Pathways to a Healthy Bernalillo County

Annual Report
July 2013 – June 2014

Office for Community Health
UNM Health Sciences Center

July 2014

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Executive Summary

This is the fifth annual report for the Pathways to a Healthy Bernalillo County Program, and provides a summary of the final year of Phase 2 (Years 3-5) of program implementation. The Pathways Program is administered through the University of New Mexico Health Sciences Center, Office for Community Health (OCH) under an agreement signed between the University of New Mexico Hospital (UNMH) and the Health Sciences Center. Under this agreement, UNMH transfers no less than $800,000 per year for the duration of the mill levy (2009-2017) to the OCH. In turn, greater than 80% (>$660,000) of this amount is contracted out to fourteen (14) community-based organizations in Bernalillo County through a competitive process. The organizations that received funding over this Phase 2, 3-year period [2011-2014] include:

- A New Awakening
- Catholic Charities Refugee Resettlement Program
- Downtown Collaborative
  - Encuentro
  - New Mexico Immigrant Law Center
- East Central Ministries - One Hope Centro de Vida clinic
- Enlace Comunitario
- First Nations Community HealthSource
- Native American Community Academy (NACA)
- Rio Grande Community Development Corporation (EleValle Collaborative)
  - Casa de Salud Family Medical Center
  - Centro Sávila
  - La Plazita Institute
  - PB&J Family Services
  - South Valley Economic Development Center
- Samaritan Counseling Center

Over this past fiscal year (Year 5 of the program), four hundred and fifty four (454) persons enrolled in the program with approximately one hundred fifty five either withdrawing (40) or being inactivated due to difficulty following up with them (115). This equates to an approximate sixty six percent (66%) retention rate, which has been fairly consistent over the first four years of the program. With the transient nature of the population participating in Pathways, the retention rates are very admirable, and demonstrate the persistence of the navigators in their efforts to assure that clients do not fall through the cracks as they attempt to access health and social services. In addition, programmatic changes have been made that place greater emphasis on continuously updating the client contact information over the period that they participate in the program.

A total of four hundred seventeen (417) completed their participation in the program over the course of the past year, which is significantly more than in the prior 2 years of this funding cycle. One thousand twenty (1,020) separate pathways were completed during this period, with Health Care Home (125), Employment (109), Legal Services (106), Behavioral Health (103), and Dental Services (79) topping the list of pathways completed. This indicates that the

individuals achieved the final step (healthy outcome) in a particular pathway. It is worth noting that an additional sixty-seven (67) completed the Education/GED pathway with another sixty-five (65) successfully completing the Housing pathway. This is a great accomplishment given the fact that historically the Dental, Education/GED, Employment, and Housing pathways have had lower completion rates in years past. The Hub will explore with the Navigators some of the possible reasons that this has occurred and build off of this positive momentum.

It is important to note that over the final quarter of this fifth year of funding, the new enrollment activities decreased substantially, as many of the organizations had either spent down most of their budgets in the first three quarters of the fiscal year, or for those who learned in April that their funding would not be renewed through the most recent RFP, they worked hard on finishing up their existing clientele before the end of June. Regrettably this happens toward the end of each funding cycle, as there is always a lot of uncertainty around whether or not the organizations should continue recruiting new clients. Both of these factors had a direct impact on the number of new people being assisted, particularly in the final 3-4 months of funding, while at the same time, resulting in a sizable increase in the number of people completing the program. See Table 1 below:

Table 1: Fiscal Year 2014 Pathways Participation

(7/1/13 – 6/30/14)

	1st	2nd	3rd	4th	Totals
# of "New" Enrollees	116	126	129	79	450
# of Completed Pathways	154	221	254	398	1027
# of Clients Completing Program	76	52	95	194	417

Over this past year, the Pathways Program conducted fifty-four (54) Exit Interviews with participants who had completed the program. To summarize, 84% were either 'completely' (35%), 'mostly' (35%), or 'satisfied' (14%) with the program; 84% either 'strongly agree' (17%) or 'agree' (67%) that what they achieved by completing their pathways will continue to help them; and 70% said that their health had either 'improved' (63%) or 'greatly improved' (7%) compared to when they began participating in Pathways. For more specific information on the Exit Interviews, please refer to pages 8 & 9 of this report.

Another positive result of the Pathways Program that is rapidly evolving as of this writing is a new initiative that our office has developed with Albuquerque Ambulance. A Community Advisory Group (PCAG) member, who works at Presbyterian Healthcare Services, and the Executive Director of Albuquerque Ambulance, which is housed under PHS, approached Pathways to explore collaborative opportunities. They both shared that the paramedics and other EMS personnel have repeatedly expressed their frustrations with their overall inability to help or provide follow-up services to many of the individuals that they transport frequently back and forth to the Emergency Department at local hospitals. Many have voiced the need to have a place that they can refer many of these folks for follow up services.

The original idea was to be able to refer to the Pathways Navigators, but the program manager was reluctant to agree to this since most or all of the Navigators are already maxed out with their client load. Ivette Cuzmar of our office is a LISW and has supervised social work students from both NM Highlands and NM State University. The idea came up that if Ivette could recruit some social work students to do their field placements under her supervision, the students could serve in the role of the Navigators and field referrals from EMS personnel through a coordinated referral system. Ivette and the Pathways program manager have been meeting regularly with a variety of personnel from the Albuquerque Fire Department, Bernalillo County Fire Department, Albuquerque Ambulance, and others, to hash out all of the details for this. Ivette has been supervising a NMSU social work/public health student this summer (2014) who is working with the Executive Director from Albuquerque Ambulance to develop protocols, interagency agreements, criteria for appropriate referrals, and other work to help prepare for a fall rollout. Ivette will be supervising 3 social work students in the fall 2014 and spring 2015 semester, all of who will be working approximately sixteen (16) hours per week for the full school year. The students will be trained on the Pathways model, shadow the Navigators, and then all referrals will be coordinated through Ivette, and ultimately to the social work students for follow-up. We are very excited to be working with the EMS staff and to see how this project evolves over time.

The pilot project, which for now is being called “Connections”, can be described as follows:

EMS providers assess patients in their homes and other environments and have the benefit of direct observations of the patient’s environment and circumstances. This, along with the medical evaluation performed, provides information that often leads to the conclusion that there are physical and/or mental health threats that may exist beyond the immediate medical issue for which EMS has been called. The social service connection process enables EMS to document this information and provide this to the social service liaisons (students), who will connect the individuals in need to the social support services that are required.

Another pilot project starting up through our office and very related to Pathways is the “Integration of Community Health Workers [CHWs] in Primary Care Settings”. The HSC Office for Community Health has recently hired and will be placing CHWs at primary care clinics to work with the health care teams and connect their clients to non-medical community resources. These are being piloted at the First Choice - South Valley Commons clinic, the Pajarito Mesa Mobile Clinic, and possibly at two UNMH clinics in the future. These CHWs will be trained as Navigators and will work closely with the Pathways partner organizations. As part of this effort our office developed a curriculum to train primary care teams to work effectively with CHW's.

In summary, throughout this past fiscal year there have been a lot of changes not only to the Pathways Program, but also to our entire office. Leah Steimel, director, moved on to a new career path in August 2013, and Claudia Medina was hired in February 2014 into the position that Leah vacated, but with a very different focus. The Urban Health Partners name was changed again to the Office of Community Health Initiatives, and our office is now being merged with the CARE NM Program into a new location some time this fall 2014. A new

Pathways RFP was released in January 2014, the independent review occurred in April, and on July 1st four new organizations joined the Pathways network, which regrettably means that four of the organizations funded in Years 3 through 5 will no longer receive funding as of July 1st.

Despite these numerous changes, the Pathways Program has continuously adapted to recommended changes and improved each year to best meet the needs of Bernalillo County residents over its first five years of operation. The program has become more established and recognized in the greater Albuquerque community as well as outside of both Bernalillo County and the State as a whole. A third and final RFP process for this funding cycle was completed in April of this years and as of July 1st, four new organizations have joined the Pathways network: Albuquerque Health Care for the Homeless, Crossroads for Women, Native American Community Academy (NACA), and the New Mexico Asian Family Center.

It is our hope that the program is not only funded again in the next mill levy cycle, but that its budget is significantly expanded so that we can consider increasing the number of "pathways per client" that we reimburse for, support more local community- based organizations and improve the lives of far more residents across the County.

Introduction

Bernalillo County, New Mexico's most populated county, has grown rapidly in the past two decades, requiring the expansion and adjustments to health systems and other social services infrastructures. Regrettably these systems have not been able to keep pace with the increased demand for services, and have thus marginalized a significant portion of the county's residents. According to the United States Census Bureau, the population of Bernalillo County has increased from 480,577 in 1990 to 556,002 in 2000, to an estimated 674,221 in 2013, resulting in an approximate 14% increase in a little more than two decades. Additional demographic characteristics are demonstrated in the table below (Table 2).

Table 2: Characteristics of Bernalillo County

	Bernalillo County	New Mexico
Population, 2013 estimate	674,221	2,085,287
Persons under 5 years, percent, 2013	6.4%	6.7%
Persons under 18 years old, percent, 2013	23.2%	24.3%
Persons 65 years old and over, percent, 2013	13.6%	14.7%
Percent of adults without health insurance	25%	29%
American Indian / Alaskan Native persons, percent, 2013	5.7%	10.4%
Black/African American persons, percent, 2013	3.4%	2.5%
Asian persons, percent, 2012	2.7%	1.6%
Persons of Hispanic or Latino origin, percent, 2013	48.8%	47.3%
White persons not Hispanic, percent, 2012	40.6%	39.4%
Foreign born persons, percent, 2008-2012	11%	9.8%
Language other than English spoken at home, age 5+, 2008-2012	31.2%	36%
Median household income, 2012	$46,200	$42,828
Persons below poverty level, percent, 2008-2012	17.3%	19.5%
Children eligible for free lunch	56%	61%
Ratio of population to primary care providers, 2011	1012:1	1356:1
Percent of adults with inadequate social support	18%	21%

References: http://quickfacts.census.gov/qfd/states/35/ 35001
http://www.countyhealthrankings.org/app/newmexico/2014/rankings/bernalillo/county/outcomes/overall/snapshot

Although many Bernalillo County statistics are better than the State of New Mexico indicators overall, there are large geographic sub-regions within the County, primarily in the southern half (i.e. International District, Far Southeast Heights, South Valley, and Southwest Mesa), where the health indicators are among the worst in the whole state. It is in these neighborhoods, primarily, where the Pathways to a Healthy Bernalillo County Program focuses its efforts. As expected, these neighborhoods coincide with the majority of the Bernalillo County residents participating in the Pathways Program.

Background

The Pathways to a Healthy Bernalillo County Program itself resulted from a nearly 2-year planning effort in 2007-2008 that involved numerous community partners, including advocates, the Bernalillo County Commission, the UNM Health Sciences Center and Hospital staff, local health and social service organizations, and others. The program derived from a care coordination model developed by Drs. Mark & Sarah Redding, two physicians in Ohio, and is now modeled by numerous other partners across the U.S. Its primary purpose here in Bernalillo County is to find the most difficult-to-reach uninsured populations throughout the county and connect these individuals to a variety of health and social services thus improving their health and well-being and ultimately, the health of the County as a whole. This is accomplished through the skills and resourcefulness 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 Program aims to identify, document, and address many of the systems barriers that surface throughout this Pathways process.

It is important to note that the Pathways to a Healthy Bernalillo County Program has been highlighted in the Federal Agency for Healthcare Research and Quality's (AHRQ) Innovations Exchange website (www.innovations.ahrq.gov/content.aspx?id=2933), and is currently one of three pilot sites nationally participating in a National Hub Certification study, which will be discussed in more detail on page 11.

Population Served

Examples of the populations that the Pathways partner organizations focus their efforts on 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 3 hospital and/or Emergency Room visits 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
- History of incarceration, including recently released returning citizens
- Homeless or near homeless
- 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

While the organizations are not limited to focusing specifically on the populations above, it does appear through conversations with the Navigators that these are a pretty accurate description of the people that they have worked with over these first five years.

Below is general demographic information describing gender, primary language, self-reported race/ethnicity, age distribution, education level, participant population by zip code, and method of learning about the Pathways Program (Initial Contact). These data show that the Pathways Program interacts mainly with:

- Women (73%) of which 75% self-identify as Hispanic/Latina
- Individuals whose primary language is Spanish (58%) or English (39%)
- Individuals who self-report as Hispanic/Latino (75%) or American Indian or Alaskan Native (~12%)
- Young to middle aged adults (75% fall within the range of 20 to 49 years of age)
- A high percentage of persons with less than a high school diploma (63%)
- Residents living in the southern part of the County (zip codes 87108, 87105, 87121, & 87123) make up 67% of the participant population; and
- 42% were referred to the program by another agency; 28% by a friend or family member

Results

As noted in the Executive Summary, over this past fiscal year (Year 5 of the program), four hundred and fifty four (454) persons enrolled in the program with approximately one hundred fifty five either withdrawing (40) or being inactivated due to difficulty following up with them (115). This equates to an approximate sixty six percent (66%) retention rate, which has been fairly consistent over the first four years of the program.

A total of four hundred seventeen (417) persons completed their participation in the program over this past year, which is significantly more than in the prior 2 years of this funding cycle. One thousand twenty (1,020) separate pathways were completed during this period, with Health Care Home (125), Employment (109), Legal Services (106), Behavioral Health (103), and Dental Services (79) topping the list of pathways completed. This indicates that the individuals achieved the final step (healthy outcome) in a particular pathway. It is worth noting that an additional sixty-seven (67) completed the Education/GED pathway with another sixty-five (65) successfully completing the Housing pathway. This is a great accomplishment given the fact that historically the Dental, Education/GED, Employment, and Housing pathways have had lower completion rates in years past. The Hub will explore with the Navigators some of the possible reasons that this has occurred and build off of this positive momentum.

Ten of the twenty one pathways identified – income support, food security, legal services, heat & utilities, transportation, domestic violence, driver's license/I.D., vision & hearing, substance use/abuse, and health care home - have over a 60% completion rate and comprise over four hundred eighty of the 1020 mentioned above (47%). On the contrary, housing, child support, pharmacy/medications, education/GED, employment, homelessness prevention, and dental all have a 50% or less completion rate. On a positive note, all completion rates have improved over prior years. For example, see comparisons below on Table 3 for specific pathways completion rates at the end of year 3 (June 2012) vs. the end of year 5 (June 2014):

Table 3: Pathways Completion Rates - Year 3 vs. Year 5

Year 3 (June 2012)	Year 5 (June 2014)
Education/GED – 20%	Education/GED – 43%
Housing – 24%	Housing – 40%
Dental – 27%	Dental – 50%
Employment – 31%	Employment – 46%
Homelessness Prevention – 34%	Homelessness Prevention – 48%

These are all very significant improvements over a 2-year period and reflect the experience, persistence, and community knowledge that the Navigators possess.

As can be expected, the performance over this past year varied from organization to organization (see Appendix A on page 17). While these data clearly demonstrate the overall effectiveness of the program, it is important to note that numbers cannot all be taken at face value, and do not measure important factors such as improvements in quality of life (i.e. decreased stress levels, financial stability, improvements in health (physical, mental, spiritual), etc. Also with a few of our partners, there were organizational challenges such as Navigator turnover, rehiring and re-training, and other factors that non profit, community-based organizations often face. Despite these, approximately four hundred fifteen (415) unduplicated individuals completed their involvement in the Pathways Program over the past year, and one thousand four hundred seventy (1,471) over the first five years of implementation!

As reported in all of our Annual Reports, below is a brief description of how the Pathways Program responds to the desired outcomes defined by the extensive community planning process that preceded the rollout of the program:

Outcome #1: People in Bernalillo County will self-report better health

Over the first five years of program implementation, it has been challenging to conduct post-Pathways interviews with past participants, as so many of them are financially strained and living in difficult situations that creates constant instability in their lives. This can be demonstrated by two examples from our risk score questionnaire, which help explain why this has been such a challenge over the past five years: Greater than 42% of the participants at the time of entering the program, answered 'yes' to the question "Have you lived in more than 3 places in the past year"?; and 39% answered 'yes' to the question, "Do you lack a phone number where you can reliably be reached or receive messages"? In response to this, our office began conducting exit interviews by telephone with as many participants as we could track down near or shortly after they complete the program.

Over this past fiscal year, fifty-four (54) Exit interviews have been conducted to assess the short-term impact that the Pathways Program had on their lives. This averages out to an approximate 12% sample population of persons who completed their participation in the Pathways Program over the past year. While not ideal, this is certainly not due to a lack of

effort. The phone interviews are conducted solely by Kelly Morantes, a member of our office, and this is not a function even written into her job description, therefore, our office is pleased that we were able to attain a 12% sample size. Kelly has shared that many of the individual's phone numbers had already been disconnected and/or they had moved from the location documented in the database at the beginning of their participation. Below are some of the general results taken from the Exit Interviews:

- 84% were either 'completely' (35%), 'mostly' (35%), or 'satisfied' (14%) with the program
- 84% either 'strongly agree' (17%) or 'agree' (67%) that what they achieved by completing their pathways will continue to help them
- 70% said that their health had either 'improved' (63%) or 'greatly improved' (7%) compared to when they began participating in Pathways
- 83% said that since their participation in Pathways, they had not gone to the Emergency Room or been admitted to a hospital at least once. **Note**: This question differs from a similar question at the time of enrollment ("Over the past 12 months, have you gone to the emergency room or been admitted to the hospital three times or more"?), of which 45% answered 'yes' to.
- 93% said that they had a place to live at the time they were exiting the program
- 76% said that they were able to help others with information and resources that they learned about by participating in Pathways
- 83% said that they had a better understanding of how to access health and social services as a result of their participation in Pathways.

Overall, these are very positive responses and point to the many accomplishments that cannot necessarily be measured in dollars as much as it can in Improvements in people's lives, which is really what the Pathways model aims to achieve, and that over time, should result in a healthier Bernalillo County.

Our office has struggled with finding a balance on how many completed pathways per participant we should reimburse our partner organizations for. Currently we reimburse for 3 completed pathways per participant, which averages out to approximately $1,500 to $1,600 per person. For each additional pathway that we reimburse for, it would equate to approximately $450 to $500 more. While this would certainly have a positive impact on the individuals being assisted, it would also result in far fewer County residents being reached. This is an ongoing discussion that will be revisited if the program is expanded.

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

Over the course of the first five years of the program, eight hundred eighty five (885) unduplicated persons (~35% of total) worked on the Health Care Home pathway, with a total of five hundred forty two (542) completing the final step (healthy outcome) of the pathway. The final step is defined as, *"CHN confirms that the client has seen a provider a minimum of 2 times and that client has established a comfortable relationship with the provider, has confidence in*

asking questions, is treated respectfully, received whole-person care, and understands follow-up treatment plan if applicable." This final step definition changed over this past year due to the findings in the Urban Health Partners report that was released in the fall 0f 2013, "Health Care Home: Experiences and Criteria in the Pathways to a Healthy Bernalillo County Program". It was the Navigator's feeling that the above definition more accurately reflects the true meaning of a health care home.

The Health Care Home pathway is still the most commonly used among all twenty one pathways, with Employment a close second at eight hundred thirty three (833); Housing at five hundred forty six (546); Behavioral Health at five hundred twenty four (524, and Legal Services at five hundred (500) rounding off the top five. Over the past year, one hundred fifty (150) participants worked on this pathway with one hundred twenty two (122) completing the final step.

In terms of where the Pathways participants completed and establish their health care homes, below are the top five clinics in order:

1. One Hope Centro de Vida @ East Central Ministries (157)
2. First Nations Community Healthsource (62)
3. UNMH Family Health Clinic - Southeast Heights (53)
4. UNMH Family Health Clinic – 1209 University Ave. (52)
5. Casa de Salud Family Medical Office (44)

Regrettably a significant number of Pathways participants are either not eligible for or cannot afford to take full advantage of the Federal Affordable Care Act. Through anecdotal information, the Navigators have shared that many people, if they feel relatively healthy, are not interested in establishing a health care home for fear of incurring a medical debt that they cannot afford. There are still tens of thousands of Bernalillo County residents that will remain dependent on a countywide safety net even after full implementation of the Affordable Care Act. It is our understanding that this is an important part of the discussions being held by the Bernalillo County-appointed Health Care Task Force as we all approach the next mill levy vote in November 2016.

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

There has not been a lot of activity in actually measuring this third goal over the past year. The Hub has witnessed first hand, the high level of collaboration among the Pathways Navigators, not only at the monthly meetings, but also at additional community-based trainings and activities. The three Albuquerque-based case managers from the Care NM program have begun to regularly attend the Pathways Navigator meetings and related trainings, the 3 social work interns that will be working with our office in the Fall 2014/Spring 2015 semesters will be regularly attending these meetings as well, and the two Well Rx Navigators that will be housed at the First Choice-South Valley clinic will also be regularly interacting with the Navigators.

With the completion of this recent round of applications for funding, the Pathways Program will have partnered with and funded, at least temporarily, a total of twenty-four (24) different community-based organizations here in Bernalillo County, including nine that have participated since the program began in 2009. These organizations include:

- Adelante Development Center
- Addus Health Care
- Albuquerque Health Care for the Homeless
- A New Awakening *
- Casa de Salud Family Medical Office *
- Catholic Charities Refugee Resettlement Program
- Centro Sávila
- Crossroads for Women
- Cuidando Los Niños
- East Central Ministries *
- Encuentro
- Enlace Comunitario *
- First Nations Community Healthsource *
- Hogares, Inc.
- La Plazita Institute *
- Native American Community Academy (NACA)
- New Mexico AIDS Services
- New Mexico Asian Family Center
- New Mexico Immigrant Law Center
- PB&J Family Services *
- Rio Grande Community Development Corporation *
- Samaritan Counseling Center
- South Valley Economic Development Center *
- The Storehouse

* Organizations that have participated in Pathways from the start

In this most recent round of applications for funding, there were a total of fourteen applicants of which eight (8) were awarded funding. Among the fourteen applicants, there were four applications proposing a collaborative, or more than one organization included in the application. Two of the four collaborative applications were awarded funding, but this also clearly demonstrates that more and more organizations are opting to partner and submit joint applications rather than competing against each other. This obviously has some risks, but the fact that organizations serving similar populations are now talking to each other about streamlining services, avoiding duplication, and partnering to more effectively reach their

specific clientele, is precisely what the Pathways community planning partners were envisioning when they identified this as one of the four primary goals for the program.

Outcome #4: Advocacy and collaboration will lead to improved health systems.

This outcome has consistently been the most difficult to address for a variety of reasons. Over the first five years, the Navigators have documented more than three hundred thirty separate barriers that they have encountered in assisting their clientele. Many of the barriers documented are systemic in nature (e.g. poor training of front line staff, organizational policies that are prohibitive rather than welcoming and/or restrictive to certain populations, unreasonably long delays in scheduling appointments, language barriers, etc.). When the barriers documented are queried, there are several institutions, both local and state, that rise to the top in terms of number of times they have been documented.

The Navigators, with very good reason, have been asking why the Hub requests that they take the time to document barriers in the database when relatively no changes or improvements for their clients have resulted from this. This is a legitimate concern that the Hub has discussed with the Pathways Community Advisory Group (PCAG) and others. As a result, the Hub inserted strong language into the most recent Request for Proposal that will "require" the directors as well as the Navigators to participate in systems change work over the next 3 years so that we can be responsive to the community defined goals as well as to the Navigators. The Hub has been meeting with a national organization called Building Movement, who has agreed to help organize a specific step-by-step plan to begin working collectively on one or more of the systemic problems identified over the past five-plus years.

Pathways Promotion & Outreach

As mentioned in prior reports, the program manager has taken the lead in coordinating a class on the main UNM campus, in collaboration with the Health Education Program, now titled, "Introduction to Health Education and Multicultural Health Beliefs". The Pathways Program Manager has served as the primary point of contact for this class, which had 24 students last fall semester and now has 36 registered for this current fall 2014 semester. The goal of this course is to expand the Pathways model by exposing these students to the social determinants of health over the first semester, preparing them for field-based experiences as "Navigators", pairing them up with a Navigator as a mentor, and placing them out in a variety of community settings in the following spring semester to expand the work of the Navigators and reach more people in Bernalillo County.

Pathways Hub Certification Pilot Program

Our Pathways Program was one of three selected nationally to participate in a Hub Certification Pilot study funded by the Kresge Foundation and led by the Rockville Institute in Rockville, MD and the Georgia Health Policy Center. Our program received a site visit in mid-November from the national team as part of the initial implementation of the program. We have received preliminary feedback from that site visit, and just recently attended a national meeting in

Chicago where many of the changes that have been made since their three site visits to the pilot sites were introduced to the group. As this demonstration program evolves, we hope to provide more information in future reports.

As part of this pilot program, what were approximately forty eight (48) Pre-Requisites and Standards have been pared down to eleven (11) Pre-requisites and twenty one (21) Standards with which we are expected to comply. Several of them might not be appropriate for our program, as they specifically relate to reimbursement from Managed Care Organizations, specific community health worker (CHW) training competencies that do not all align with the competencies that the State of New Mexico is in the process of developing, and may require rewriting a large number of our pathways and their specific steps. Our program will continue to participate in this pilot study now finishing up its second year of a 3-year funding period, and offer recommendations for improvement.

Sample of Navigator Success Stories

In each report it is important to include some of the many positive success stories that have come out of the Pathways Program over the past five years. As mentioned earlier in this report, it is sometimes very difficult to "quantify" the dollar value of such stories, but vitally important for the public to see how this program has impacted the lives of many Bernalillo County residents. Below are samples of these stories over this past year of funding. A larger list can be made available upon request.

- XXX, a refugee from a Sub-Saharan African country was finally able to find employment. After being a client for almost 4 years, numerous places were not able to hire her/him because of the language barrier. Our case manager worked closely with a caregiver facility and was able to advocate on behalf of our client. Pathways allowed Catholic Charities to follow up with supportive services such as ESL, counseling, transportation and financial literacy to ensure that client reaches self-sufficiency.
- We were able to work with a pregnant immigrant woman and also a mother to a young infant with no place to go. Through Pathways we were able to get her connected to food stamps, TANF and Medicaid. Upon receiving Medicaid, she was able to obtain vaccinations and pre-natal care as well as her application for her employment authorization document (EAD). She was also helped with budgeting and placed in an apartment.
- Client was referred from FNCH Homeless Outreach Program needing immediate housing. The Navigator (CHN) was able to work with client and secure housing through client's friends. The CHN referred client to FNCH Full Circle for CIB, Medical, and Dental services. Client was able to receive care within 2 weeks for all services. The CHN and client made an action plan for employment. However, client decided since he secured housing he will start taking classes at UNM. The CHN started an education action plan with client, and referred client to appropriate UNM services for registration and financial aid assistance. Client started classes in the 2014 spring semester at UNM.

- A client who had been working tirelessly in her job seeking efforts was finally able to secure a job and maintain it. As of this writing, she has been there for 5 months and has been happy to have consistent employment.
- Another client was finally able to receive adequate, affordable medical care in an environment where she felt respected and treated with dignity. This is the first time she reports this happening since she has been living in the United States.
- Three clients were able to take care of dental problems that they had – one due to Medicaid enrollment and thanks to reasonable prices or no charge at Community Dental Services, Inc. and Perfect Teeth. Additionally two clients were able to get their teeth cleaned for free at High Country Dental at their dental clinic in April.
- One of my clients who has lived in Bernalillo County for many years, went to visit her partner in Arizona and they both made plans to move in together. On one of the visits to Arizona her partner became very aggressive and severely beat her. He also took away her car keys so that she couldn't escape. At one point, she took advantage when he wasn't paying attention and fled. Fortunately she had a spare key and drove away in fear with the intent of returning to Albuquerque. Being so frightened and panicked, she was stopped by the police and was not able to produce either a driver's license or vehicle registration. As a result she was given multiple fines and was required to show up in an Arizona court at a later date. Her license was temporarily suspended. When she came to our agency, she was very afraid, stressed, and unsure what to do. Her partner continued to call her and send her threatening text messages. The fines that she had incurred were very expensive and she could not afford to pay them. To begin, we filed a temporary protective order (5 years) to ensure her safety, and then contacted the State of Arizona, sent them verification that she had both a driver's license and vehicle registration, and were able to have the fines significantly reduced. With the Pathways Emergency Funds, we were also able to reactivate her driver's license here in New Mexico. Her current situation has improved considerably.

Sample of Systems Barriers

- Client has been attempting to make an appointment at the Mexican Consulate to get her matricula consular for over a month. She states that she has called many times, but that nobody answers the phone. The website to make an appointment online has been under construction for this time as well. Client has been unable to make an appointment in person. Client urgently needs a matricula consular so that she can get her State of New Mexico ID so that she can take out a work permit to sell food, generate her own income, and leave the domestic abuse situation in which she finds herself. The Mexican Consulate has written on its website (translated into English): "The primary objectives of the Mexican Consulate are to facilitate your assimilation into your new place of residence, anywhere in the world and to help you maintain your contact with Mexico, your traditions and your language. The goal is to help and improve the quality of life for Mexican communities outside of Mexico". "It is difficult to see how the Mexican Consulate can claim to be living up to its promise to the community when they

make it so incredibly difficult for one of their own citizens to obtain a basic form of identification."

Note: Casa de Salud navigators have been successful in scheduling appointments for clients because we have a contact in the administrative office. Clients are able to walk into the consulate, present our business card, and receive immediate and courteous service. Mexican citizens and residents should not have to have a back door connection to receive basic services such as appointment scheduling for IDs and to be treated with dignity.

- There were several separate cases cited of barriers that the Navigators and their clients experienced at the NM Motor Vehicle Division. These included mixed messages (required to set up a second appointment to provide additional documents that were apparently fine at the first visit); poorly trained staff that are discourteous and make it especially difficult for non-English speaking clients to obtain their I.D.'s or driver's licenses, supervisors who aren't even familiar with their own policies, and others.
- Several other systems barriers were cited centering on the Income Support Division, Human Services Department. These included clients experiencing ongoing difficulties and delays in obtaining both Medicaid and SNAP (food stamps); online registration requirements when a high percentage of the Pathways participants do not have access to nor understand how to use computers; lengthy call-center waiting times where clients are often disconnected after waiting more than 15 minutes; numerous clients receiving letters from ISD stating their benefits had been cancelled, when that was not the case at all, etc.
- Finally, several other barriers cited pertained to UNMH. These include:
    - "There is a lack of communication/follow-up for referrals made between the Albuquerque Indian Health Service and UNM Hospital. Clients must repeatedly follow-up with their PCP to ensure referrals for specialty care have been submitted, schedule their own appointments, and file their own insurance claims. Clients have reported that IHS and UNMH providers are rude to clients and have not been delivering adequate care. Additionally, IHS Contract Health and the UNM Native American Liaisons are not educating/assisting clients with financial support. Clients have reported it is very difficult to the navigate system and it is extremely time consuming. Each specialist waitlist is 2-3 months and over 8 months to establish as a new patient with the Indian Health Service."
    - The UNMH Financial Services programs and policies are exclusionary to certain populations. Representatives are poorly trained and largely uninformed of current financial services policies. Individual financial services offices do not communicate with one another, and client payments are often lost, resulting in accounts being sent to collections, even while client is continuing to make payments. Staff (including supervisors) are largely discourteous and do not treat clients with respect in person or over the phone. These barriers have been overcome at times through extensive work and advocacy on the part of the Navigator, as well as through the personal connections a particular Navigator may have. For Bernalillo County residents to receive policy-compliant care at

UNMH Financial Services, Navigators should not have to have to name drop and educate representatives on their own policies".

Additional Comments from the Pathways Program

The Program Manager has been collaborating very closely with the NM Dept. of Health Office of Community Health Workers and serves as co-chair of the NM Community Health Workers Advisory Council. Because of the implementation of the Affordable Care Act and a recent ruling by the Centers for Medicare & Medicaid (CMS) regarding possible Medicaid reimbursement for preventive services offered by community health workers (CHWs), there is a great deal of interest statewide and nationally from health clinics and other organizations that hire community health workers (CHWs) to establish a statewide certification program. The Program Manager actively serves on the New Mexico Community Health Workers Advisory Council and has been highly involved in the planning and eventual roll out of the voluntary statewide certification program.

As mentioned in the prior report, Pathways has contracted with Sara Nelson from Soda Creek Consulting to develop several training modules that will be designated for the Pathways Navigators and also contribute to the statewide certification efforts. Sara has completed the draft versions for all three training modules requested under the contract and the materials, activities, and overall content have been very well received by the reviewers. The pilot trainings have slowly begun, and the State Office of Community Health Workers, along with the NM Department of Health Legal Team are finalizing the rules required through passage of the New Mexico Community Health Worker Act. The rules should be available for public comment by September and the official implementation of the certification program is scheduled to be in place by January 2015.

Conclusion

Overall, the 5th year of Pathways to a Healthy Bernalillo County was successful and challenging, as we completed the final RFP process under this current funding cycle, four of the participating organizations in Years 3 through 5 were not refunded, and four new organizations have started as of July 2014. Over the past year, we continued to fine-tune the data collection efforts, added new features to the database, and strengthened communication with both internal and external partners.

As the County-appointed Health Care Task Force wraps up their meetings and discussion prior to making recommendations for the County Board of Commissioners' approval, we are optimistic that both the general public and the County Commission has seen the incredible value of the Pathways Program and will see fit to propose expansion of Pathways in subsequent years. More than two thousand five hundred (2,500) people have participated in Pathways in its first five years of operation. Appendix B on page 18 demonstrates the number of

unduplicated persons that have completed each pathway over the first five years of this program, including five hundred forty two (542) acquiring a health care home; three hundred eighty five (385) accessing behavioral health services; three hundred sixty six (366) securing gainful employment; three hundred forty nine (349) gaining access to legal services; and one hundred ninety eight (198) finding an affordable place to live. It is evident from this chart the powerful impact that the Pathways Program has on the people it serves. It is our intent over this next fiscal year to gather and videotape and record client testimonies about how Pathways has affected their lives in a positive way.

Upon completion of this report and the presentation to the UNMH Board of Trustees, the Pathways Program will be coordinating its fifth Report-to-the-Community sometime in the fall. This program will remain an integral part of the class curriculum being taught on the main campus and we will continue to explore different venues, both local and national, to highlight the successes of this unique community-based program.

Appendix A

Breakdown by Organization of Pathways Accomplishments (July 2013 – June 2014)

Partner Organizations	Number of New Clients	Clients Completed	Pathways Started	Pathways Completed	Top 3 Pathways Completed
A New Awakening	31	26	93	79	Employment – 25 Housing – 22, Substance Use - 8
Casa de Salud Family Clinic	43	15	153	65	Behavioral Health - 14 Employment, Food Security - 9
Catholic Charities	31	27	95	60	Income Support - 12 Health Care Home - 11, Disability Income, Empl. - 7
Centro Sávila	34	24	102	85	Behavioral Health - 17 Legal - 16, Food Security - 12
East Central Ministries	35	51	116	131	Health Care Home - 30 Dental - 27, Vision & Hearing - 16
Encuentro	20	46	90	75	Education/GED - 13 Vision & Hearing – 12, Hlth Care Home, Dental - 10
Enlace Comunitario	49	33	114	74	Legal - 23 Behavioral Health - 18, Housing, DV - 9
First Nations Community Healthsource	50	14	136	49	Health Care Home - 9 Housing - 8, Behavioral Health - 6
La Plazita Institute	23	24	60	58	Food Security - 14 Employment - 11, Educ./GED - 9
Native American Community Academy	35	22	71	38	Education/GED - 7 Employment - 6, Food Security - 4
New Mexico Immigrant Law Center	24	43	101	78	Food Security, Legal - 12 Health Care Home, Dental - 10
PB&J Family Services	17	39	59	82	Employment – 13 Behavioral Health - 10, Legal - 9
Samaritan Counseling Center	31	31	93	79	Legal - 16 Health Care Home - 13, Educ./GED -12
South Valley Economic Dev. Center	31	20	108	67	Vision & Hearing - 13 Legal - 12, Dental - 8
Total	**454**	**415**	**1391**	**1020**	

Appendix B

Number of Pathways Completed
FY10 – FY14

Pathway	Definition of Final Step (Completion)	Number of Persons Completed
Health Care Home	CHN confirms that the client has seen a provider a minimum of 2 times and that client has established a comfortable relationship with the provider, has confidence in asking questions, is treated respectfully, received whole-person care, and understands follow-up treatment plan if applicable	**542**
Behavioral Health	Client has appropriate health coverage or financial assistance program in place to establish behavioral health care home and has seen a behavioral health specialist a minimum of 3 times. Client reports that they are no longer experiencing the negative symptoms that before, interfered with their quality of life	**385**
Employment	Client has found consistent source[s] of steady income and is gainfully employed over a period of 3 months	**366**
Legal Services	Client reports that legal issue has either been resolved or that their current legal situation has significantly improved	**349**
Food Security	Client has achieved food security and has had over the last 3 months, access to a minimum of 2 hot meals per day	**321**
Vision & Hearing	CHN confirms that client completed services and has obtained affordable new pair of glasses, hearing aid, or other needed services	**259**
Housing	CHN confirms that client is placed and has moved into an affordable housing unit for a minimum of 2 months	**198**
Dental Home	Client has appropriate dental health coverage or financial assistance program in place to establish a dental care home and has seen a dentist a minimum of 2 times at their new dental care home	**193**
Medical Debt	CHN confirms that client is now able to manage outstanding or remaining debt and reports less stress related to their medical debt. Client understands what is covered under their financial assistance plan and has a record keeping system to manage medical bills	**174**
Education/GED	CHN confirms that client has completed the course or term and has established a plan to fulfill their educational goals	**159**

Transportation	Client has full understanding of, and over the last 3 months, has accessed transportation routes across Bernalillo County	**140**
Income Support	Client has received a debit card with available assistance	**136**
Heat & Utilities	CHN confirms that client is receiving the necessary assistance to keep all appropriate utilities turned on and functioning for a minimum of 2 months	**121**
Domestic Violence	CHN confirms that client understands her own abilities and the effects of domestic violence in hers and her family's lives. Client is in a place that is safe and free from domestic violence, and sustains mental and physical health	**100**
Driver's License/I.D.	Client received and has in his/her possession the appropriate I.D. card	**81**
Substance Use/Abuse	Client reports that treatment plan was successful and CHN confirms that client attended at least 75% of sessions	**77**
Homelessness Prevention	CHN assures that the client has obtained and maintains stable housing for no less than 3 months	**60**
Disability Income/Appeal	CHN confirms that client is receiving SSI (Medicaid) or SSDI (Medicare) check and assists client with choosing appropriate medical provider if eligible OR If client's application was denied, CHN assists client with appeal process and teaches client how to file a proper appeal if denied a second time	**42**
Child Care	Client has children enrolled in a licensed, safe, and affordable child care setting for a minimum of 3 months and parent is knowledgeable on requirements for retaining children on site and communicates regularly with day care staff	**28**
Pharmacy/Medications	Client has overcome barriers to accessing a pharmacy and has, at a minimum for the last 3 months, received all necessary medications at an affordable rate	**18**
Child Support	CHN confirms the client has consistently received child support payments for a minimum of 3 months	**17**

CHN = Community Health Navigator

Appendix C

Pathways Enrollment Trends
FY10 - FY14

Year One
(7/1/09 – 6/30/10)
Number of Enrollees by Quarter
Number of Completed Pathways by Quarter
Note: Database went live in mid-November

	1st	2nd	3rd	4th
# of "New" Enrollees	N/A	179	214	204
# of Completed Pathways	N/A	N/A	111	333
# of Clients Completing Program	N/A	N/A	5	62

Year Two
(7/1/10 – 6/30/11)
Number of Enrollees by Quarter
Number of Completed Pathways by Quarter
Number of Clients Completing Program

	1st	2nd	3rd	4th
# of "New" Enrollees	137	142	184	69
# of Completed Pathways	227	170	138	193
# of Clients Completing Program	130	107	108	93

Year Three
(7/1/11 – 6/30/12)
Number of Enrollees by Quarter
Number of Completed Pathways by Quarter
Number of Clients Completing Program

	1st	2nd	3rd	4th
# of "New" Enrollees	156	141	158	76
# of Completed Pathways	122	168	247	283
# of Clients Completing Program	81	52	76	95

Year Four
(7/1/12 – 6/30/13)
Number of Enrollees by Quarter
Number of Completed Pathways by Quarter
Number of Clients Completing Program

	1st	2nd	3rd	4th
# of "New" Enrollees	115	110	121	65
# of Completed Pathways	188	179	265	317
# of Clients Completing Program	69	71	72	79

Year Five
(7/1/13 – 6/30/14)
Number of Enrollees by Quarter
Number of Completed Pathways by Quarter
Number of Clients Completing Program

	1st	2nd	3rd	4th
# of "New" Enrollees	116	126	113	69
# of Completed Pathways	154	221	252	360
# of Clients Completing Program	76	52	95	172

Appendix D

Pathways Financial Report
Thru 6/30/14

Community Contracts:

Organization	Amount of Contract	Expenditures 6/30/14	Percent Spent (%)
A New Awakening	$68,000	$67,885	99%
Catholic Charities	$50,000	$46,985	94%
East Central Ministries	$70,000	$70,000	100%
Encuentro	$92,000	$92,000	100%
Enlace Comunitario	$60,000	$59,997	100%
First Nations	$50,000	$50,000	100%
Native American Community Academy	$45,000	$34,095	76%
Rio Grande Community Dev. Corp.	$240,000	$240,000	100%
Samaritan Counseling Center	$60,000	$60,000	100%
Totals	**$735,000**	**$720,962**	**98%**

Professional Services:

Organization	Amount of Contract	Expenditures 6/30/14	Percent Spent (%)
UNM Institute for Social Research	$30,000	Transferred to ISR Index Code	100%
Ruby Creek Design (Database)	$10,000	$9,956	99%
Soda Creek Consulting	$43,700 Note: $8700 from the UHP index code	$41,417	95%
Totals	**$83,700**	**$81,373**	**97%**