Pathways to a Healthy Bernalillo County

Annual Report
July 2014 – June 2015

Office of CHW Initiatives
UNM Health Sciences Center

July 2015

Table of Contents

	Page
Executive Summary	1
• Table 1: Fiscal Year 2015 Pathways Participation	2
Introduction	4
• Table 2: Characteristics of Bernalillo County	4
Background	5
Population Served	5
Results	6
• Table 3: Pathways Completion Rates - Year 5 vs. Year 6	7
• Table 4: Top 10 Pathways Completed – Years 1, 2, & 3 vs. Years 4, 5, & 6	8
• Outcome #1: People in Bernalillo County will self-report better health	8
• Outcome #2: People in Bernalillo County will have a health care home	10
• Outcome #3: Health and social service networks in Bernalillo County will be strengthened and user friendly	11
• Outcome #4: Advocacy and collaboration will lead to improved health systems	12
Pathways Promotion and Outreach	13
Pathways Hub Certification Pilot Program	13
Sample of Navigator Success Stories	14
Sample of Systems Barriers	15
Description of Program Expansion & Innovation	16
• Expansion of Current Efforts	17
• Support Education = Health Initiative	
• Provide “In-reach” to incarcerated Persons at MDC and Navigation Services as they are released as Returning Citizens Returning Citizens	18
• Improve Quality Assurance	19
Program Outcomes	19
Additional Comments from the Pathways Program	20
Conclusion	20

Appendix A - Breakdown by Organization of Pathways Accomplishments 22

Appendix B - Number of Pathways Completed 24

Appendix C - Pathways Enrollment Trends 26

Appendix D - Pathways Financial Report 28

Executive Summary

This is the sixth annual report for the Pathways to a Healthy Bernalillo County Program, and provides a summary of the first year of Phase 3 (Years 6-8) of program implementation. The Pathways Program is administered through the University of New Mexico Health Sciences Center, Office of Community Health Worker initiatives (OCHWI) 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. Over this past fiscal year, the program had contracts with community partner organizations totaling $730,000.

Over this past fiscal year (Year 6 of the program), five hundred and sixty five (565) persons enrolled in the program with approximately two hundred nineteen either withdrawing (53) or being inactivated due to difficulty following up with them (166). This equates to an approximate sixty-one percent (61%) retention rate, which has actually decreased slightly over this past year. This can possibly be attributed to the addition of several new organizations and Community Health Navigators over this past year, and will be monitored closely over this next year of funding. With the transient nature of the population participating in Pathways, these retention rates are still 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.

Over the past year, greater than two hundred forty participants (243) completed their involvement in the program. Nine hundred twenty eight (928) separate pathways were completed during this period, with Health Care Home (108), Income Support (91), Legal Services (89), Employment (72), Dental (60), Housing and Behavioral Health (59), and Education/GED & Vision & Hearing (57) topping the list of pathways completed. This indicates that the individuals achieved the final step (healthy outcome) in a particular 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 is encouraged by this new development and 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 sixth year of funding, the new enrollment activities decreased substantially, as many of the organizations had spent down most of their budgets in the first three quarters of the fiscal year. This has been a common occurrence in the final quarter of funding for every year since the program began. See Table 1 below:

Table 1: Fiscal Year 2015 Pathways Participation

Year Six
(7/1/14 – 6/30/15)

	1st	2nd	3rd	4th
# of "New" Enrollees	150	166	154	97
# of Completed Pathways	127	213	266	321
# of Clients Completing Program	36	46	59	102

Over this past year, the Pathways Program conducted fifty-three (53) Exit Interviews with participants who had completed the program. To summarize, 100% were either 'completely' (43%), 'mostly' (38%), or 'satisfied' (19%) with the program; 94% either 'strongly agree' (13%) or 'agree' (81%) that what they achieved by completing their pathways will continue to help them; and 90% said that their health had either 'improved' (64%) or 'greatly improved' (26%) 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 began in October 2014 is the Connections Program, a new initiative that our office has developed with Albuquerque Ambulance. Ivette Bibb of our office is overseeing this program and is supervising social work students from both NM Highlands and NM State University to follow up with individuals on referrals made by the paramedics out in the field. The students commit to a full year internship in the role as a social service liaison (quasi-Navigator) under Ivette's supervision. All of the students receive training on the role of a Community Health Worker (CHW), the Pathways model, and have opportunities to shadow the paramedics out in the field as well as the Navigators at their sites.

As this program has rolled out, we have learned a great deal about the 911 system and have continually modified the program as time goes on. The social work students make every effort to follow up with the referrals made by the paramedics out in the field, but have learned (the hard way) that many people, although frequent users of the 911 system, have no interest in receiving assistance from the students. This of course, does not apply to everyone and for those who are willing and request assistance, the students conduct home visits and try and connect them to the necessary resources to improve their health, stabilize their particular situations, and reduce the number of calls to the 911 system. We have also learned over these first eight months that a much higher percentage of the people using the 911 system are elder in age, which often presents a whole different set of needs than the mostly younger participants in the Pathways Program.

The Connections Program is receiving some financial assistance from Presbyterian Healthcare Services to compensate the students for mileage, and continues to explore other funding opportunities since it is a program that has no budget and continues to grow. An additional 7 or 8 social work students from New Mexico Highlands and NMSU will be working with Connections under Ivette's supervision this fall and next spring semester.

Another pilot project that started in this past year and has greatly expanded as of July 2015 is the "Integration of Community Health Workers [CHWs] in Primary Care Settings". The HSC Office Community Health Worker Initiatives, in collaboration with UNMH has recruited and trained Community Health Workers (CHWs) who are currently placed in three UNMH clinics: Southeast Heights, Southwest Mesa and the new North Valley clinic. In addition our office also has placed two CHWs at the First Choice Community Health clinic in the South Valley Health Commons (FCCH). Each of these clinics now has two CHWs funded by UNMH and one CHW funded by our office with resources coming from Blue Cross/Blue Shield of NM and Molina, for a total of 9 CHWs in the UNMH clinics and 2 at FCCH. Furthermore our office also has hired 3 new CHWs, who work on primary prevention efforts in Pajarito Mesa, the South Valley and the International District. These CHWs are engaging many of the same families accessing the community-based clinics.

These CHWs will receive ongoing training by our office and will work closely with the Pathways partner organizations. As part of this effort our office has 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. The former Urban Health Partners name was changed again to the Office of Community Health Worker Initiatives, our office is now co-housed with the CARE NM Program, and we have relocated to the 1650 University Avenue NE building along with other HSC and UNMH offices.

Despite these numerous changes, the Pathways Program has continuously adapted to recommended changes to try and best meet the needs of Bernalillo County residents over its first six years of operation. The program has become more established and recognized in the greater Albuquerque community as well as across the State.

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 reimbursing for an increased number of "pathways per client", greatly increase the number of Navigators hired out in the community, expand the program into the Bernalillo County Detention Center, and strengthen our efforts to reach more people and improve the health of the community as a whole.

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 675,551 in 2014, an approximate 21% increase since 1990. Additional demographic characteristics are demonstrated in the table below (Table 2).

Table 2: Characteristics of Bernalillo County

	Bernalillo County	New Mexico
Population, 2014 estimate	675,551	2,085,572
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, 2009-2013	10.9%	9.8%
Language other than English spoken at home, age 5+, 2009-2013	31.0%	36.1%
Median household income, 2009-2013	$48,801	$44,927
Persons below poverty level, percent, 2009-2013	18.0%	20.4%
Percent of Children Living in Poverty	27%	30%
Percent of Families with Severe Housing Problems	17%	17%
Percent of population under 65 years without health insurance	19%	22%

References: http://quickfacts.census.gov/qfd/states/35/ 35001.html
http://www.countyhealthrankings.org/app/new-mexico/2015/rankings/bernalillo/county/outcomes/overall/snapshot

Although statistically, many Bernalillo County residents appear better off than their peers from around the State overall, there are large geographic sub-regions within the County, primarily in the southern half (i.e. International District, Far Southeast Heights, South Broadway/San José, 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, Faith-based 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 (https://innovations.ahrq.gov/profiles/community-health-navigators-use-pathways-model-enhance-access-health-and-social-services), and is currently one of three pilot sites nationally that has participated in and received provisional Pathways National Hub Certification, which will be discussed in more detail on page 13.

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 past six years.

The organizations that received funding over this Phase 3, 3-year period [2014-2017] include:

- Albuquerque Health Care for the Homeless
- A New Awakening
- East Central Ministries - One Hope Centro de Vida clinic
- Enlace Comunitario
- Native American Community Academy (NACA)
- New Mexico Asian Family Center
- PB&J Family Services
    - Crossroads for Women
- Rio Grande Community Development Corporation (EleValle Collaborative)
    - VIDA/Casa de Salud Family Medical Center
    - Centro Sávila
    - Encuentro
    - La Plazita Institute
    - South Valley Economic Development Center

Samaritan Counseling Center

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 73% self-identify as Hispanic/Latina
- Individuals whose primary language is Spanish (54%) or English (41%)
- Individuals who self-report as Hispanic/Latino (73%) or American Indian or Alaskan Native (11%)
- Young to middle aged adults (73% fall within the range of 20 to 49 years of age)
- A high percentage of persons with less than a high school diploma (62%)
- Residents living in the southern part of the County (zip codes 87108, 87105, 87121, & 87123) make up 66% of the participant population; and
- 42% were referred to the program by another agency; 27% by a friend or family member

Results

As noted in the Executive Summary, over this past fiscal year (Year 6 of the program), five hundred and sixty five (565) persons enrolled in the program with approximately two hundred nineteen either withdrawing (53) or being inactivated due to difficulty following up with them (166). This equates to an approximate sixty-one percent (61%) retention rate, which is lower than the average over the first five years (~66%) of the program. The program manager will be paying very close attention to this over the next year, particularly with the three organizations that make up 99 of the 219 persons lost. With the unstable living conditions in which so many

of the Pathways clients experience, it is to be expected that a significant number of the participants will never complete the program.

A total of two hundred and one (201) persons completed their participation in the program over this past year, which is also less than in the prior year, but consistent with the first year of funding for new organizations. This number should increase over the next year. Nine hundred twenty eight (928) separate pathways were completed during this period, with Health Care Home (108), Income Support (91), Legal Services (89), Employment (72), and Dental (60) 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 fifty-nine (59) completed both the Behavioral Health and Housing pathways, with fifty-seven (57) completing the Education/GED and Vision & Hearing pathways.

Ten of the twenty one pathways identified – income support, food security, legal services, heat & utilities, domestic violence, vision & hearing, substance use/abuse, driver's license/I.D., health care home, and transportation - have over a 60% completion rate and comprise over five hundred twenty seven of the 928 mentioned above (57%). On the contrary, housing, pharmacy/medications, education/GED, employment, child support, dental, and homelessness prevention all have a 50% or less completion rate and comprise only two hundred seventy three (29%) of the pathways completed. This sharp contrast clearly points out some of the challenges that the Navigators face in accessing services for their clients, and in Table 3 below it demonstrates that these challenges have remained consistent over the past year:

Table 3: Pathways Completion Rates - Year 5 vs. Year 6

Year 5 (June 2014)	Year 6 (June 2015)
Education/GED – 43%	Education/GED – 43%
Housing – 40%	Housing – 40%
Dental – 50%	Dental – 50%
Employment – 46%	Employment – 45%
Homelessness Prevention – 48%	Homelessness Prevention – 50%

For comparisons sake, on page 8 below, Table 4 depicts the top 10 pathways completed for Years 1-3 (July 2009 - June 2012) vs. Years 4-6 (July 2012 - June 2015). What is particularly encouraging is that the Employment and Housing pathways increased from ~8% and 4% of the total number of pathways in the first three years, to ~10% and ~7% of the pathways over the past 3 years. From the Hub's perspective, these are probably two of the most challenging pathways to complete and coincidentally, the two that the program reimburses at the highest level for.

Table 4: Top 10 Pathways Completed – Years 1, 2, & 3 vs. Years 4, 5, & 6

Top 10 Completed Pathways - 1, 2, & 3	Top 10 Completed Pathways - 4, 5, & 6
Health Care Home - 316 (15%)	Health Care Home - 334 (12%)
Behavioral Health - 235 (11%)	Employment –-278 (10%)
Food Security - 200 (9%)	Legal - 269 (9%)
Legal - 175 (8%)	Behavioral Health - 245 (9%)
Employment - 171 (8%)	Vision & Hearing - 194 (7%)
Vision & Hearing - 133 (6%)	Food Security - 191 (7%)
Transportation - 133 (6%)	Housing - 189 (7%)
Housing - 86 (4%)	Dental - 187 (7%)
Income Support - 79 (4%)	Education/GED - 175 (6%) **
Dental - 77 (4%)	Income Support – 161 (6%)

** Education/GED pathways was added in January 2011

As can be expected, particularly with the newly funded organizations, the performance over this past year varied from organization to organization (see Appendix A on page 20). 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 difficulties recruiting for and identifying appropriate applicants for the Navigator positions, Navigator turnover, which requires rehiring and re-training, and other factors that non profit, community-based organizations often face. Despite these, approximately two hundred and forty (240) unduplicated individuals completed their involvement in the Pathways Program over the past year, and one thousand seven hundred (1,700) over the first six 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 six 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 six years: Greater than 50% 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 42% 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-three (53) 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 22% sample population of persons who completed their participation in the Pathways Program over the past year. Eneyda Ramos, an undergraduate student working in our office is now conducting exit interviews on a regular basis. Eneyda 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:

- 100% were either 'completely' (43%), 'mostly' (38%), or 'satisfied' (19%) with the program
- 94% either 'strongly agree' (13%) or 'agree' (81%) that what they achieved by completing their pathways will continue to help them
- 90% said that their health had either 'improved' (64%) or 'greatly improved' (26%) compared to when they began participating in Pathways
- 81% 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 44% answered 'yes' to.
- 100% said that they had a place to live at the time they were exiting the program
- 100% said that they were able to help others with information and resources that they learned about by participating in Pathways
- 89% 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 under the current funding levels. 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 six years of the program, one thousand and fifty two (1,052) unduplicated persons (~36% of total) worked on the Health Care Home pathway, with a total of six hundred fifty (650) 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."*

The Health Care Home pathway is still the most commonly used among all twenty one pathways, with Employment a close second at nine hundred ninety four (994); Behavioral Health at eight hundred twenty two (822); Housing at six hundred eighty (680);, and Legal Services at six hundred forty (640) rounding off the top five. Over the past year, one hundred seventy (170) participants worked on the Health Care Home pathway with one hundred nine (109) 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 (152)
2. UNMH Family Health Clinic - Southeast Heights (62)
3. First Nations Community Healthsource (61)
4. Casa de Salud Family Medical Office (58)
5. UNMH Family Health Clinic – 1209 University Ave. (56)

Regrettably a significant number of Pathways participants are either not eligible for or cannot afford to take full advantage of the Affordable Care Act (ObamaCare). 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. A series of goals and recommendations were made by the Bernalillo County-appointed Health Care Task Force to address this issue, including, but not limited to:

- Goal 1: Assure Healthcare Coverage for All County Residents
- Goal 2: Meet Native American Healthcare Obligations
- Goal 3: Increase Availability of Behavioral Health Services
- Goal 4: Build an Integrated System of Primary Care and Navigation Support
- Goal 5: Provide Continuity of Care for Incarcerated People
- Goal 6: Increase County Oversight and Accountability for Mill Levy Funds

The Bernalillo County Commission will be entering into negotiations with UNM Hospital around both the current County/UNM Hospital Lease Agreement as well as plans for the mill levy funds

over the next 8-year period (2017-2025). Many people in the community are advocating for the above-mentioned goals to be factored into the final agreements between the County Commission and UNM Hospital as we approach the next mill levy vote in November 2016. This will obviously have a large impact on the future of the Pathways Program.

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 however, a MPH student, Patricia Rodriguez-Espinoza, will be working with our office over the next full school year to fulfill her community health practicum requirements. One of her primary program activities will be to interview the Executive Directors, Supervisors, and Navigators from all of the Pathways partner organizations (past and present). Several questions specific to this third goal will be imbedded into the interview questions, which will provide us with valuable information on this goal that will be included in future reports.

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 four Albuquerque-based and one Valencia County-based CHWs from the Care NM program have begun to regularly attend the Pathways Navigator meetings and related trainings. In addition, the ten positions hired through our Medical Home pilot project will also be regularly attending the monthly Navigator meetings thus expanding those meetings to more than thirty-plus participants. With the positions based in the three community-based UNM Hospital clinics (Southeast Heights, Southwest Mesa, and North Valley), we are confident that the levels of communication and collaboration between the Pathways Program and UNM Hospital will greatly improve. Several staff members from the UNMH Patient Financial Assistance Office are scheduled to provide an in-service at our next Pathways navigator meeting in August.

Over the first six years of the program, Pathways 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 (CLN Kids)
- 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 (EleValle) *
- Samaritan Counseling Center
- South Valley Economic Development Center *
- The Storehouse

* Organizations that have participated in Pathways from the start

In addition to the organizations above, our office is currently collaborating very closely with Albuquerque Ambulance, which is under Presbyterian Healthcare Services, and both New Mexico Highlands and New Mexico State University through our Connections Program, First Choice Community Healthcare, Molina Healthcare, Presbyterian, and Blue Cross/Blue Shield through our Care NM and Medical Home programs, and numerous other community partners. It appears that more and more community-based organizations have brought into the collective impact philosophy, which is exactly what the numerous community partners that participated in the Pathways planning process were envisioning when they defined this as one of the four primary goals of the Pathways 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 six years, the Navigators have documented more than four hundred fifteen 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.

Over this past year, the Hub has had the leadership from both the Human Services Department, Income Support Division, and the Motor Vehicle Division attend two separate Pathways Navigator meetings where the Navigators were provided the opportunity to share directly with the leadership some specific examples of barriers that they had encountered at the locally-based offices. The leadership from these two State agencies provided their contact information to all of the Navigators and agreed to try and address some of the issues brought up in the meeting. They also agreed to return to a future Navigator meeting if the Navigators continued to have difficulties.

While this is a start, it still falls well short of the goal that the Pathways planning group established, and there are a number of other agencies/institutions identified in the 'Barriers' section of the database that haven't yet been contacted. In discussions with the Pathways Community Advisory Group (PCAG), the Hub is trying to be more responsive to the concerns brought up by the Navigators, mainly 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. We will continue to explore ways to more effectively address this important community-defined goal.

Pathways Promotion & Outreach

Our office is presently coordinating with Bernalillo County to have some time on the agenda at one of the next Bernalillo County Commission general meetings to briefly present on Pathways. As of this writing, it appears as if we will be given some time for the Commission meeting scheduled for August 25th. It is our hope to demonstrate the value of the program to the community and to allow several program participants to share their personal stories on how participation in Pathways has impacted their lives.

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. In October 2014, our program was awarded provisional status as a Certified Pathways Community Hub. This current year there are six other programs across the country going through a similar process, utilizing the "lessons learned" from the first three pilot sites. A meeting in Washington, DC is scheduled for late September to learn more about the status of these efforts at the national level. Our program will continue to participate in this pilot study now finishing up its third year of a 3-year funding period, and offer recommendations for improvement. As this continues to evolve, we hope to provide more information in future reports.

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 six 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.

- A client came in one day looking for help because he had just moved to Albuquerque. The man had no family here and did not know how to get around or navigate systems. After administering the risk score questionnaire, he quickly qualified for the Pathways Program and began working very closely with Navigator. The client began to receive health care services and not only was he able to find a 1 job with the help of the Navigator, but he was actually able to find 2 jobs. The client has been working there for quite some time already and he was able to buy a car and now has his own apartment. The client is very grateful and we are very happy to see that he is doing really well. In addition to his employment, the client also has established a health care home at One Hope Centro de Vida.
- Client has been in the program for a long time. She is separated from her husband and has 2 young children. Our agency has offered counseling to her and her children. Her biggest priority right now is to be approved for affordable housing because where she is currently housed is too expensive and she has had numerous problems with the landlord. Her water has been cut off due to the negligence of her landlord and the City has closed the entire condominium due to a ruptured pipe in one of the bathrooms. She has been forced to live in a motel for more than a week. Navigator has been meeting with City Housing Authority staff and advocating on behalf of her client to get her application approved as soon as possible. In the meantime, our agency continues to help meet her short-term needs. Client reported that she feels relieved that she has the support of the Navigator through this difficult process.
- Client came to XXX after separating from ex partner. She had suffered severe abuse throughout their relationship. Since separation, the client has enrolled in ESL and GED classes in order to eventually be able to attend college. She has continued to attend counseling and actively participate in parenting classes. Client has also been able to find employment and has been able to sustain her residence which she didn't think she would be able to since ex partner was the sole provider. She has gained more confidence and has been empowered to continue with education so she can be economically self-sufficient.
- I have a client that was referred by a co-worker. This client is very young, has experienced a significant level of trauma as a child and adult and has been involved with drugs/alcohol. She has been the victim of exploitation and although has not worked on the streets, she has placed herself, out of desperation, into situations that for the most part are equivalent to sex work. Additionally this client is involved in family dysfunction that continues to affect her well being, including her recovery. Prior to coming to

Pathways she had never even considered any type of treatment or counseling, or any kind of assistance with personal issues. She wouldn't even talk about it. She has been my client for about 2 to 3 months. During the course of her involvement she has been consistent w/office meetings and has begun talking about herself and her experiences. I have referred her for therapy which I feel will be very beneficial to the trauma she's experienced. We are also in the process of establishing a Health Care Home for her since she does have some medical issues that need to be addressed, and prior to this she has been ignoring her personal health, and for a while even here was reluctant to see a doctor. All in all, this young woman has made considerable progress and although there is much to be done, she is now open to some things in her life that she never thought she would be doing.

- I have done a lot of work and helped a lot of clients get into school, jobs, housing, clean from drugs. This year has just begun and I already have ten new clients. There are so many people that need help and Pathways is needed more than ever. We need more than the 1% to really help all the people that need it.
- Our organization collaborated with the Lion's Club and VSP Vision Care earlier this year. We helped a total of 135 low-income Bernalillo County residents who were uninsured. All received a pair of glasses. There are still 12 that will need some form of eye surgery and the Lion's Club is working with Eye Associates to arrange for these services to be provided. Clients were able to bring family members to this event and much gratitude was expressed along with many smiles and handshakes. This was so beneficial for the community!

Sample of Systems Barriers

- MVD would not take a notarized letter from Bank of America as a proof. They would only take bank statements. MVD would not take a letter from client's school that she is registered in their ESL classes. They needed a letter saying that she is "enrolled". Client made over 5 trips to MVD!
- It seems that there are ongoing issues with MVD that keep arising. We know that Pathways has already been in discussions with MVD, but if we could provide any support or testimonies to some of the issues our clients have been having with this agency, please let us know. **Note: The Hub will be following up with MVD and request that they return to another Navigator meeting to converse directly with the CHWs and collectively explore solutions together.**
- Affordable housing is an ongoing issue. At this moment, the City is not receiving applications due to the high volume that they've already received and are processing. Section 8 applications will not open up again until January. Apparently they changed their software and in at least one occasion, this resulted in them losing the application that my client and I submitted.
- One of my clients was being given the run around at ISD/SL Start. They had mishandled her case so many times and cancelled her TANF payments. She was very upset and didn't know what to do. I went with her and asked for her case notes. They didn't want

to give them to us at first but after looking at them we quickly saw that they did not follow procedure on her case several times and were clearly violating her rights. We went to the Center for Law and Poverty who quickly took her case and agreed that it was mishandled. They helped her Pro-Bono and asked for a fair hearing. Her TANF benefits were reinstated within a month and she received back pay for the 4 months she was not getting paid like she should have. My client was very happy and she was able to use the back pay to get into a new home. It was enough for the deposit and first month's rent.

- I would like to know how we could work with organizations and clinics in a way that they do not get offended when we comment on how they could improve their services. How can the agencies/clinics see that we are not criticizing them but rather trying to help them improve their facilities?
- The New Mexico Asian Family Center has documented on numerous occasions, different scenarios when their clients could not access services due to language barriers and unaffordable interpretation services.

Description of Program Expansion & Innovation

As noted in Table 2 on page 4, approximately 18% of Bernalillo County residents (~121,600 persons) live below the federal poverty level. In its first six years of funding, the Pathways program has reached over 2,960 vulnerable, disconnected Bernalillo County adults, connecting them with a wide array of health care and social service resources, and confirming that they have attained positive, healthy outcomes. Regrettably, this number equates to less than 2.5% of the total number of County residents living in poverty, a major contributor to poor health status.

The Pathways client population is largely uninsured and many have become eligible (for the first time) for public or subsidized health coverage through the Affordable Care Act that began in January 2014. Many of the Community Health Navigators have and continue to assist their clientele in enrolling in the most appropriate form of health coverage that they are eligible for under this new law.

Pathways clients reside in the poorest areas in our County and a community needs assessment conducted by the Bernalillo County Collective Impact for County & Neighborhood Health (CINCH) program staff in 2012 revealed six geographic "hot spots" where poverty and poor health indicators collide to indicate a high need for concentrated and coordinated efforts toward health improvement. The Pathways Program has aligned with the County's priority areas and focused its efforts primarily in these hot spots areas over the past six years. In the most recent RFP issued in January 2014, all applicant organizations had to commit to serving residents from at least one of the hot spot areas.

As mentioned earlier in this report, our office, in partnership with UNMH, First Choice Community Health, Albuquerque Ambulance, and several Managed Care Organizations (MCOs) has hired additional CHWs who all are referring persons from clinics and members of the MCOs

to these same 14 community partner organizations with Pathways funding. A very high percentage of the people being referred to the Pathways partners are among the estimated ~121,600 County residents living in poverty. These referrals, along with the existing caseload of the Navigators is creating serious capacity issues within the Pathways organizations. These community-based non-profits are in need of additional funding that would enable them to hire more staff to keep up with the demand for their services. In addition, Pathways would like to significantly expand its network of partner organizations to enhance existing services as well as provide additional services that currently are not being offered by our existing partners.

Should additional funds become available, the program has laid out plans below for how to best use these funds to reach more County residents:

a) *Expansion of Current Efforts*:
Pathways would like to increase funding for many of our existing community-based partner organizations at a higher level (approximately $105,000 per organization/2.0 FTE CHNs); increase the number of Navigators from its current 20 to ~38; increase the Navigator minimum hourly rate from its current $14/hour to a minimum $15/hour; and reimburse for a fourth pathway per participant (increasing to a maximum payment per participant of approximately $1,950);.

b) *Support Education = Health Initiative*:
With expanded funding, the program will commit to supporting the *Education=Health* pilot project in the International District. A ten-block area in the South San Pedro neighborhood, consisting of approximately 425 households will serve as the primary location for program implementation and is within one of the CINCH "hotspot" areas. Meaningful outcomes for individuals will be attained using the Pathways model to identify individuals and provide them with the structured support to navigate complex systems and achieve education and employment goals, as well as connection to a health care home. A unique neighborhood engagement strategy will complement the Pathways Program model, using Community Health Navigators (CHNs) to visit families through door to door canvassing on a regular basis, and completing a block-by-block audit of household goals for education, employment and health, to organize their work. The CHNs will support, and be supported by the International District Healthy Communities Coalition (IDHCC). As time and capacity allow the ten-block intervention area will be expanded in a geographically contiguous manner. Each year, education and health improvement activities will reach an additional 150 individuals and/or families in the International District through this project.

Although many services and resources are in place to support individuals and families that are facing economic, educational, housing and other health-related struggles, accessing them can be very difficult for people living in the International District. Adult Basic Education services, for example, may be limited to daytime options, making it impossible for working people to attend. A discussion with the Singing Arrow Community Center, for example, revealed that there is demand for Adult Basic Education and GED or equivalent preparation classes, but these must be available in the evening hours. Language barriers make accessing services or resources

difficult, so increasing access and availability of English as a Second Language classes is needed, particularly with the growing refugee community in the International District. Computer literacy is also a need, as more and more employment applications are available only through an online format, and many jobs require computer skills. Finally, the GED program has transitioned to a national private for-profit company as of January 2014, and with this transition, two important changes have taken place: the cost of the GED exam increased from an average of $40 - $50 to $120; and the exam is now only be available in an online format. Education advocates in the community are looking into alternatives to the GED exam. Project funding will be dedicated to reducing access barriers to educational services for the target area to boost the potential for success.

c) *Provide "In-reach" to Incarcerated Persons at MDC and Navigation Services as they are released as Returning Citizens:*

With expanded funding, Pathways will place Navigators (CHNs) in the jail to begin the trust-building process with incarcerated persons scheduled for release. These efforts will be modeled after a successful program in Muskegon, Michigan, where the principles of the original Pathways model was applied to a prisoner reentry program. In the Michigan example, a community based organization collaborated with prisons to visit soon-to-be released prisoners to provide information about resources and services they may need upon release, and to arrange for Medicaid enrollment and a medical home assignment, including transfer of their medical records. Once released, the same CHN will continue to provide care coordination services so that connections to health care and other needs are confirmed.

Current and potentially new Pathways organizations that demonstrate interest and competency in working with this population will make arrangements to conduct "in-reach" sessions at the County Detention Center to provide health and social services information to inmates scheduled for release in Bernalillo County. Navigators will begin meeting with identified inmates in the jail 2 to 3 months before their release date so that upon release the inmates will connect with the same Pathways Navigators who can then immediately begin to address their complicated circumstances, such as no residence or family to stay with upon release, lack of employment, history of addiction, or complex health needs, for example. The Navigator will coordinate with the case managers and other support services in the jail, will ensure Medicaid enrollment, and will continue to provide care coordination after release to confirm positive outcomes in various pathways. If feasible, a plan to track recidivism rates will be made available. In the Michigan program, the overall recidivism rate fell from 46 to 23.8% (March 2012), for example[1].

[1] Michigan Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism (citation)

d) *Improve Quality Assurance*:
With additional funding our office would like to significantly increase the level of funding allotted for program evaluation; support the development of a database that can capture the work done by all the CHWs in the field (the ones at clinics, the Pathways CHNs from community based organizations, the CHWs working with MCOs through our office, and the Social Work students working with the Connections Program); hire an additional staff person to focus on quality improvement; and setting aside funding to support continuing education opportunities for the Navigators.

Program Outcomes

In 2011 and 2012, interviews were conducted with approximately 17% of Pathways clients (135 individuals) that had completed the program six or more months previous to the interview date to assess the longer-term impact that the Pathways Program had on their lives. Combined results demonstrated that 73% of respondents had sustained health improvement (responding that their health was "much better" or "a little better") since program participation.

In addition, an exit interview process was initiated in July 2012, to update client information for a future interview encounter, and to assess their satisfaction with the program. Approximately two hundred two (202) exit Interviews have been conducted with clients completing the program, with the following results:

- 93% were either 'completely' satisfied, 'mostly' satisfied, or 'satisfied' with the help that they received from the Navigator and their organization;
- 87% reported that what they did with the Navigator on specific pathways will continue to help them;
- 76% reported that their overall health has either 'greatly improved' or 'improved' since they began participating in the program;
- 82% reported having a better understanding of how to access health and social services as a result of their participation in Pathways;
- 82% have been able to help others with information and resources/services that they had learned about from participation in Pathways.

These data are encouraging and demonstrate that the Pathways Program is having a positive impact not only on the participants, but also on the greater Bernalillo County community.
The Pathways program continues to explore more effective strategies to measure longer-term outcomes with the program participants, and with expanded funding would commit a much larger share of its resources toward more comprehensive program evaluation.
As noted in prior reports, the program has been contracting with the UNM Institute for Social Research (ISR) to conduct a cost study for Pathways clients vs. a control group, but limited only to those accessing UNMH for their health care. The Hub was hoping that the final report would be available at the time of this writing, but the ISR required a little more time to conduct some additional research, fine-tune the report, and complete the conclusion and recommendations. We anticipate that this report will be completed by the end of the summer.

Additional Comments from the Pathways Program

The total allocation for the Pathways program at the end of FY15 was ~$885,000. Of that amount, 730,000 (82.5%) of the budget was distributed through contracts with community organizations and the remaining $145,000 supports the "Hub", which is the coordinating body for program administration, evaluation, retention of the database consultant, and support for the Pathways Community Advisory Group (PCAG). UNM Health Sciences Center Office of Community Health Worker Initiatives serves as the Hub for the Pathways program. The average amount per contract for participating community organizations in this current funding cycle ranges from $50,000 to $60,000 per year.

With expanded funding, the program would propose to fund each of the partner organizations at a higher level (approximately $105,000 per organization/2.0 FTE CHNs); increase the number of Navigators from its current ~20 to 35; reimburse for a fourth pathway per participant (increasing to a maximum payment per participant of approximately $1,950); quadrupling the funding allotted for program evaluation; hiring an additional staff person to focus on quality improvement; and setting aside funding to support continuing education opportunities for the Navigators.

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 2013 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. The NM Dept. of Health Office of Community Health Workers will begin distributing applications for grandfathering status for CHW certification on August 3rd. This is a huge accomplishment, as many of us have been working diligently for well over a decade to make this happen.

Conclusion

Overall, the 6th year of Pathways to a Healthy Bernalillo County was successful and challenging, as several new organizations joined the ever-expanding Pathways network. Over the past year, we continued to fine-tune the data collection efforts, ramp up the number of Exit interviews conducted, and strengthen 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. Approximately three thousand (~3,000) people have participated in Pathways in its first six years of operation. Appendix B on page 18 demonstrates the number of unduplicated persons that have completed each pathway over the first six years of this program, including six hundred forty nine (649) acquiring a health care home; four hundred seventy nine (479) accessing behavioral health services; four hundred forty nine (449) securing gainful employment; four hundred forty two (442) gaining access to legal services; and two hundred seventy five (275) 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 next Report-to-the-Community sometime in the fall. 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 (FY15)
July 2014 – June 2015

Partner Organizations	Number of Clients	Clients Completed	% Clients Completed	Pathways Started	Pathways Completed	% Pathways Completed	Top 3 Pathways Completed
Albuquerque Health Care for the Homeless	51 [21] 59% Retention	5 Note: Navigator wasn't hired until October	10%	174	75	43%	Income Support - 24 Health Care - 16 Vision & Hearing - 7
A New Awakening	77 [35] 54% Retention	11	14%	95	46	48%	Housing, Income Support, Vision & Hearing - 7
Casa de Salud Family Clinic/VIDA	66 [34] 52% Retention	24	36%	119	67	56%	Food Security - 8 Dental, Health Care, Medical Debt - 7
Centro Sávila	76 [13] 83% Retention	39	51%	119	75	63%	Food Security - 11 Behavioral. Health - 10 Health Care - 9
Crossroads for Women	42 [19] 55% Retention	20	48%	134	67	50%	Income Support - 15 Health Care - 10 Behavioral Health, Dental - 7
East Central Ministries	37 [9] 76% Retention	19	51%	127	82	65%	Health Care - 15 Vision & Hearing - 14 Behavioral Health, Dental - 12
Encuentro	35 [7] 80% Retention	12	34%	97	41	42%	Education/GED - 7 Heat & Utilities - 6 Health Care, Vision & Hearing - 5
Enlace Comunitario	49 [30] 39% Retention	11	22%	163	93	57%	Legal - 25 Education/GED - 9 Income Support - 8
La Plazita Institute	64 [13] 80% Retention	23	36%	109	80	73%	Employment - 18 Food Security - 10 Education/GED - 8
Native American Community Academy (NACA)	29 [13]	3	10%	88	21	24%	Income Support - 5

Partner Organizations	Number of Clients	Clients Completed	% Clients Completed	Pathways Started	Pathways Completed	% Pathways Completed	Top 3 Pathways Completed
New Mexico Asian Family Center	29 [2] 93% Retention	2	7%	56	22	39%	Legal - 7 Driver's License/I.D. - 5 Health Care - 3
PB&J Family Services	36 [4] 89% Retention	21	58%	118	69	58%	Employment - 12 Housing, Legal - 9 Education/GED - 6
Samaritan Counseling Center	34 [8] 75% Retention	20	59%	100	64	64%	Legal - 11 Income Support - 10 Health Care - 9
South Valley Economic Dev. Center	62 [11] 82% Retention	31	50%	155	95	61%	Legal - 19 Vision & Hearing - 14 Health Care, Employment - 9
TOTALS	**687 [219]** Note: This # includes those clients carried over from FY14 68% Retention	**241**	**35%**	**1658**	**903**	**54%**	**Health Care - 108** **Income Support - 91** **Legal - 89** **Employment - 69** **Dental - 60**

Appendix B

Number of Pathways Completed
FY10 – FY15

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	**649**
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	**479**
Employment	Client has found consistent source[s] of steady income and is gainfully employed over a period of 3 months	**449**
Legal Services	Client reports that legal issue has either been resolved or that their current legal situation has significantly improved	**442**
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	**388**
Vision & Hearing	CHN confirms that client completed services and has obtained affordable new pair of glasses, hearing aid, or other needed services	**327**
Housing	CHN confirms that client is placed and has moved into an affordable housing unit for a minimum of 2 months	**275**
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	**264**
Income Support	Client has received a debit card with available assistance	**240**
Education/GED	CHN confirms that client has completed the course or term and has established a plan to fulfill their educational goals	**218**
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	**196**

Transportation	Client has full understanding of, and over the last 3 months, has accessed transportation routes across Bernalillo County	**160**
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	**158**
Driver's License/I.D.	Client received and has in his/her possession the appropriate I.D. card	**136**
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	**110**
Substance Use/Abuse	Client reports that treatment plan was successful and CHN confirms that client attended at least 75% of sessions	**96**
Homelessness Prevention	CHN assures that the client has obtained and maintains stable housing for no less than 3 months	**87**
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	**64**
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	**60**
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	**57**
Child Support	CHN confirms the client has consistently received child support payments for a minimum of 3 months	**29**

CHN = Community Health Navigator

Appendix C

Pathways Enrollment Trends
FY10 - FY15

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)

	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

Year Six
(7/1/14 – 6/30/15)

	1st	2nd	3rd	4th
# of "New" Enrollees	150	166	154	97
# of Completed Pathways	127	213	266	321
# of Clients Completing Program	36	46	59	102

Appendix D

Pathways Financial Report
Thru 6/30/15

Community Contracts:

Organization	Amount of Contract	Expenditures 6/30/15	Percent Spent (%)
Albuquerque Health Care for the Homeless	$55,000	$46,878	85%
A New Awakening	$55,000	$53,966	98%
East Central Ministries	$55,000	$55,000	100%
Enlace Comunitario	$60,000	$60,000	100%
Native American Community Academy	$55,000	$35,910	65%
New Mexico Asian Family Center	$50,000	$30,625	61%
PB&J Family Services	$105,000	$105,000	100%
Rio Grande Community Dev. Corp.	$240,000	$240,000	100%
Samaritan Counseling Center	$55,000	$51,458	94%
Totals	**$730,000**	**$678,837**	**93%**

Professional Services:

Organization	Amount of Contract	Expenditures 6/30/15	Percent Spent (%)
UNM Institute for Social Research	$10,000	Transferred to ISR Index Code	100%
Ruby Creek Design (Database)	$10,000	$9,990	99%
Totals	**$20,000**	**$19,990**	**99%**