Pathways to a Healthy Bernalillo County

Annual Report
July 2015 – June 2016

CHW Initiatives
Office for Community Health
UNM Health Sciences Center

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Executive Summary

This is the seventh annual report for the Pathways to a Healthy Bernalillo County Program. It provides a summary of the second year of Phase 3 (Years 6 through 8) of program implementation. The Pathways Program is administered through the University of New Mexico Health Sciences Center, Office for Community Health (OCH), Community Health Worker Initiatives (CHWI) under an agreement signed between the University of New Mexico Hospital (UNMH) and the Health Sciences Center (HSC). Under this agreement, UNMH transfers no less than $800,000 per year for the duration of the mill levy (2009-2017) to the OCH. The OCH contracts over 80 percent (>$660,000) of this amount to support the work of community health navigators (CHNs) at thirteen community-based organizations in Bernalillo County. For fiscal year 2016, the program had contracts with community partner organizations totaling $710,000. Contracts are awarded through a competitive process.

Over the past year (year 7 of the program), 1,004 separate pathways were completed. Health Care Home (116), Income Support (88), Food Security (84), Employment (80), Education/GED (78), Legal Services (75), Vision & Hearing (65), and Housing (64) topped the list of pathways completed. To complete a pathway, an individual must achieve the pathway's final step, a healthy outcome. This is a great accomplishment and demonstrates the importance of including many of the social issues that impact health within the list of pathways from which clients may choose. Only one of the top eight pathways completed over the past year is specifically health-related (Health Care Home), although all have an impact on a person's health and/or wellbeing.

Additionally, during this period, 521 persons enrolled in the program, more than 308 completed their involvement in the program, and 271 remain active. Another 210 were lost to follow up either because they withdrew from the program (66) or were inactivated (144) due to difficulty maintaining contact. It should be noted that since clients carry over from one fiscal year to the next, the numbers above also reflect clients that were active prior to July 2015. As we have learned over the years, the vast majority of Pathways' participants lead transient lives and have a multitude of complex needs. While the navigators do their best to assess their clients' levels of program readiness, the realities of life at the margins often interferes. Despite these challenges, the retention rates are still very admirable, and demonstrate the persistence of the navigators in their efforts to ensure that clients do not fall through the cracks as they attempt to access health and social services. The program continually emphasizes the importance of regularly updating client contact information, but even so, some are inevitably lost to follow up.

Over the past year, the Pathways Program conducted 44 exit Interviews with participants who had completed the program. To summarize: 98 percent of exit interviewees were either 'completely satisfied' (25%), 'mostly satisfied' (34%), or 'satisfied' (39%) with the program; 91 percent agree that what they achieved by completing their pathways will continue to help them; and 75 percent said that their health had either 'improved' (48%) or 'greatly improved' (27%) compared to when they began participating in Pathways. For more specific information on the exit interviews, please refer to pages 8 and 9 of this report.

A major project undertaken by the Pathways Program this year was gathering feedback from the agencies who have been funded by Pathways over the last six years. Patricia Rodriguez-Espinoza, a MPH graduate student (and doctoral student) implemented this project as part of her year-long Community Health Practicum with the program. A survey tool was developed with a great deal of input from the Pathways Community Advisory Group (PCAG) and administered to 40 different people representing either currently funded Pathways partner organizations or formerly-funded partners. These included navigators, their supervisors, and many executive directors. Patricia presented a summary of her findings at a recent Pathways Report to the Community held in May, which highlighted the excellent feedback that the program received from its partners. In addition, a full written report was developed that provides more detail and has been shared with the partners that participated in the interviews. This report will also be shared with the community at large. Patricia did an excellent job that far exceeded program expectations. We were very fortunate that she selected Pathways for her Community Health Practicum!

In November 2015, the Pathways Program began contracting part-time with Dr. Kelly O'Donnell who, in addition to doing a thorough assessment of the Pathways database, is currently working on a cost analysis for five specific pathways: health care home, housing, education/GED, behavioral health, and employment. Dr. O'Donnell will be estimating return on investment (ROI) for each of these pathways. The program intends to continue working with Dr. O'Donnell in FY17 as well.

During the past year, the Community Health Worker Initiatives (CHWI) and the HSC Office for Community Health partnered with Presbyterian Healthcare Services (PHS) in the development of an Accountable Health Communities (AHC) grant application funded by the Centers for Medicare & Medicaid Services (CMS). Other partners in this application included two UNMH community-based clinics and the UNMH Emergency Department, First Choice Community Healthcare, First Nations Community Health, Albuquerque Health Care for the Homeless, Health Insight, Roadrunner Food Bank, Community Dental Services, the Bernalillo County Community Health Council, and two of Presbyterian Medical Services' Albuquerque sites, among others. Notification of awards should be released in September/October 2016, and we feel that we made a very strong case for Albuquerque to be selected. Should this application be funded, an additional ten CHW positions should be filled at the clinical sites mentioned above. These new CHWs will join the ones already integrated into the UNMH clinics and First Choice in an effort to screen 75,000 Medicaid beneficiaries in Bernalillo County using a tool designed by CMS to identify and address the social determinants of health. In addition, the grant calls for all the participating partners to work together to develop a plan and align resources to deal with the systemic issues that are more prevalent among the individuals screened by the CHWs. The role of the CHWI will be to implement the project at each clinic site including hiring, training, and supervising all the CHWs and collecting and analyzing data collected at each site.

Last year, in addition to continuing to work with UNMH to integrate CHWs at all its primary care clinics, the CHWI started a formal pilot project: Integrating Primary Care and Community Support (IPaCS), which placed an additional CHW at three UNMH clinics (SEH, SW Mesa and North Valley) and at a First Choice clinic (South Valley). These additional CHWs have been screening Medicaid beneficiaries (members of BCBS and Molina only) for social determinants and connecting those who screen positive with services necessary to address their socio-economic needs. Data collected during the pilot is being analyzed by the Office for Community Health to assess if, for those Medicaid beneficiaries participating in the pilot, healthcare costs were reduced, health outcomes were improved, and/or the patient experience was enhanced. Once completed, the results of this evaluation will be shared not only with the partner MCOs but also with the New Mexico Human Services Department (HSD), which will determine if the pilot should be expanded statewide. As part of this process the OCH created a manual to guide primary care clinics on how to implement a similar program. These CHWs have been receiving ongoing training from our office and many are now fully integrated and regularly participate in the standing monthly navigator meetings.

In summary, the past fiscal year brought many changes, not only to the Pathways Program, but also to the entire CHWI office. Despite numerous changes, over its first seven years of operation, the Pathways Program has continuously adapted to best meet the needs of Bernalillo County residents. As a result, the program has become more established and recognized in the greater Albuquerque community as well as across the state.

Introduction

Bernalillo County, New Mexico's most populous county, has grown rapidly in the past two-plus decades, requiring expansion and adjustments of health systems and other social services infrastructures. Regrettably, these systems have been unable to keep pace with the increased demand for services, and thus a growing number of the county's residents have become marginalized and disengaged from supports critical to their health and welfare. According to the United States Census Bureau, the population of Bernalillo County increased from 480,577 in 1990 to 556,002 in 2000, to an estimated 676,685 in 2015, an approximate 41 percent increase since 1990. Additional demographic characteristics are presented in Table 1 below.

Table 1: Characteristics of Bernalillo County

	Bernalillo County	New Mexico
Population, 2015 estimate	676,685	2,085,109
Persons under 5 years, percent, 2015	6.2%	6.5%
Persons under 18 years old, percent, 2015-	22.7%	23.8%
Persons 65 years old and over, percent, 2015	14.7%	15.8%
Percent of adults without health insurance	25%	29%
American Indian / Alaskan Native persons, percent, 2015	6.0%	10.5%
Black/African American persons, percent, 2015	3.4%	2.6%
Asian persons, percent, 2015	2.8%	1.7%
Persons of Hispanic or Latino origin, percent, 2013	48.8%	48.0%
White persons not Hispanic, percent, 2015	39.8%	38.4%
Foreign born persons, percent, 2010-2014	10.9%	9.9%
Language other than English spoken at home, age 5+, 2010-14	31.2%	36.1%
Median household income, 2010-2014	$48,390	$44,968
Persons in poverty, percent	18.7%	21.3%
Percent of children living in poverty	25%	28%
Percent of families with severe housing problems	18%	18%
Percent of population 0 to 65 years without health insurance	15.4%	16.8%

References: http://quickfacts.census.gov/qfd/states/35/ 35001.html
http://www.countyhealthrankings.org/app/new-mexico/2016/rankings/bernalillo/county/outcomes/overall/snapshot

Although statistically, many Bernalillo County residents appear better off than the average New Mexican, 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 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 are home to the majority of the Bernalillo County residents participating in the Pathways Program. Table 2 on the next page presents data for the zip codes within which most Pathways participants reside.

Table 2: Characteristics of Key Pathways Zip Codes

	Bernalillo County	87105 S. Valley	87108 SE Heights	87121 W. Mesa	87123 Far SE Heights
Total population	676,685	57,878	38,150	77,052	43,626
% under 5 years	6.20%	6.5%	7.1%	8.6%	7.4%
% under 18 years	22.70%	25.5%	21.6%	32.5%	24.5%
% 65 years and over	14.7%	13.4%	11.1%	6.1%	13.5%
% Hispanic	48.8%	79.9%	50.1%	81.3%	41.7%
% White, Non-Hispanic	39.8%	13.9%	34.2%	11.6%	43.3%
% Black or African American	3.4%	1.6%	2.8%	2.8%	4.1%
% American Indian	6.0%	3.6%	8.0%	2.6%	5.9%
% Asian	2.8%	0.3%	2.2%	0.5%	3.4%
Total households	263,719	19,025	16,994	22,270	17,438
Average household size	2.51	3.02	2.2	3.35	2.5
Family households with children	73,924	5,913	3,717	10,390	5,036
% single mother families	30.0%	31.3%	43.0%	36.9%	37.3%
% single father families	11.0%	11.1%	14.2%	10.6%	13.3%
% births that are to single mothers	40.6	47.7	59.3	52.9	47.4
% resident ages 16+ in labor force	64.1%	58.4%	61.5%	65.9%	62.5%
% labor force that is unemployed	8.7%	12.2%	11.6%	12.2%	8.2%
% children ages 0-5, all parents in labor force	62.8%	57.5%	63.4%	68.6%	65.8%
Median household income	$48,390	$36,676	$26,963	$41,856	$41,748
Median earnings for workers	$29,684	$23,257	$21,517	$24,903	$26,745
% residents living in poverty	18.7%	26.2%	35.7%	23.9%	21.3%
% residents <18 in poverty	25.0%	39.0%	47.3%	32.6%	32.9%
% residents ages 18-64 without health insurance	25.00%	32.00%	34.9	32.20%	23.80%
% noninstitutionalized residents with a disability	13%	15%	15%	11%	14%
% residents ages 5+ speak language other than English at home	31.2%	55.1%	42.6%	51.8%	27.9%
Speak English less than "very well"	8.5%	16.5%	15.5%	17.4%	9.4%
% population ages 1+ in current residence 1+ year	84.0%	88.8%	76.2%	86.8%	82.1%
% total population foreign born	10.9%	16.6%	18.6%	19.0%	10.4%
% foreign-born not a U.S. citizen	64.5%	72.2%	77.4%	75.6%	65.3%
% foreign-born from Africa	1.7%	0.0%	1.9%	0.1%	1.1%
% foreign-born from Asia	18.4%	1.4%	11.6%	2.6%	21.1%
% foreign-born from Europe	7.8%	0.8%	3.3%	2.3%	10.4%
% foreign born from Latin America	70.4%	97.5%	82.1%	94.9%	67.3%
% residents ages 25+, high school graduate or higher	88%	73%	80%	74%	87%

Source: 2010-2014 American Community Survey 5-Year Estimates

Background

The Pathways to a Healthy Bernalillo County Program 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 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 wellbeing 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 the 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 through this Pathways process.

Pathways to a Healthy Bernalillo County 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 only a few sites from around the country that has received full Pathways National Hub Certification.

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 more 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 characteristics pretty accurately describe the people that they have worked with over the past seven years.

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

- Albuquerque Health Care for the Homeless
- 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 including gender, primary language, self-reported race/ethnicity, age distribution, education level, zip code of residence, 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 percent self-identify as Hispanic/Latina
- Individuals whose primary language is Spanish (54%) or English (40%)
- Individuals who self-report as Hispanic/Latino (73%) or American Indian or Alaskan Native (10%)
- Young to middle aged adults (71% 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 65% of the participant population; and
- 42 percent were referred to the program by another agency; 28 percent by a friend or family member

Results

As noted in the Executive Summary, over the past fiscal year (year 7 of the program), 521 persons enrolled in the program and 1,004 individual pathways were completed. Approximately 210 either withdrew (66) or were inactivated due to difficulty following up with them (144). This number is a bit higher than in past years and the program manager is in the process of setting up site visits with each organization to better understand the potential reasons behind this. Given the unstable living conditions of many Pathways clients, it is to be expected that a significant number of the participants will never complete the program.

A total of 308 persons successfully completed their participation in the program over the past year; 107 more than the prior fiscal year.

Of the 1,004 separate pathways completed, Health Care Home (116), Income Support (88), Food Security (84), Employment (80), Education/GED (78), Legal Services (75), Vision & Hearing (65), Housing (64), Dental (56) and Behavioral Health (46) were the top ten pathways completed.

Nine of the 21 pathways identified – Income Support, Food Security, Heat & Utilities, Legal Services, Domestic Violence, Substance Use/Abuse, Vision & Hearing, Health Care Home, and Transportation - have completion rates of over 60 percent and comprise over 52 percent (52.7%) of the 1004 mentioned above. On the contrary, Housing, Child Support, Education/GED, Employment, Homelessness Prevention, and Dental all have completion rates of 50 percent or less and comprise only 306 (30%) of the pathways completed. This sharp contrast highlights some of the challenges that the navigators face in accessing services for their clients. Table 3 below demonstrates that these challenges have remained consistent over the past year:

Table 3: Pathways Completion Rates - Year 6 vs. Year 7

Year 6 (June 2015)	Year 7 (June 2016)
Education/GED – 43%	Education/GED – 46%
Housing – 40%	Housing – 41%
Dental – 50%	Dental – 50%
Employment – 45%	Employment – 46%
Homelessness Prevention – 50%	Homelessness Prevention – 48%

Table 4 on page 8 compares the top ten pathways completed for Years 1-3 (July 2009 - June 2012) and Years 5-7 (July 2013 - June 2016). What is particularly encouraging is that the Employment and Housing pathways increased from approximately 8 percent and 4 percent of the total pathways in the first three years, to roughly 9 percent and 6 percent of pathways over the past three years. From the Hub's perspective, these are probably two of the most challenging pathways to complete and thus the two that the program reimburses at the highest

level for. In addition, Legal and Dental increased from ~8 percent and ~4 percent in the first three years, to ~9 percent and ~7 percent respectively.

Table 4: Top 10 Pathways Completed – Years 1, 2, & 3 vs. Years 5, 6, & 7

Top 10 Completed Pathways - 1, 2, & 3	Top 10 Completed Pathways - 5, 6, & 7
Health Care Home - 316 (15%)	Health Care Home - 346 (12%)
Behavioral Health - 235 (11%)	Legal - 269 (9%)
Food Security - 200 (9%)	Employment –-255 (9%)
Legal - 175 (8%)	Behavioral Health - 208 (7%)
Employment - 171 (8%)	Income Support – 204 (7%)
Vision & Hearing - 133 (6%)	Education/GED - 195 (7%) **
Transportation - 133 (6%)	Dental - 193 (7%)
Housing - 86 (4%)	Food Security - 190 (6%)
Income Support - 79 (4%)	Housing - 187 (6%)
Dental - 77 (4%)	Vision & Hearing - 175 (6%)

** Education/GED pathway was added in January 2011

As has been the norm over the past seven years, the performance over this past year varied from organization to organization (see Appendix A on page 22). 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, during the past year, four of the 13 partner organizations brought on new navigators, requiring individualized orientation and training. Despite this, approximately 308 unduplicated individuals completed their involvement in the Pathways Program over the past year, a 28 percent increase over year 6. Roughly 1,970 participants completed the Pathways Program over the first seven 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

This year, as in the previous six, it was extremely challenging to conduct post-Pathways interviews with past participants, as so many of them, despite their participation in the program, have high levels of instability in their lives. Two examples from our risk score questionnaire help explain why post-completion follow-up has been such a challenge over the past seven years: At the time they entered the program, 50 percent of participants answered 'yes' to the question "Have you lived in more than three places in the past year?"; and 42 percent 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 fully understanding that many of the clients would never be reached by this method.

Over the past year, the Pathways Program conducted 44 exit interviews with participants who had completed the program. This averages out to an approximate 14 percent 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 conducts the exit interviews as time permits. She 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:

- 98 percent were either 'completely satisfied' (25%), 'mostly satisfied' (34%), or 'satisfied' (39%) with the program;
- 91 percent agree that what they achieved by completing their pathways will continue to help them;
- 75 percent reported that their health had either 'improved' (48%) or 'greatly improved' (27%) compared to when they began participating in Pathways;
- 84 percent said that, since their participation in Pathways, they had not gone to the Emergency Room or been admitted to a hospital even once. **Note**: This question differs from a similar question asked 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"?), to which 48 percent answered 'yes.'
- 97 percent said that they had a better understanding of how to access health and social services as a result of their participation in Pathways

Although a small sample these very positive responses point to the many accomplishments that cannot necessarily be measured in dollars as much as they 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 to find a balance between the number of completed pathways per participant we reimburse our partner organizations for and the total number of clients we can serve. Currently we reimburse for three completed pathways per participant, which averages out to approximately $1,500 to $1,600 per person. Each additional pathway costs approximately $450 to $500 more per client. While additional pathways would certainly have a positive impact on the individuals being assisted, it would also reduce the number of county residents who could be 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 seven years of the program, 1,223 unduplicated persons (~33% of total) worked on the Health Care Home pathway, with a total of 767 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 1166; Behavioral Health at 925; Housing at 856, and Legal Services at 776, rounding off the top five. Over the past year, 179 participants worked on the Health Care Home pathway with 116 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 (166)
2. UNMH Family Health Clinic - Southeast Heights (76)
3. Casa de Salud Family Medical Office (72)
4. First Nations Community Healthsource (65)
5. UNMH Family Health Clinic – 1209 University Ave. (61)

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 in November 2014 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

From the program's perspective, the Bernalillo County Commission has been in negotiations with UNM HSC and Hospital leadership 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). It is the program's hope that these recommendations are being considered in the negotiations as we approach the next mill levy vote in November 2016. The final agreement between the

County and UNM Board of Regents, along with the November mill levy vote 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.

In the interviews that Patricia conducted with our current and former partner organizations, there were two questions in the interview tool specific to this 3rd goal. The questions read as follows:

"*Please speak about whether your participation in Pathways has strengthened your organization's relationships with other Pathways partner organizations? If so, please describe a few examples of new collaborations."*

"Have there been collaborations with non-Pathways organizations as a result of your engagement with Pathways? Do you feel that this is important to your organization? Please explain."

According to the final report, within the Pathways network, 88 percent of the forty persons interviewed reported increased or enhanced collaborations as well as new collaborations. In addition, 68 percent expressed that collaboration is essential for non-profits that serve at-risk populations with limited resources. Interviewees reported that intra-network collaboration enhanced client outcomes by facilitating and expediting referrals and coordination of services.

Along with collaboration within the Pathways network, 65 percent reported collaborating with entities outside of the Pathways network.

Another question related to collaboration asked, "*Has your participation in Pathways expanded capacity within your organization? In other words, has it increased your abilities to expand "business as usual", or has it helped your organization diversify the level of services offered?"*

Nearly 80 percent of the partners reported having diversified their services as a result of participating in Pathways. It was stated that Pathways has encouraged organizations to expand the services they provide their clients, and to expand how they think about clients' needs in context. It has also enabled organizations to develop expertise in areas that were initially outside of their purview.

Over the first seven years of the program, Pathways will have partnered with and funded, at least over one funding cycle, a total of 24 different community-based organizations here in Bernalillo County, including seven 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 sum, the Hub is confident that this 3rd community-defined outcome is being met. Only several weeks ago in July 2016, a meeting was coordinated with the majority of persons that participated in this survey, including all of the current Executive Directors and several members of the Pathways Community Advisory Group (PCAG), to discuss the results of this survey and to develop an action plan. The directors expressed interest in meeting at least 2 times over this next fiscal year, as most felt the importance of continued relationship building and exploring opportunities for stronger collaboration. Should Pathways continue to receive funding during the next mill levy cycle (2017-2025), many of the recommendations made by the partners in Patricia's report will be incorporated into the next 8-year period.

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 seven years, the Navigators have documented more than five hundred twenty 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 Hub has worked closely with the NM Center on Law & Poverty (CLP) over this past year on the CLASP grant that they received. The focus has been on the State Human Services Department, Income Support Division, which oversees both the Supplemental Nutrition Assistance Program (SNAP) and of course Medicaid. With the assistance and participation of the Navigators and other CHWs, the Hub has been able to provide CLP with numerous documented cases of barriers at the local ISD offices that help CLP with their legal proceedings.

This 4th community-defined outcome was a major part of the discussion that the Hub had recently at the recent meeting mentioned on the prior page. While UNMH, particularly the Financial Assistance Office, has been brought up on many occasions in terms of unnecessary barriers being created by the front desk staff, it is important to note that our office's level of collaboration with UNMH has improved dramatically. UNMH is making a sincere attempt to elicit feedback from the community on the revision of all of its brochures that will be used for the public, they will be active participants in the Accountable Communities for Health (AHC) grant if funded, and they have been good partners on our efforts to integrate CHWs into primary care clinics. While there is always room for improvement, especially around program eligibility for undocumented County residents, it is our feeling that these relationships have been strengthened considerably over the past couple of years.

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 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 April 2016, our program met the requirements for Level 1 Certification was awarded full certification for a 2-year period. Six other programs across the country went through this process during FY16, utilizing the "lessons learned" from the first three pilot sites. A meeting in Akron, Ohio is scheduled for late September to learn

more about the status of these efforts at the national level. Our program continues to be a leader for the Pathways model at the national level.

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 seven 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.

- "My client is a middle-aged lady with a young daughter. The two of them are by themselves with no additional support, no family, and only few friends in this country. My client used to speak very little English, just the necessary words to communicate with other people. Her daughter always joined in on her conversations to translate, even though she is only 12 years old. When my client came to see me, she told me that she just needed a pair of glasses because she hadn't been able to update her prescription for a few years. However, after our conversations together and with my encouragement, she decided to visit the dentist, as well as to go to school. Her daughter convinced her to learn English and to finish her GED. At first, my client was hesitant to do so. She said that learning English was hard for her. Finally though, I found a school for her and I enrolled her at CNM. She started classes this semester and ever since she started attending the school she looks happier, she is talking a great deal, and her self-esteem has increased. She is very excited about the class, her classmates, her teachers, and the progress that she is making. Her daughter, a middle school student, helps her with her homework and assignments. Her daughter tells her how important she is to her and how important the school is. It makes me happy to see mother and daughter working together on their goals. Once more, this program has shown me how important it is.

- "A client who has been homeless for over a year after fleeing a domestic violence relationship was finally able to save enough money to rent an apartment for her and her son after receiving help finding a job and finishing her GED classes. Client still has some struggles but is in a much better situation than she was when she first arrived in Albuquerque."

- "A client has been here for over 25+ years. She had come to the agency to get help with getting a free phone and recertifying for free phone several times. Client had never opened up about her situation until she got really comfortable with navigator. Navigator qualified client for Pathways services and she is extremely happy that she is working on goals to better her life. Even though client hasn't finished any pathways yet, she is just so happy for having the opportunity to get help."

- "A client who came to NM on a fiancée visa. Once she got here she was terribly abused by her fiancée and was locked in a room every day for many hours at a time. Through Pathways services, we were able to get client connected with legal aid attorney to get her protective order. Client was also referred to get counseling and she reported that she feels mentally and physically better.

- "_____ came to our organization to thank me for helping him move into his new place. He was so excited that he said he felt like The Jeffersons moving on up. It was great to see how happy this guy was and some of the staff, including my boss heard this guy's excitement. It was so cool that he came all the way over to thank me in person. That's what Pathway is all about, helping people to make a better life. Client is clean from the substances he was using and is working on getting off the prescriptions. He does acudetox every other Wed and says it really helps him, so it's great to see how happy this dude is."

- "This success story is still in the process. Client has begun an investigation on her partner and father to her children. He has been trafficking her for several years. After much advocating, legal services, and contacting Homeland Security, we helped get the trafficker investigated. Client has found a job and is looking into school. She is working with an attorney to hopefully receive her U-Visa. Client is also attending a church, which she says she was not allowed to do when living with her trafficker. Client is still afraid of her trafficker getting out of jail, as it is a possibility, but we have safety plan if this happens. You would have to see a before and after to just see the change in confidence and ability to talk about the trauma."

- "A client came to me saying that her husband was diagnosed with Cancer at UNMH and they were not aware of available source of help. I shared with her that UNMH has a program at the Cancer Clinic that will help with some costs and medications. He is now being seen at UNMH Cancer clinic on a regular basis, and is making lots of progress. I also scheduled her an appointment to get some for counseling. She has continued to see her counselor and has made tremendous progress because she was overwhelmed and stressed. Now she's getting her life back together, enjoying her children and the whole family's spirits are up."

- "Client was referred to Navigator. Client identifies as _____ and was in need of work authorization, was nearly $20,000 of medical debt at _____, and was unable to continue receiving medical care in the community. In addition client had a heart condition and unmet oral health needs. Navigator got client connected to primary care provider and dental services. Client enrolled in UNM Care Indigent Care Program, which helped cover much of the costs of medications for the heart condition. Navigator submitted an application for financial assistance on behalf of client. Client completed the medical debt pathway with all debts adjusted to $0. Client obtained SNAP and Medicaid benefits with assistance from the Navigator, and finally, client showed the Navigator his/her new work authorization card!"

- "This client is a 32 single mother of 5 children. Client and her children fled from _____ approximately 8 months ago, due to severe domestic violence she suffered by her ex-partner, who attempted to kill client. Client and her children's lives were in danger, and due to the severity of the case; client and her children were granted asylum. When client came to _____ to do her intake, she had already lived in three different places in a short time and was residing at a shelter. Navigator accompanied client to the Mexican Consulate in order to obtain financial assistance and some of their birth certificates, and with this financial assistance client was able to buy shoes for her children. Client was able to to obtain an apartment through Enlace's Rental Assistance Program. Client also was able to obtain furniture and house items through NM Rapid Respond. NMILC has been helping client on her immigration case."

Sample of Systems Barriers

In the Pathways database, there is a section for the Navigators to document any systemic barriers that they may encounter while trying to access services for their clients. In addition, each quarterly report required by the Hub asks a question on barriers experienced over the prior quarter. As a result, over the past seven years of program implementation, a significant number of barriers have been identified. Below is a small sample of how the barriers are documented in the database and on the reports:

- 6/16/2016 - Navigator went to Child Support Enforcement Division (CSED) with client to find out the status of application filed back in February. Although the client was there with the Navigator, CSED still refused to give any personal information or status updates regarding the case even though it was filed 4 months prior.
- 6/06/2016 - Client was told that she was accepted for housing program through the Albuquerque Housing Authority and was given an amount of rent that she would be paying, which was affordable. A few days later, they told her that they had made a mistake with the amount of rent because they had not noticed that not all children had a social security number. They increase her rent amount and her deposit amount, and this made it impossible for client to afford it, and prevented her from moving.
- 3/02/2016 – Income Support Division sent a notification letter saying that client was denied her Medicaid application even though she received an approval letter and card in December 2015. Client called the Income Support office and the representative apologized for their mistake but cannot activate client's Medicaid card again. She asked Client to reapply for Medicaid. This means that client will have no health insurance while reapplying.
- Follow up with Child Support Enforcement Division. We don't know what kind of rules they follow but they always make it very hard for navigator/case manager to help our client such as the example in the barriers section. In addition, not in the barrier listed above but with other clients that we have had, we were not able to help our client make phone calls to get information. They will not allow us to help interpret for our client even when they are with us but then they will not provide an interpreter other than Spanish. Therefore, we would have to go into the office.

- There still appears to be some confusion around the new eligibility criteria for UNM Care (now primarily a secondary coverage) and the new Indigent Care Program, an enrollment requirement in order to avoid being sent to Collections. The Hub will be arranging a presentation by UNMH staff for the Navigators/CHWs at one of the upcoming monthly meetings.

Additional information pertaining to systems barriers has already been mentioned earlier in this report under "Outcome #4: Advocacy and collaboration will lead to improved health systems" on pages 13 & 14.

Description of Program Expansion & Innovation

As noted in Table 2 on page 4, approximately 18.7% of Bernalillo County residents (~126,540 persons) live below the federal poverty level. In its first seven years of funding, the Pathways program has reached over 3,700 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 3.0% of the total number of County residents living in poverty, the 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 seven 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.

An unfortunate and probably unintended consequence of the increased focus on the social determinants of health by CHWs and others is that the majority of financial resources administered by Medicaid and Managed Care Organizations stay within healthcare settings, and do not reach the community-based social service organizations. Meanwhile, it is the staff at these community-based organizations that receive referrals from the clinics to address the social determinants, which has placed an unfair burden on Navigators and other staff at these organizations. A very high percentage of the people being referred to the Pathways partners

are among the estimated ~126,540 County residents living in poverty. These referrals along with the existing caseload of the Navigators, is creating 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 $100,000 per organization/2.0 FTE CHNs); increase the number of Navigators from its current 18 to ~36; 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. 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 Inmates at MDC and Navigation Supports for their Return to the Community*

With expanded funding, Pathways has proposed to 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. Ideally, 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].

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 Navigators, the CHWs working with MCOs through our office, and the social work students); hire an

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

additional staff person to focus on quality improvement; and setting aside funding to support continuing education opportunities for the Navigators.

Program Outcomes

In Pathways, demonstrating outcomes is, in one sense, streamlined and straightforward, and, in another sense, complex and challenging. An intense focus on outcomes is one of the features that make Pathways to a Healthy Bernalillo County unique and uniquely effective. Accountability is intrinsic to the Pathways model, guiding how Pathways administration interacts with community organizations, how organizations interact with navigators, and how navigators interact with clients. The Pathways approach -- achieving meaningful, measurable outcomes through a systematic, transparent process that documents each critical step toward the attainment of well-defined goals – exemplifies accountability by embedding process evaluation in the delivery of services. The contracts Pathways enters into with community organizations link payments to outcomes and contract administration emphasizes continuous and thorough documentation of client progress. Therefore, when a client completes the Pathways program, three critical outcomes have already been achieved and documented.

However, due to the extremely high-risk, often transient population Pathways serves, measuring long term outcomes and the extent to which those outcomes impact health is much more challenging. There is an extensive body of high-quality research documenting the impact on health of each of the social determinants Pathways seeks to address. Further, there is ample evidence that improvements in these areas improve health outcomes, and, more often than not, save money. However, a randomized controlled study tracking Pathways participants over time could easily consume half of Pathways' entire budget. Administrative data collected by public sector service providers, like UNMH or the justice system, can provide some lower-cost insight, but rarely, if ever, can such systems provide the depth of data necessary to accurately track the multiple causal relationships between social determinants, health outcomes, service utilization, and cost. Studies that ignore these limitations may produce results that are inaccurate or misleading.

With limited revenue and a commitment to returning as much funding as possible to the high-needs communities it serves, Pathways is tracking longer-term outcomes and measuring program impact in four primary ways:

1. Exit interviews with clients shortly after their completion of Pathways, conducted by UNM students employed by Pathways.
2. Return on investment analyses of key pathways by UNM health economist, Kelly O'Donnell, PhD, who works with Pathways on an on-going, part-time basis.
3. Analyzing the patterns of arrest and incarceration for the 20 percent of Pathways clients who have recently been released from jail to measure the impact Pathways may have on recidivism (negotiations to obtain these data are on-going with Bernalillo County).
4. Providing technical support and guidance to program evaluators for the EleValle collective of Pathways partner organizations. It is hoped that this evaluation, funded by

the Kellogg Foundation, will document longer-term outcomes for the subset of Pathways clients served by EleValle partner organizations including Centro Savila, La Plazita Institute, South Valley Economic Development Center, and Casa de Salud.

The Pathways program connects the community's most underserved and disenfranchised members to a variety of services that they are either unaware of or unable to access without help. These hard-to-reach individuals are often the clients for whom the services are most beneficial. Thus, the "value added" by Pathways are the connections that would not otherwise be made and the additional benefits community organizations generate when they serve the highest need clients.

The Return on Investment (ROI) analysis of the Health Care Home pathway, due to be released in August 2016, finds that connecting 713 Pathways clients to Health Care Homes produced net benefits (benefits less costs) of $1.7 million and a benefit-to-cost ratio of 3.47 over the life of the program. ROI analyses draw on Pathways' rich client database and the extensive notes Navigators include in each client record to profile the Pathways clients who complete specific pathways. A literature review is then conducted to identify high quality evaluations and research studies that estimate the impact on health care utilization, health outcomes, and health-related costs of programs similar to those that pathways navigators connect their clients to. Effect sizes, derived from the results of the most relevant and rigorous studies, are used to estimate benefits. Costs for both the Pathways program and the programs Pathways clients are connected to are subtracted to estimate net benefit.

Additional Comments from the Pathways Program

The FY 2016 allocation for the Pathways program totaled roughly $885,000. Eighty percent ($710,000) of the budget was distributed through contracts with community organizations. Pathways distributed slightly less to community partners in FY 2016 than it distributed in FY 2015 due to the decision by A New Awakening, early in the fiscal year, to cancel their $55,000 contract. Many of the funds forfeited by A New Awakening were re-appropriated to other, more successful partner organizations, but the Pathways administration retained a small amount to contract with Dr. Kelly O'Donnell for program evaluation. The remaining $150,000 supported the "hub", which is the coordinating body for program administration, retention of the database consultant, and support for the Pathways Community Advisory Group (PCAG). The UNM Health Sciences Center's 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 (2016-2017) funding cycle ranges from $50,000 to $60,000 per year. It is hoped that the new contract between Bernalillo County and the UNMHSC will provide additional funding for Pathways. If funding is expanded, the program proposes to increase the amount distributed to community organizations to approximately $105,000, enough to support two full-time community health navigators at each partner organization.

Pathways' program manager continues to serve on the statewide New Mexico Community Health Worker (CHW) Advisory Council with the NM Department of Health Office of Community Health Workers. Establishment of the statewide CHW board pursuant to the 2014 Community Health Workers Act (24-30-1, NMSA 1978 and 7.29.5 NMAC) has altered the role of the Advisory Council and thus affected the nature of its collaboration with the state.

Conclusion

Overall, the 7th year of Pathways to a Healthy Bernalillo County was successful and challenging. The excellent work performed by Patricia Rodriguez-Espinoza and the addition of Dr. Kelly O'Donnell, have provided insight and information that we look forward to applying in the next eight year funding cycle. Dr. O'Donnell continues to fine tune the data collection efforts and has been developing a series of pathway-specific cost analyses that we intend to publish throughout the final year of the current funding cycle.

Since 2009, over 3,750 vulnerable Bernalillo County residents have worked toward critical life goals with the aid of Pathways. Appendix B on page 25 provides an unduplicated count of clients that have completed each pathway over the last six years, including 762 who acquired a health care home; 535 who secured gainful employment; 524 who accessed behavioral health services; 515 who obtained legal services; and 349 who found an affordable place to live. These figures make evident the powerful impact that the Pathways Program has on the people it serves. As County officials and Health Sciences Center leadership finish negotiating the new lease agreement and we all look forward to re-authorization of the mill levy in November, we are proud of what Pathways has accomplished in its first seven years, and optimistic that voters, County Commissioners, and HSC leadership perceive and value the contribution Pathways has made to health and well-being in Bernalillo County.

Appendix A
Breakdown by Organization of Pathways Accomplishments
(July 2015 – June 2016)

Partner Organizations	Number of New Clients	Clients Completed	Pathways Started	Pathways Completed	Top 3 Pathways Completed
Albuquerque Health Care for the Homeless	37	19	143	65	Income Support - 13 Dental - 9, Legal - 9
Casa de Salud Family Clinic	47	26	190	78	Food Security - 20, Health Care - 10, Employment, Dental, Vis & Hear - 8
Centro Sávila	47	17	136	67	Income Support - 14 Health Care - 11, Pharm/Meds - 11
Crossroads for Women	48	27	140	81	Housing - 26 Employment - 17, Behavioral Health - 12
East Central Ministries	30	29	97	88	Dental - 19 Health Care - 14, Vision & Hearing - 14
Encuentro	18	18	82	61	Heat & Utilities - 16, Health Care - 11, Employment, Vis & Hear, Educ/GED - 8
Enlace Comunitario	64	16	255	71	Legal - 12, Driver's Lic./ID - 9, Child Support, Homeless Prev. - 7
La Plazita Institute	39	39	88	70	Income Support - 14, Food Sec - 11, Housing, Subst Use, Employment - 8
Native American Community Academy (NACA)	20	4	106	39	Transportation - 9 Income Support - 8
New Mexico Asian Family Center	31	15	56	42	Legal - 13 Income Support - 7, Disab Inc, Health Care - 5
PB&J Family Services	66	43	239	160	Educ./GED - 28, Food Security - 25, Employment - 20, Health Care - 15
Samaritan Counseling Center	39	20	115	72	Health Care - 17 Legal - 14, Educ./GED - 9, Employment - 8
South Valley Economic Dev. Center	29	27	103	90	Vision & Hearing - 23 Health Care - 12, Educ./GED, Dental - 10
Total	**515**	**300**	**1750**	**984**	**6/28/16**

Appendix B

Number of Pathways Completed
FY10 – FY16

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	**762**
Employment	Client has found consistent source[s] of steady income and is gainfully employed over a period of 3 months	**535**
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	**524**
Legal Services	Client reports that legal issue has either been resolved or that their current legal situation has significantly improved	**515**
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	**470**
Vision & Hearing	CHN confirms that client completed services and has obtained affordable new pair of glasses, hearing aid, or other needed services	**388**
Housing	CHN confirms that client is placed and has moved into an affordable housing unit for a minimum of 2 months	**349**
Income Support	Client has received a debit card with available assistance	**325**
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	**319**
Education/GED	CHN confirms that client has completed the course or term and has established a plan to fulfill their educational goals	**296**
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	**217**
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	**193**
Transportation	Client has full understanding of, and over the last 3 months, has accessed transportation routes across Bernalillo County	**181**

Driver's License/I.D.	Client received and has in his/her possession the appropriate I.D. card	**175**
Substance Use/Abuse	Client reports that treatment plan was successful and CHN confirms that client attended at least 75% of sessions	**119**
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	**118**
Homelessness Prevention	CHN assures that the client has obtained and maintains stable housing for no less than 3 months	**104**
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	**88**
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	**85**
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	**74**
Child Support	CHN confirms the client has consistently received child support payments for a minimum of 3 months	**39**

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

Year Seven
(7/1/15 – 6/30/16)
Number of Enrollees by Quarter
Number of Completed Pathways by Quarter
Number of Clients Completing Program

	1st	2nd	3rd	4th
# of "New" Enrollees	144	111	122	144
# of Completed Pathways	214	263	247	280
# of Clients Completing Program	71	62	79	96

Appendix D

Pathways Financial Report
Thru 6/30/16

Community Contracts:

Organization	Amount of Contract	Expenditures 6/30/16	Percent Spent (%)
Albuquerque Health Care for the Homeless	$55,000	$42,241	77%
East Central Ministries	$55,000	$54,866	100%
Enlace Comunitario	$60,000	$59,550	99%
Native American Community Academy	$45,000	$37,810	84%
New Mexico Asian Family Center	$30,000	$30,000	100%
PB&J Family Services	$155,000	$155,000	100%
Rio Grande Community Dev. Corp.	$255,000	$252,502	99%
Samaritan Counseling Center	$55,000	$55,000	100%
Totals	**$710,000**	**$686,969**	**97%**

Professional Services:

Organization	Amount of Contract	Expenditures 6/30/16	Percent Spent (%)
UNM Institute for Social Research	$2,500	Transferred to ISR Index Code for Final Report	100%
Ruby Creek Design (Database)	$12,000	$4,980	42%
Kelly O'Donnell @ 0.4 FTE	$19,930	$19,930	100%
Totals	**$34,430**	**$27,410**	**80%**