuals' and population's health can be addressed. Pathways has potential for influencing both of these.

2. People in Bernalillo County will have a health care home

Configuration of clinic services as patient-centered health care homes is a goal of UNMH and other provider systems within Bernalillo County. It is explicitly promoted within national health care reform legislation. While steps are being taken, it is likely to be several years for a broad conversion to occur that will approach an advanced health care home model that would address standards of accreditation and be broadly available. In this context, Pathways' "Health Care Home" goal is decidedly rudimentary, defined merely as engagement over time with at least two visits with a single provider. This acknowledges the reality that the most Pathways clients either have no regular care at all or are receiving only inconsistent, sporadic care. For Pathways clients in the "Health Care Home" pathway, their patterns of usage of services at UNMH can be assessed using administrative databases at the hospital, however, those establishing health care homes at other sites outside of UNMH may be more difficult to ascertain. For example, it will be possible to document before/after patterns consistent with individual care coordination and reductions of emergency usage and make usage comparisons with others who are matched demographically and diagnostically. This is planned for Year 2. Pathways looks forward to considering changes to its current definition of "Health Care Home" as the UNMH moves toward its own goals for medical homes.

3. Health and social service networks in Bernalillo County will be strengthened and user friendly

Notwithstanding the heterogeneity across the various partner agencies, abundant feedback from many of the sites during monthly navigator meetings and quarterly reports document how sites' participation in Pathways has enhanced scopes of service at the level of the specific agencies (moving from categorical to more client oriented), broadened awareness of community resources and services, and generated new referral networks both within and outside the group of partner agencies. The extent to which this impacts non-Pathways clients as well as Pathways clients will be explored in Year 2.

Client follow-up interviews will include a debriefing and qualitative data on access and use of the health services.

4. Advocacy and collaboration will lead to improved health systems

(Note: the Pathways Project came into being via a combination of advocacy and collaboration.) The very existence of Pathways demonstrates the willingness of leadership at UNM HSC to recognize and act upon the interaction between a person's social circumstances and that person's ability to access and successfully engage and benefit from a health care system. Unusual even for most publicly supported hospitals, Pathways does this through active outreach, targeting high risk persons who are outside the health system. Addressing a person's social needs, as Pathways does, requires developing new configuring of strategies and service provision. One example in the Pathways model is the centrality of the community health worker as navigator. It will be several years to determine the impact of the Pathways innovations. Measures will include the extents to which the Pathways model becomes institutionalized and to which attention to a client's social circumstances broadens within health care.

In this first year, we have not otherwise documented systems changes as a result of Pathways. We anticipate any changes will occur in small increments. Pathways navigators see *themselves* changing in terms of their own more effective use of current systems. In addition, they greatly appreciate the specific adaptations that have been made to accommodate Pathways clients within existing systems, for example using Care One at UNMH to bypass the often-extreme lengths of time before clinic appointments might otherwise be scheduled. This worthy accommodation, however, appears to be specific to Pathways and does not represent a system-wide change.

Overall, the OCA, Evaluation Team, and the PCAG are in agreement that the first year of Pathways implementation has been successful in identifying many of Bernalillo County's most disconnected residents and getting them linked up with a variety of health and social services and thus improving their physical and mental well-being. Many systems barriers, some expected and others not, have surfaced as a result of the incredibly resourceful work of the Navigators; and the networking and collaboration, at least among the Pathways partners themselves, has improved dramatically. In Year 2, the OCA will continue to promote the Pathways Project, not only locally, but also state and nationwide. The Program Manager has been reluctant to aggressively promote Pathways too much too soon to avoid inundating the Navigators with unmanageable caseloads. It is our feeling that if there were more funds available to support the local organizations and their Navigators, the potential is great for this model to reach many more of Bernalillo County's most vulnerable populations and continue to connect these County residents to more services, ultimately improving the health of the County as a whole.

Appendix A

Below is a summary of barriers, challenges, successes, and recommendations as documented by the Navigators in the Pathways database. The names of specific organizations identified in the database have been removed for the purposes of distribution to the public. Additionally, the following information has been broken down into thematic areas (i.e. Housing, Employment, etc.).

Challenges at the Systems Level:

- There just aren't sufficient resources available to residents without proper documentation of for those living in extreme poverty (both legal and undocumented)
- "Many employers screen against any criminal history. Our most vulnerable citizens for re-offense have the most difficult time being able to support their families legally. This also applies to housing for individuals with a felony conviction (even if they are gainfully employed). We lock these folks up to do time for their crime and be rehabilitated, yet when they re-enter our community they cannot find employment nor housing nor access to doctors, equating to three strikes and they are back out on the streets violating their probation and committing crimes because they are not given a chance to succeed. This system that we have is creating unsafe communities and is destroying families".
- Clients often lack identification cards, birth certificates, certificates of Indian Blood and are constantly losing their documents. There appears to be an increase in clients with court evictions resulting in more "doubling-up" and an even greater potential for becoming homeless.
- Throughout this year several of the Navigators asked us to expand our services in the South Valley to other areas, Pajarito Mesa in particular. As we began to go out to Pajarito Mesa we soon learned that Bernalillo County does not have the capacity to offer social services to this neglected community. We visited the residents fairly frequently and attempted to offer services, but the lack of resources and poor infrastructure forced us to stop working out there, as we could not be effective. Perhaps in the future we can integrate the pathways organizations with the local government to figure out a way to more effectively utilize and distribute the resources and not forget about the County's most marginalized populations.

Housing-related:

- There is a two-year wait for Section 8 housing. We have helped our clients with the required documents and some have applied but the need is generally for immediate affordable housing.
- Clients are intimidated by the housing applications. Most programs ran out of funding or never had much to begin with. Other agencies couldn't help either because client could not prove how he would pay the next month's rent. Most clients need financial help with the deposits required and overall, there is a general lack of funding for rental and/or utility assistance
- Certain organizations do not have any consistency with their admittance procedures and clients end up getting the "run-around" without ever being able to access their supposed services. Many clients get so frustrated with the extremely long wait to get housing that they end up getting themselves in more trouble than they were at the beginning of the application process.

Health Care-related:

- Clients are having difficulty establishing a Health Care Home at the places with long waiting lists. Completing this Health Care Home pathway has been very difficult and even though clients may get enrolled in UNM Care or already have Medicaid, it seems like every clinic in town are not taking new referrals.

- Many low income clients have incurred unmanageable medical debts that they may never be able to fully pay off. The stress associated with this medical debt is often compounded by collection agencies that continually harass clientele who have defaulted on their payments.
- Regrettably undocumented residents in Bernalillo County are not eligible for the majority of insurance programs offered to low income U.S. citizens and with the exception of occasional charity care and self-pay discount programs, these folks are left to fend for themselves, often putting off needed health care due to their ability to pay. Everyone living in Bernalillo County should have equal access to health care regardless of their immigration status. This is unjust.

Successes:

- Erased $80,727.31 in medical debt from a primary hospital provider in Albuquerque for a heart attack that occurred at work. Even though client was insured by employer for worker's insurance, the insurer claimed it was not an accident. Payment to insurance company has been deducted from paycheck for several years and client was left to pay this outstanding bill on his own. Navigator contacted Financial Services office at the hospital and they stated that nothing could be done because, on-file, he *was* insured. After explaining the case and showing them the insurer's letter of denial, they agreed to cancel the entire medical debt.
- Navigator worked with an entire family where the mother obtained a steady job and a new pair of prescription glasses. The medical debt that the father had incurred for some illnesses was waived, and finally the family has achieved economic and emotional stability, and is very grateful and happy with the assistance that they received.
- A navigator checked in with a former Pathways client to see how she is doing and the client was doing well, working in a job, and even stated that she'd like to rearrange her work schedule to be able to assist as a volunteer with one of the support groups offered by the organization. Another ex-client from the same organization confirmed that she was doing well and is actively working as a volunteer in the church where she was receiving free food several times per month.
- A victim of domestic violence and substance use fled to Albuquerque from another community with her three children, ages 11, 13, & 16. She had nowhere to stay and it was four days before Christmas. Within 24 hours of her arrival the Navigator had introduced her to a potential landlord who took a chance on her and allowed her to move in immediately without having to pay the deposit until she received her social security check two weeks later. The Navigator utilized the Pathways partners and the family received clothes, dishes, furniture, gift cards for food, and even presents for her three children. The client is still doing well, living in the same apartment, and her children completed school and all advanced to the next grade level. The mother and children are still receiving counseling and is doing well thanks to the loving community.
- Although it can be difficult to qualify individuals to receive services, it is nice once they accept their pathways. It is simple and easy to move forward with regard to the documentation being kept at a minimum.
- Participating in Pathways has been a great way to learn about available resources like Community Voice Mail. Meeting with the other Navigators has helped build networking skills and the ability to become a better case manager for the clients. Knowing about program updates from ISD and Housing has been very helpful to the agency overall.
- The Suboxone Program offered at the Casa de Salud has been very beneficial to the clients with opiate addiction. Sometimes it takes several attempts before they can be totally clean, but eventually they get there.

UNMH-related Successes

- A recent client was seen by the UNMHSC nursing students that are at the Storehouse for about six weeks each quarter. The client said she had been diagnosed with congestive heart failure. A Pathways navigator was immediately contacted and the client qualified for Pathways. A call was immediately made to the Care One Program and UNMH (Duly) and the client had an appointment scheduled for financials and to see Dr. Binder the next day. After seeing Dr. Binder she was given an appointment to see her primary care the next week. Dr. Binder also gave her a lab slip the same day.
- We have been taking a Pathways family to the 4th floor of UNMH and they have been given immediate appointments to the Financial Dept. and assigned a primary care provider. They have even been connected to a specialist if required and are overall very friendly and warm.
- A pathways client has been going to the UNMH Cancer Center for treatment. She has been receiving very good treatment and her primary physician has reviewed all of her paperwork and confirmed that she has an aggressive form of cancer. She had surgery to try and remove the tumor and she is currently on chemotherapy and her problem is improving.