SERVICE AGREEMENT
BETWEEN SANTA FE COUNTY AND SANTA FE INDIGENOUS CENTER

This Agreement is entered into on this **8th** day of **March**, 2024, between **Santa Fe County** (the "County"), a political subdivision of the state of New Mexico, and **Santa Fe Indigenous Center**, 1420 Cerrillos Rd., Santa Fe, NM 87505 (the "Contractor").

Background

WHEREAS, the Santa Fe County Community Services Department (CSD) has implemented the *Accountable Health Community* also known as CONNECT; and

WHEREAS, the purpose of CONNECT is to provide funding assistance to organizations who provide services to individuals or clients who are in high-risk or high-need populations due to social determinants that have influenced a person's health and well-being; and

WHEREAS, CONNECT helps residents and citizens to navigate available community services and clinical care and offers providers access to data and information to better serve the health needs of residents and clients; and

WHEREAS, pursuant to NMSA 1978, Section 13-1-98.1 (B) ((Hospital and health care exemption), the Procurement Manager has determined that the procurement of these services to be provided by the Contractor are exempt from a competitive solicitation; and

WHEREAS, the Contractor was formerly known as the Santa Fe Indian Center, Inc. however it has undergone a name change and is now the Santa Fe Indigenous Center. The Contractor's fiscal sponsor for purposes of this Agreement is the New Mexico Foundation or NMF, a 501(c)(3) organization that provides administrative assistance to organizations that have a charitable purpose; and

WHEREAS, the County wishes to benefit from the Contractor's services that will help to provide increased capacity and additional resources to the CONNECT network.

NOW THEREFORE, it is agreed between the parties:

Agreement

1. CONTRACTOR'S SERVICES

   a. Provide case manager(s)/navigator(s) to provide navigation services to individuals seeking basic needs. Contractor's designated navigator(s) should be experienced and qualified and engage in continued educational opportunities on an annual basis to increase professional qualifications.
   b. Screen for demographics and social needs of patients using categories and screening tool described in Attachment A (CONNECT SDOH Screen).

c. Assess clients' social determinants of health, including safe and secure housing, nutritional food, reliable utilities and transportation and access to health insurance.
d. Provide navigation to individuals in need of supportive housing, including assisting individuals to access immediate needs related to shelter, medical services, benefits enrollment, food, clothing, hygiene, and referral to services to meet longer term needs (job skills training and placement, literacy and life skills, legal support and advocacy), using the screening tool, Unite Us platform and other coordinated entry systems.
e. Assure navigator(s) participation in facilitated trainings offered by CSD.
f. Deliver navigation services tailored to the individual's priorities that are culturally relevant and based on a team approach of service delivery that documents cross-agency collaboration.
g. Develop a primary navigation plan with the individual or ensure a warm hand off to a CONNECT partner agency navigator who will do so. The navigation plan sets appropriate goals, such as: addressing safe and secure housing, food, utilities and transportation, health system enrollment, access and navigation; education and literacy; prevention care and treatment; chronic disease management; and effective social and community referrals.
h. Identify community and social resources tailored to the individual's needs and develop and facilitate a network/team to address priorities of the navigation plan, develop sustainable relationships with community resources, provide and document a warm hand-off. Referrals will be complete if a sustained relationship has been verified by the individual service provides and documented by the navigator.
i. Using the Unite Us platform, provide CSD with quarterly data on the social determinants of health, demographics, and emergency room and jail utilization of clients.
j. Using the Unite Us platform, participate in data sharing with other community and social organizations on activities related to navigation plans with consent of the clients served and participate in negotiating agreements with community partners. Share aggregate and non-medical client data with other County-funded partners and CSD.
k. Using Share NM, post the organization's community education, outreach and training events on a community calendar, and register and update organization information as needed.
l. Assure that all employees receive training on the Health Insurance Portability and Accountability of 1996 (HIPAA) standards, P.L. 104-191, and the HIPAA Privacy Rule, 45 CFR Part 160, 162, and 164, and strictly adhere to all HIPAA requirements and policies.
m. Adhere to Navigation Protocols and Flexible Fund protocol developed and provided by the County to serve as a payer of last resort for one-time expenses related to social determinants of health and Network Standards (see Attachment B - Navigation Protocols and Network Standards).
n. Ensure clients served meet the eligibility for the Santa Fe County Health

Gregory

Care Assistance Program as defined by Santa Fe County Resolution No. 2014-47.

B. The County will:

a. Provide Contractor with a login to the Unite Us platform for Contractor's designated case manager(s)/navigator(s) or assigned staff.
b. Reimburse Contractor at a rate of $1,000.00 per individual served.
c. Reimburse Contractor for expenses made to access funds according to the Flexible Funds guidelines established in the Navigation Protocols (see Attachment B).
d. Provide training and on-going technical assistance on the use of the Unite Us platform.

2. ADDITIONAL SERVICES

A. The parties agree that all tasks set forth in Section 1 (Contractor's Services) must be completed to the satisfaction of the County and for the amount set forth in section 3 (Compensation, Invoicing and Set-off) and for no other cost, amount, fee or expense.

B. The County may request changes in the Contractor's Services. Such changes which are mutually agreed upon by and between the County and the Contractor will be incorporated in a written amendment.

3. COMPENSATION, INVOICING, AND SET-OFF

A. In consideration of its obligations under this Agreement the Contractor will be compensated as follows:

1) Of the total not-to-exceed compensation of $23,900.00, $20,000.00 will be available to reimburse Contractor for navigation services provided to clients who met the criteria of the Santa Fe County Health Care Assistance Program (HCAP) (see Santa Fe County Resolution No. 2014-47). This is calculated based on a minimum of 20 HCAP-eligible clients being served or provided with navigation services by the Contractor at the rate of $1,000.00 per client.

2) Of the total not-to-exceed compensation of $23,900.00, the sum of $3,900.00 will be available to reimburse the Contractor solely for costs relating to addressing emergency circumstances faced by an indigent clients and that are related to social determinants of health. *No funds under this Agreement will be issued directly to Contractor's clients.* Funds under this Agreement may be utilized by the Contractor after all other resources of revenue have been sought and exhausted. The Contractor must submit the request for reimbursement to CSD on a quarterly basis.

3) The total amount of compensation payable to the Contractor for the term of

this Agreement will not exceed **$23,900.00**, *inclusive* of NM GRT.

4) This amount is a maximum and not a guarantee that the services to be performed by Contractor under this Agreement will equal the amount stated above. The parties do not intend for the Contractor to continue to provide services without compensation when the total compensation amount is reached. The County will notify the Contractor when the services provided under this Agreement reach the total compensation amount. In no event will the Contractor be paid for services provided in excess of the total compensation amount without this Agreement being amended.

B. Contractor must submit a written request for payment to the County when payment is due under this Agreement. Upon the County's receipt of the written request, the County will issue a written certification of complete or partial acceptance or rejection of the services for which payment is sought.

1) The County's representative for certification of acceptance or rejection of services is **Jennifer N. Romero, Health Services Division Director, (505) 995-9526, email jnromero@santafecountynm.gov**, or such other individual as may be designated in the absence of the County representative.
2) The Contractor acknowledges and agrees that the County may not make any payment hereunder unless and until it has issued a written certification accepting the services.
3) Within 30 days of the issuance of a written certification accepting the services, the County will tender payment for the accepted items or services. In the event the County fails to tender payment within 30 days of the written certification accepting the services, the County will pay late payment charges of 1.5% per month until the amount due is paid in full.

C. In the event the Contractor breaches this Agreement, the County may, without penalty, withhold any payments due the Contractor for the purpose of set-off until such time as the County determines the exact amount of damages it suffered as a result of the breach.

D. Payment under this Agreement will not foreclose the right of the County to recover excessive or illegal payment.

4. EFFECTIVE DATE AND TERM

This Agreement will be effective on the date of last signature by the parties and will terminate one year from such date, unless earlier terminated pursuant to Section 5 (Termination) or Section 6 (Appropriations and Authorizations). The County has the option to extend the term of this Agreement in one-year increments, not to exceed four years total.

5. TERMINATION

A. Termination of Agreement for Cause. Either party may terminate the Agreement

based upon any material breach of this Agreement by the other party. The non-breaching party will give the breaching party written notice of termination specifying the grounds for the termination. The termination will be effective 30 days from the breaching party's receipt of the notice of termination, during which time the breaching party will have the right to cure the breach. If, however, the breach cannot with due diligence be cured within 30 days, the breaching party will have a reasonable time to cure the breach, provided that, within 30 days of its receipt of the written notice of termination, the breaching party began to cure the breach and advised the non-breaching party in writing that it intended to cure.

B. Termination for Convenience of the County. The County may, in its discretion, terminate this Agreement at any time for any reason by giving the Contractor written notice of termination. The notice must specify the effective date of termination, which will not be less than 15 days from the Contractor's receipt of the notice. The County will pay the Contractor for acceptable services performed before the effective date of termination but will not be liable for any services performed after the effective date of termination.

6. APPROPRIATIONS AND AUTHORIZATIONS

This Agreement is contingent upon sufficient appropriations and authorizations being made for performance of this Agreement by the Board of County Commissioners of the County and/or, if state funds are involved, the Legislature of the State of New Mexico. If sufficient appropriations and authorizations are not made in this or future fiscal years, this Agreement will terminate upon written notice by the County to the Contractor. Such termination will be without penalty to the County, and the County will not have the duty to reimburse the Contractor for expenditures made in the performance of this Agreement. The County is expressly not committed to expenditure of any funds until such time as they are programmed, budgeted, encumbered and approved for expenditure by the County. The County's decision as to whether sufficient appropriations and authorizations have been made for the fulfillment of this Agreement will be final and not subject to challenge by the Contractor in any way or forum, including a lawsuit.

7. INDEPENDENT CONTRACTOR

The Contractor and its agents and employees are independent contractors and are not employees or agents of the County. Accordingly, the Contractor and its agents and employees will not accrue leave, participate in retirement plans, insurance plans, or liability bonding, use County vehicles, or participate in any other benefits afforded to employees of the County. Except as may be expressly authorized elsewhere in this Agreement, the Contractor has no authority to bind, represent, or otherwise act on behalf of the County and agrees not to purport to do so.

8. ASSIGNMENT

The Contractor must not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the advance written approval of the County. Any attempted assignment or transfer without the County's advance written approval will be void.

9. SUBCONTRACTING

The Contractor must not subcontract or delegate any portion of the services to be performed under this Agreement without the advance written approval of the County. Any attempted subcontracting or delegating without the County's advance written approval will be void.

10. PERSONNEL

A. All services performed under this Agreement will be performed by the Contractor or under its supervision.

B. The Contractor represents that it has, or will secure at its own expense, all personnel required to discharge its obligations under this Agreement. Such personnel (i) must not be employees of or have any contractual relationships with the County and (ii) must be fully qualified and licensed or otherwise authorized or permitted under federal, state, and local law to perform such services.

11. RELEASE

Upon its receipt of all payments due under this Agreement, the Contractor releases the County, its elected officials, officers, agents and employees from all liabilities, claims, and obligations whatsoever arising from or under or relating to this Agreement.

12. CONFIDENTIALITY

Any confidential information provided to or developed by the Contractor in the performance of this Agreement will be kept confidential and will not be made available to any individual or organization by the Contractor without the prior written approval of the County.

13. PUBLICATION, REPRODUCTION, AND USE OF MATERIAL; COPYRIGHT

A. The County has the unrestricted right to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data, or other material prepared under this Agreement.

B. The Contractor acknowledges and agrees that any material produced in whole or in part under or pursuant to this Agreement is a work made for hire. Accordingly, to the extent that any such material is copyrightable in the United States or in any other country, the County will own such copyright.

14. CONFLICT OF INTEREST

The Contractor represents that it has no and will not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of its obligations under this Agreement.

15. NO ORAL MODIFICATIONS; WRITTEN AMENDMENTS REQUIRED

This Agreement may not be modified, altered, changed, or amended orally but, rather, only by an instrument in writing executed by the parties. The Contractor specifically acknowledges and agrees that the County is not be responsible for any changes to section 1 (Contractor's Services) unless such changes are set forth in an amendment to this Agreement.

16. ENTIRE AGREEMENT; INTEGRATION

This Agreement incorporates all the agreements and understandings between the parties concerning the subject matter, and all such agreements and understandings are merged into this Agreement. No prior or contemporaneous agreement or understandings, verbal or otherwise, of the parties or their agents will be valid unless embodied in this Agreement.

17. NOTICE OF PENALTIES

The Procurement Code, NMSA 1978, Section 13-1-28, imposes civil and criminal penalties for its violation. In addition, New Mexico criminal statutes impose felony penalties for bribes, gratuities, and kickbacks.

18. EQUAL EMPLOYMENT OPPORTUNITY COMPLIANCE; NON-DISCRIMINATION

A. The Contractor agrees to abide by all federal, state, and local laws, ordinances, and rules and regulations pertaining to equal employment opportunity and unlawful discrimination. Without in any way limiting the foregoing general obligation, the Contractor specifically agrees not to discriminate against any person with regard to employment with the Contractor or participation in any program or activities or services offered pursuant to this Agreement on the grounds of race, age, religion, color, national origin, ancestry, sex, physical or mental handicap, serious medical condition, spousal affiliation, sexual orientation, or gender identity.

B. The Contractor acknowledges and agrees that failure to comply with this section constitutes a breach of this Agreement.

19. COMPLIANCE WITH APPLICABLE LAW; CHOICE OF LAW

A. In performing its obligations hereunder, the Contractor will comply with all applicable laws, ordinances, and regulations.

B. Contractor will comply with the requirements of Santa Fe County Ordinance 2014-1 (Establishing a Living Wage).

C. This Agreement will be construed in accordance with the substantive laws of the State of New Mexico, without regard to its choice of law rules. Contractor and the County agree that the exclusive forum for any litigation between them arising out of or related to this Agreement will be state district court of New Mexico, located in Santa Fe County.

20. RECORDS AND INSPECTIONS

A. To the extent its books and records relate to (i) its performance of this Agreement or any subcontract entered into pursuant to it or (ii) cost or pricing data (if any) set forth in this Agreement or that was required to be submitted to the County as part of the procurement process, the Contractor agrees to (i) maintain such books and records during the term of this Agreement and for a period of six years from the date of final payment under this Agreement; (ii) allow the County or its designee to audit such books and records at reasonable times and upon reasonable notice; and (iii) to keep such books and records in accordance with generally accepted accounting principles (GAAP).

B. To the extent its books and records relate to (i) its performance of this Agreement or any subcontract entered into pursuant to it or (ii) cost or pricing data (if any) set forth in this Agreement or that was required to be submitted to County as part of the procurement process, the Contractor also agrees to require any subcontractor it may hire to perform its obligations under this Agreement to (i) maintain such books and records during the term of this Agreement and for a period of six years from the date of final payment under the subcontract; (ii) to allow the County or its designee to audit such books and records at reasonable times and upon reasonable notice; and (iii) to keep such books and records in accordance with GAAP.

21. INDEMNIFICATION

A. The Contractor shall indemnify the County and its elected officials, agents, and employees from any liabilities, damages, demands, suits, costs or expenses, including court costs and legal fees, resulting from the Contractor’s performance or non-performance of its obligations under this Agreement.

B. The County may control and participate in the defense of any demand, suit, or cause of action that relate to the County. No matter will be settled without the County's consent. Consent must not be unreasonably withheld.

C. The Contractor’s obligations under this indemnification section will not be limited by the terms of the insurance policy the Contractor is required to maintain under this Agreement.

22. SEVERABILITY

If any term or condition of this Agreement is held invalid or non-enforceable by a court, the remainder of this Agreement will not be affected and will be valid and enforceable.

23. NOTICES

Any notice required to be given to either party must be in writing and delivered in person, by courier service or by U.S. mail, either first class or certified, return receipt requested, postage prepaid, as follows:

To the County: Santa Fe County
Community Services Department
Attn: Jennifer N. Romero, Health Services Division Director
100 Catron Street
Santa Fe, New Mexico 87501

To the Contractor: Santa Fe Indigenous Center
Attn: Caren Gala, Director
1420 Cerrillos Rd.
Santa Fe, NM 87505

24. CONTRACTOR'S REPRESENTATIONS

The Contractor hereby represents and warrants that:

A. This Agreement has been duly authorized by the Contractor, the person executing this Agreement has authority to do so, and, once executed by the Contractor, this Agreement constitutes a binding obligation of the Contractor.

B. This Agreement and Contractor's obligations hereunder do not conflict with Contractor's governing agreement or purpose.

C. Contractor is legally registered and is properly licensed by the State of New Mexico to provide services anticipated by this Agreement and agrees to maintain such registration and licensure in good standing throughout the duration of the Agreement.

25. FAX and ELECTRONIC SIGNATURE

The parties hereto agree that a fax or electronic signature has the same force and effect as an original for all purposes.

26. NO THIRD-PARTY BENEFICIARIES

This Agreement was not intended to and does not create any rights in any persons not a party.

27. INSURANCE

A. General Conditions. The Contractor will submit evidence of insurance as is required herein. Policies of insurance must be written by companies authorized to write such

insurance in New Mexico.

B. General Liability Insurance, Including Automobile. The Contractor will procure and maintain during the life of this Agreement a comprehensive general liability and automobile insurance policy with liability limits in amounts not less than $1,000,000.00 combined single limits of liability for bodily injury, including death, and property damage for any one occurrence. Said policies of insurance must include coverage for all operations performed for the County by the Contractor; coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment, both on and off work; and contractual liability coverage under which this Agreement is an insured contract. The County of Santa Fe will be named as an additional insured on the policy.

C. Workers' Compensation Insurance. The Contractor must comply with the provisions of the Workers' Compensation Act.

D. Increased Limits. If, during the life of this Agreement, the Legislature of the State of New Mexico increases the maximum limits of liability under the Tort Claims Act, NMSA 1978, Section 41-4-1, the Contractor agree to increase the maximum limits of any insurance required herein.

28. PERMITS, FEES, AND LICENSES

Contractor must procure all permits and licenses, pay all charges, fees, and royalties, and give all notices necessary and incidental to the due and lawful performance of its obligations.

29. NEW MEXICO TORT CLAIMS ACT

No provision of this Agreement modifies or waives any sovereign immunity or limitation of liability enjoyed by County or its "public employees" at common law or under the New Mexico Tort Claims Act, NMSA 1978, Section 41-4-1.

30. CAMPAIGN CONTRIBUTION DISCLOSURE FORM

The Contractor agrees to compute and submit simultaneous with execution of this Agreement a Campaign Contribution Disclosure form approved by the County.

31. SURVIVAL

The provisions of following paragraphs will survive termination of this Agreement: INDEMNIFICATION; RECORDS AND INSPECTION; RELEASE, CONFIDENTIALITY, PUBLICATION, REPRODUCTION, AND USE OF MATERIAL; COPYRIGHT; COMPLIANCE WITH APPLICABLE LAW; CHOICE OF LAW; NO THIRD-PARTY BENEFICIARIES; and SURVIVAL.

IN WITNESS WHEREOF, the parties have duly executed this Agreement as of the date of last signature by the parties.

SANTA FE COUNTY:

	3/8/2024
Gregory S. Shaffer	Date
Santa Fe County Manager	

Approved as to form:

Roberta D. Joe for J.Y.	February 23, 2024
Jeff Young	Date
Santa Fe County Attorney	

Finance Division:

N/A	N/A
Yvonne S. Herrera	Date
Finance Director	

CONTRACTOR - SANTA FE INDIGENOUS CENTER:

	3/5/2024
Signature	Date

Caren Gala, Director
Print name and title

Justin S. Greene
Commissioner, District 1

Anna Hansen
Commissioner, District 2

Camilla Bustamante
Commissioner, District 3

SANTA FE COUNTY

Anna T. Hamilton
Commissioner, District 4

Hank Hughes
Commissioner, District 5

Gregory S. Shaffer
County Manager

MEMORANDUM

Date: December 26, 2023

To: Procurement File

From: Bill Taylor, Procurement Manager BT

Via: Rachel O'Connor, Community Services Director
Jennifer N. Romero, Health & Human Services Division Director

Subject: **Determination Pursuant to the Hospital and Health Care Exemption, NMSA 1978, 13-1-98.1B to Procure Navigational Services with Santa Fe Indigenous Center, for an Amount Not to Exceed $23,900.00, Inclusive of NM GRT.**

Background:

The Santa Fe County Community Services Department ("Department") has implemented the healthcare network CONNECT within Santa Fe County. CONNECT provides navigation and financial assistance to meet the various health needs of County residents, including navigational and financial assistance to members of the healthcare network CONNECT to meet the needs of County residents for the social determinants of health, including food, housing, utilities, transportation, and other needs such as behavioral health. The CONNECT network relies on the participation of navigators and community services organizations with which we contract.

Santa Fe Indigenous Center was founded in 2008 and has been serving our Indigenous community by linking individuals to vital resources including food, housing and clothing. They have been a main access point for our Indigenous population and have grown to serve individuals outside their primary focus. The Santa Fe Indigenous Center participated in the CONNECT Planning Committee as we began to build the network in 2017. Unfortunately, at that time they did not have the human capacity nor the technical requirements to participate at the level required for them to contribute in a meaningful way. Over the years they have increased staff and secured the proper technology needed to join the network. Providing flexible funds in addition to the Navigation services provided by Santa Fe Indigenous Center will complement and enhance services for the individuals in our community who are seeking basic needs.

As part of the healthcare network CONNECT, the Department is requesting to utilize NMSA 1978, 13-1-98.1. (B) Hospital and health care exemption to contract with Santa Fe Recovery to provide navigational services through the CONNECT network.

Determination:

It is the determination of the County Procurement Manager and Chief Procurement Officer that the intent to contract with Santa Fe Indigenous Center, Inc. to provide navigational services through the CONNECT network will improve the quality of and access to healthcare services within Santa Fe County.

Therefore, contracting with Santa Fe Indigenous Center to join the CONNECT healthcare network meets the intent of the Hospital and Health Care Exemption, pursuant to NMSA 1978, 13-1-98.1B.

UNITE US

CONNECT SDOH Screen

updated 1/2022

Name: _____

Navigator: _____

Date: _____

1. What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I am worried about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following? (Choose all that apply)

- ☐ Pests such as bugs, ants or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes
- ☐ No

6. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Already shut off

7. How often does anyone, including family and friends, physically hurt you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

8. How often does anyone, including family and friends, insult or talk down to you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

9. How often does anyone, including family and friends, threaten you with harm?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

10. How often does anyone, including family and friends, scream or curse at you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

11. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services?

☐ Yes ☐ No ☐ Don't Know

If "Yes," what insurance do you have:

☐ Medicaid
☐ Medicare
☐ Veterans Administration
☐ Indian Health Service
☐ Other through my employer
Name: _____
☐ Other that I pay for myself
Name: _____

12. Do you have any sources of income?

☐ Yes ☐ No

If "yes," what are your sources of income?

- ☐ Alimony or other spousal support
- ☐ Business Income
- ☐ Child Support
- ☐ Earned Income (wages, salaries, tips, etc.)
- ☐ Pensions and/or annuities
- ☐ Private Disability Insurance
- ☐ Rental Income
- ☐ Retirement Account Distributions
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Social Security Retirement/Survivors Income
- ☐ State-specific Cash Assistance
- ☐ State-specific Disability Income
- ☐ Supplemental Security Income (SSI)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Unemployment Insurance
- ☐ VA Non-Service-Connected Disability Pension
- ☐ VA Retirement Pension
- ☐ VA Service-Connected Disability Compensation
- ☐ Workers Compensation
- ☐ Other Source

If "other," please explain:

13. What is your total annual income?

14. If you are a student, what is your status?

- ☐ Student, full-time
- ☐ Student, part-time

15. What is the highest level of education you have achieved?

- ☐ Less than a high school diploma
- ☐ GED/High School Diploma
- ☐ Some College, No Degree*
- ☐ Trade/Technical/Vocational Training*
- ☐ Associate's Degree*
- ☐ Bachelor's Degree*
- ☐ Master's Degree*
- ☐ Professional Degree/Doctorate*

*What was the focus of your degree or certification?

16. How many children live with you in your household?

if 0, go to Q19
if 1+, go to Q17

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 or more

17. Do you need child care now or in the next 6 months?

if yes, go to Q18
if no, go to Q19

- ☐ Yes
- ☐ No

18. Please select the childcare need for any of the following:

- ☐ Infants (birth - 12 months)
- ☐ Toddlers (1 - 2 years)
- ☐ Pre-school (3 years)
- ☐ Pre-K (4 - 5 years)
- ☐ Before/after school care for school aged children

19. Do you speak a language other than English at home?

☐ Yes ☐ No

20. What is the primary language you speak?

☐ English ☐ Spanish ☐ Navajo

☐ Pueblo ☐ Other ☐ Other: _____

The additional SDOH questions are supplemental, to be asked at the discretion of the navigator and are not mandatory.

21. How hard is it for you to pay for the very basics like food, housing, medical care and heating? Would you say it is:

☐ Very hard ☐ Somewhat hard ☐ Not hard at all

22. Do you want help finding or keeping work or a job?

☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help

23. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

☐ I don't need any help ☐ I could use a little more help

☐ I get all the help I need ☐ I need a lot more help

24. How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

25. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

☐ Yes ☐ No

26. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

27. On average, how many minutes did you usually spend exercising at this level on one of those days?

☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40

☐ 50 ☐ 60 ☐ 90 ☐ 120 ☐ 150 or greater

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you.

28. During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor?

☐ _____ days per week

☐ _____ days in the past 30 days

☐ No drinks in the past 30 days

29. Considering all types of alcoholic beverages, how many times during the past 30 days did you have [5 for men/4 for women] or more drinks on an occasion?

☐ _____ number of time ☐ None ☐ Don't know/Not sure

30. How many times in the past 30 days have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

☐ Every day ☐ Some days ☐ Never

31. How many times in the past 30 days have you used prescription drugs for non-medical reasons?

☐ Every day ☐ Some days ☐ Never

32. How many times in the past 30 days have you used illegal drugs?

☐ Every day ☐ Some days ☐ Never

UNITE US

Evaluation Screen

CONNECT COMMUNITY is our Greatest Resource

Name: _____

Navigator: _____

Date: _____

Has the Program Evaluation Consent Form been signed and uploaded?

☐ Yes ☐ No

If not, please ask for the individual for verbal assent to evaluate the community-wide impact of CONNECT.

Navigator script: *"We hope to grow to meet the needs of all residents of Santa Fe City and County over time. To do that we need to prove the value of CONNECT. One of the ways we do that is by helping residents like you - and you can help spread the word about our good work to people you know. Another way to prove value is by completing an evaluation that shows that when CONNECT provides community members with the assistance they need now it saves emergency, hospital, medical and jail costs later. You can help us prove that."*

(Note: Medical information from the New Mexico Health Information Exchange is protected by state and federal privacy laws and will not be made public and will not be shared with any other state, county or federal agencies.)

Assent:
"Will you allow Santa Fe County to electronically access health information and any records maintained by city or county public safety agencies in Santa Fe, to be used ONLY to evaluate the community-wide impact of CONNECT?"

☐ Yes ☐ No

1. **Would you in general say that your health is:**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?**

☐ _____ number of days ☐ None

3. **Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?**

☐ _____ number of days ☐ None

4. **During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?**

☐ _____ number of days ☐ None ☐ N/A

5. **Have you been in the hospital (in the last 30 days)?**

☐ No ☐ Don't Know or refused

☐ Yes
If yes, when were you discharged? _____

6. **Have you been in the ER (in the last 30 days)?**

☐ No ☐ Don't Know or refused

☐ Yes
If yes, when were you discharged? _____

7. Have you been in jail/detention (in the last 30 days)?

☐ No ☐ Don't Know or refused

☐ Yes

If yes, when were you discharged? _____

8. Has your phone number, email or home address changed since the last time we spoke?

☐ No

☐ Yes, *update client's FaceSheet*

COMMUNITY
is our Greatest Resource

CONNECT Navigation Protocols

Fiscal Year 2023

A SANTA FE COUNTY + CITY OF SANTA FE
COMMUNITY PARTNERSHIP

Contents

INTRODUCTION 2
MEET OUR NETWORK 4
NAVIGATION: LET'S GET STARTED! 4
SCREENING 5
ENROLLMENT 6
NAVIGATION PLAN DEVELOPMENT 8
PATHWAYS TO SUCCESS 8
HOUSING 9
FOOD 10
TRANSPORTATION 11
UTILITIES 12
INTERPERSONAL SAFETY 12
FLEXIBLE FUND 14
REPORTING and INVOICING REQUIREMENTS 16
DATA 16
REPORTS 17
INVOICES 17
NAVIGATION MONTHLY MEETINGS 18
PROFESSIONAL DEVELOPMENT 18
CLINICAL GUIDANCE 19
COMMUNITY ENGAGEMENT 21
Advisory Committee 21
Empowerment, Collaboration and Feedback 22
CONTACT US 22

"The Accountable Health Community (now referred to as CONNECT) respects the people of Santa Fe City and County, serving the community with compassion and resourcefulness, creating a network of trust to effect health and well-being for all."

-Value Statement developed by navigators 7/24/18

INTRODUCTION

CONNECT is a network of navigators at clinics, hospitals, schools, community service organizations and city and county programs that link people to the services and resources. Santa Fe City and Santa Fe County recognize the need to address Social Determinants of Health (SDOH) that impact health outcomes for residents. The World Health Organization defines social determinants as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." Social Determinants include access to health care, housing, healthy food, transportation, and other social and material supports.

To focus on this priority, Santa Fe City and County Community Services Departments fund community organizations for delivery of navigation services to address factors that influence health by linking residents to goods and services that address these unmet needs. Benchmarks include reductions in jail recidivism, emergency department utilization and hospitalizations while improving individual and population health.

CONNECT is based on the Accountable Health Community (AHC) model developed by the Centers for Medicare and Medicaid Services (CMS). In an effort to align with current national trends we chose to use the CMS Social Determinant of Health Screening Tool while tailoring the initiative to the strengths and needs of our community.

Using an "any door" philosophy, organizations in the network screen Santa Fe City and County residents at any door of programs in our network rather than single points of entry in health care systems. Like the CMS model, people who screen positive on the assessment tool uniformly used by participating organizations receive assistance to meet SDOH needs. We refer to this assistance-particularly when accompanied with discussion, prioritization of SDOH needs and plan

development-as navigation. Navigation is further defined as an activity which solidly links residents to needed resources via evidence-based practices by qualified, culturally competent staff.

For the first two and a half years the network was called the Accountable Health Community and was funded by Santa Fe County. In July of 2019 the Community Services Departments of both the County and the City of Santa Fe partnered to expand the program by adding additional organizations and creating a leadership team. As a result of facilitated discussions with stakeholders and partnership with the City, the name was changed to CONNECT in March of 2020.

The vision of CONNECT is: All City and County residents regardless of income have access to high-quality health care and are linked to the resources they need for health and well-being.

Goals include:

- Residents and providers collectively identify problems and co-create solutions.
- Navigators link residents to resources within a cohesive provider network.
- Social, economic, and physical environmental resources are available to all residents.
- Information systems are coordinated. Data is collected, monitored and evaluated to improve services and population health while reducing health care costs.

Eligibility differs based on whether a partner organization is contracted by the City or County. Grantees with the City of Santa Fe offer screening for social determinants and navigation services to all City residents and there are no eligibility requirements.

Navigation services provided by organizations contracted through the County are available to Santa Fe County residents who qualify for the Santa Fe County Health Care Assistance Program, eligibility for which is based on financial status as required by Santa Fe County Resolution No. 2014-47 (Resolution 2014-47).

Santa Fe FY 2023 income limits are as follows:

PERSONS IN FAMILY	1	2	3	4	5	6	7	8
INCOME	47,800	54,600	61,450	68,250	73,750	79,200	84,650	90,100

CONNECT navigators use protocols, network standards and an on-line referral platform (Unite Us) to develop inter and intra-agency workflows that utilize and facilitate a network/team approach to address priorities of the individual. The goal is to build a responsive team with the right resources to address health related needs, reduce duplication of service, clearly identify and delineate responsibility to achieve goals, and provide opportunities for regular updates with other navigators and agencies involved for better coordination of service.

The Flexible Fund serves as a payor of last resort for emerging and emergency needs. With a goal of averting a crisis, the fund quickly addresses unmet resource needs. A list of approved expenditures is found on pages 15-17 in this document. Additional funding is being sought to provide a wider range of resources to more people in need.

Navigation Protocols provide guidelines for organizations contracted by both the County and City. Instructions that differ and are specific to County or City contractors are otherwise clearly marked.

MEET OUR NETWORK

The CONNECT Network has grown significantly in the past six years. The network started in July of 2017 with thirteen navigators from eight organizations.

Growing the network to include more organizations and creating a larger and more cohesive provider network in our community is a foundational goal. In July of 2019, partnership with the City of Santa Fe allowed for twenty navigators from thirteen additional organizations to join the network and use the Unite Us platform. The County and City partnership aligns contracts, streamlines protocols, and creates a larger network with a common vision and is hoped to be a model for replication and planned growth.

Today the network has over 225 navigators from almost 65 community programs. For an up-to-date list of CONNECT organizations and navigators refer to the "My Network" tab in the Unite Us platform.

As a response to COVID-19, more City and County funded organizations joined the network to provide short term navigation and Flexible Funding for COVID-19 related needs. A public facing portal was added to allow people to self-refer and receive navigation from CONNECT hub navigators comprised of City and County employees. City and County youth funded organizations and navigators joined the network in 2020 and La Sala Crisis Center joined in 2021. The Mountain Center, Casa Milagro, New Mexico Immigrant Law Center and Santa Fe Law Enforcement Assisted Diversion (LEAD) are the latest to join.

NAVIGATION: LET'S GET STARTED!

Three levels of navigation are funded and responsibilities vary in each tier.

Tier I focuses on safety net service delivery. Tier 1 navigators provide individuals with units or items of service delivery such as food, clothing, hours of counseling, etc. and send and close referral loops. Tier I funded organizations are encouraged to attend monthly navigation meetings and must fully participate in collaborating with other agencies.

Tier II focuses not only on safety net service delivery and closing referral loops, but also on screening and navigation services. Tier II navigators will screen for needs and connect individuals to safety net services and navigate them to other priority community services. The SDOH Screening Tool determines unmet needs. Navigators coordinate care and services using the Unite Us platform (as well as other resources outside the platform when necessary), leading to greater holistic and person-centered care captured on a Navigation Plan. Tier II navigators attend monthly navigation meetings and fully participate in collaborating with other agencies.

Tier III focuses on providing services other than navigation. Organizations are required to allow a city, county or partner agency navigator to be present if a need arises or participate in events for outreach and to collaborate when appropriate.

Tier I and Tier II navigators in the network have licenses to use the Unite Us platform. The Unite Us platform supports and documents the daily work of the navigators and allows for consistent data collection and reporting of social determinants and related outcomes.

Please refer to the pdf titled **CONNECT Network Standards** dated June 2023 for information on best practices, data standards, expected workflow and referral and response standards for using the Unite Us platform. The information applies to navigators within the network who have a license to use the platform.

The **CONNECT Digital File** includes Network Standards and supplemental information of use to navigators. The file is emailed to every navigator either at the beginning of the fiscal year or when navigators join the network during the year. It provides digital versions of the SDOH Screening Tool, the Evaluation Screen, the Unite Us Consent and Consent for Health Information Exchange for program evaluation in English and Spanish and navigation plan templates that can be printed. The file is not intended to supplant the Unite Us platform but to replicate some of the forms found on it. We recognize internet access and some locations where navigation occurs aren't conducive to using an on-line platform. Paper forms allow navigators to collect information to be uploaded or entered at a later time.

SCREENING

Screening and enrollment occur at any CONNECT site or partner service organization that has a working agreement, navigators and/or clinic contract with Santa Fe County or the City of Santa Fe Community Services Departments. A self-referral portal is available on the City and County websites allowing people to refer into the network on their own. CONNECT hub navigators provide screening, intake and navigation for people who self-refer.

Individuals are screened by navigators to identify unmet Social Determinants of Health. The **SDOH Screening Tool** is used during the intake process and throughout service provision to identify social needs of the individual. Repeat visits to the screening tool questions are suggested as people's circumstances and needs change over time. Navigators are encouraged to use their

discretion and adapt the screening tool questions to suit the individual and their level of comfort at the moment. Building trust with the individual and creating a safe environment to talk is an important aspect of providing navigation. Some of the questions on the screen may trigger responses for people with trauma. Please adapt the intake to accommodate the person. **The SDOH Screening Tool is a required screening for all individuals enrolled in CONNECT and should be completed at the time of enrollment and every 12 months or at a life changing event thereafter.**

Electronic versions of the SDOH Screening Tool in English and Spanish are available and included in the CONNECT Digital File.

In Fiscal Years 2018-19 the following Social Determinants of Health were included in the screening:

Safe Housing	**Reliable Transportation**	**Reliable Utilities**
Access to Nutritious Food	**Personal Safety**	

In Fiscal Year 2020 additional SDOH questions have been added that address:

Finances	**Employment**	**Family/Community Support**
Education	**Physical Activity**	**Substance Use**
Mental Health	**Disabilities**	

The additional SDOH questions are supplemental, to be asked at the discretion of the navigator and not mandatory.

The Navigator shall proceed to enroll the individual if an individual:

(1) screens positive for any of the above and,
(2) is a Santa Fe City or County resident and,
(3) if a County resident qualifies for the Santa Fe County Health Care Assistance Program

ENROLLMENT

The person will be considered enrolled if the individual:

(1) screens positive for any of the Social Determinants of Health on the SDOH Screen and,
(2) would like assistance to address unmet needs and,
(3) signs a **Unite Us Consent** and a paper copy of the **NM Health Information Exchange (HIE) Consent or provides a verbal assent** for the HIE is documented for program evaluation. If a person declines signing the consent for Unite Us the enrolling organization will keep paper copies of the Client Record, SDOH Screen, Evaluation Screen and receipts for Flexible Fund use. In such instances, referrals will not be sent via Unite Us, but will need to be completed via email or by phone.

As an individual is enrolled, the **Evaluation Screening Tool** should be completed by all navigators. The screen asks questions used for program evaluation and should be asked once a month as navigators see individuals after initial enrollment. **The Evaluation Screening Tool is a required screening for all individuals enrolled in CONNECT and should be completed at the time of enrollment and every three months thereafter.**

The **COVID-19 Screening Tool** should be completed by all navigators and is particularly important if COVID Relief funds (ARPA) are being disbursed or an individual discloses that their current unmet SDOH need is related to COVID. **The COVID-19 Screening Tool is a required screening for all individuals utilizing COVID relief funds.**

The consent for program evaluation can be completed by verbal assent and documented in Unite Us. Alternatively, if a verbal assent is not documented, the **Health Information Exchange Consent** is found in the Digital File and should be signed by the individual during intake. The consent or assent provides permission by the individual for program evaluators to electronically access information from the New Mexico Health Information Exchange. The medical information will be protected by state and federal privacy laws, will not be made public, and will only be used to evaluate the impact of CONNECT.

A **script** for the Health Information Exchange (HIE) Consent for program evaluation is included in the CONNECT Digital File. The script describes how information is bundled together, or aggregated, enabling evaluators to look at the positive impact of our work. Assure the individual that their data will be used in the aggregate to assess the impact of CONNECT on the health of our community. No individual or identifying data will be used by CONNECT, shared with any state, county or federal agencies, or made public.

Both signed consents are in effect until the individual withdraws permission in writing or opts out of the NM Health Information Exchange. Navigators will upload a signed copy of the program evaluation consent in the Unite Us platform on the Upload Page if verbal assent is not documented in the Unite Us platform.

If an individual does not want to sign either consent navigation services may still be provided. Contact the contract manager for advice on how to document your work to invoice for services provided.

At enrollment the individual will be asked to identify organizations they have current or previous relationships with to determine possible referral sites or inclusion on the navigation/care team and documented in the Unite Us platform on the Profile Page.

NAVIGATION PLAN DEVELOPMENT

A **Navigation Plan** is a tool designed to identify the root cause of SDOH challenges, co-create solutions, and assist individuals with identifying and accessing appropriate resources and support services. The Navigation Plan is required for individuals provided with navigation, based on the SDOH Screening Tool results and/or referrals generated by Unite Us and will include measurable goals based on the individual's priorities. The plan is developed after completing the SDOH screen and having a conversation with the individual to discuss priorities.

The navigation plan notes priorities, the primary navigator conducting the intake, and the care/navigation team. Navigators from community service partners who are listed on the care team are providing resources and services to the individual. Tier 1 navigators are also encouraged but not required to develop a Navigation Plan with the individual. The Navigation Plan should be completed and uploaded onto the platform within 30 days of enrollment. Training for navigation planning is provided by CONNECT on an annual basis.

The Navigation Plan will include the following components:

- Name of primary navigator and organization developing the plan
- Measurable goals
- Signatures of the individual and the primary navigator (if plan is completed in person)
- Date of plan development
- Review date of Navigation Plan

Goals will follow the SMART model of being Specific, Measurable, Achievable, Relevant and Time-bound.

1. **Specific** - Consider who, what, when, where, why and how in developing the goal.
2. **Measurable** - Include a numeric or descriptive measurement.
3. **Achievable** - Consider the resources needed and set a realistic goal.
4. **Relevant** - Make sure the goal is results focused and links with the mission.
5. **Time-bound** - Set a realistic deadline.

Community partner organizations may use CONNECT Navigation Plans or the organization's plan if the above plan components are included. Two Navigation Plan templates are included in the Digital File and a Navigation Plan is in the Unite Us platform in the Forms tab. A completed plan should be uploaded to the Unite Us platform and a copy provided to the individual.

PATHWAYS TO SUCCESS

The following steps or pathways addressing housing, food, transportation, utilities and personal safety are guides created by navigators to successfully address each domain and may help in navigation planning.



HOUSING

Step 1. Develop a relationship with the individual. Document history of homelessness, medical and behavioral health needs if any that need to be addressed in emergency, short (30 day) and long-term housing options.

Step 2. What programs does the individual or family qualify for? Review housing resources at the local and federal level that include veteran, senior and low-income housing options. Some vouchers for permanent supportive housing only become available if a person is chronically homeless; that is, a documented period of one year within the last three.

If the person and/or family screen positive for a housing need complete a VI-SPDAT screen to determine eligibility for housing options to be added to the Homeless Management Information System (HMIS) database and make a referral to an appropriate organization. If you have not been trained to complete a VI-SPDAT please refer to an organization that can. Check with resources in surrounding counties if housing vouchers are available. Identify potential barriers to housing. Are there previous evictions, legal or medical issues? Does the individual have an ID?

Step 3. Collect documents that include: identification, credit history, income status, bank statements. Provide assistance with applications and prepare the individual for appointments and interviews. Make copies of documents for the individual and for organization files, following organization policies for file storage.

Step 4. Navigator and individual contact appropriate organization(s), schedule an appointment, meet and discuss housing options. Navigator confirms that the individual attended appointment and has at the very least been put on a waiting list for housing and/or resolved immediate housing crisis.

Step 5. Navigator maintains contact throughout the application process, schedules regular appointments to check in while individual is on waiting lists. Provide follow-up for a year to ensure housing voucher renewal (if relevant) is completed within the correct time frame, rent is paid, and property is maintained.

Step 6. Anticipate and develop goals to address emergency, interim and long-term options for housing.

Use Flexible Funds for:

- Rent (up to 3 months per calendar year)
- Sleeping mat

- Sleeping bag
- Mold remediation
- Pest removal
- Housing repairs, appliance replacement or safety modifications related to plumbing and water leaks, electrical, heat, oven, hot water heater, smoke detectors or grab bars ($2,000 max)
- Fees for identification needed to obtain housing
- Hotel (up to 3 months per calendar year)

NO:

- Security Deposit
- Tent

Final Step: The pathway is completed when the individual is housed with adequate support services for 3 months.



FOOD

Step 1. Assess the need and possible solutions for immediate and long-term access to healthy food. Navigator talks with individual about programs they may be eligible for and uses the Unite Us Platform to make referrals and share in-network food resources. The SHARE/ New Mexico resource directory can be used to print and provide options as well. (SNAP, WIC, food distribution sites, prepared meal delivery services and drop-in meal sites).

Please note documentation status can exclude people. Check options available specifically for people who are not US citizens.

Use Flexible Funds for:

- Groceries
- Hot meal
- MoGro membership
- Baby formula
- Breastfeeding supplies
- Prenatal vitamins
- Fees for identification needed for SNAP application
- Grocery card (identification required for use)

Step 2. If eligible for SNAP, the navigator assists with application and in-person or phone interview with the Income Support Division at the Human Services Department.

Step 3. Whether or not eligible for SNAP benefits, Navigator explores with the individual all possible food distribution and meal sites and how to access them with local transportation options. Navigator provides referrals to programs with specific age or health requirements.

Step 4. Navigator accompanies the individual to first visit of site. (warm hand-off, if agency policy permits)

Step 5. Navigator meets with the individual to assess progress and barriers and to develop food goals in a navigation plan.

Final Step: The pathway is completed when the individual has reliably accessed healthy food resources for 1 month.



TRANSPORTATION

Step 1. Assess the need and possible solutions for immediate and long-term transportation.

Step 2. Review public transportation resources that are applicable to the individual. For County Contractors: If vehicle repair or parts are needed use Emergency Flexible Fund as leverage for in-kind or private contributions. Encourage the individual to pay whatever they can to contribute.

Use Flexible Funds for:

- Bus pass
- Fuel for vehicles
- Uber and Lyft gift cards
- Fees for Driver's License or identification needed to obtain license
- Vehicle repairs and parts to keep vehicle roadworthy ($1,500 max per vehicle)
- Car seat
- Vehicle insurance (up to 6 months)
- Bicycle parts and repair
- Gas card (identification required for use)

Step 3. Create goals in a Navigation Plan with the individual to address ongoing transportation needs. Identify transportation options that address immediate and long-term transportation.

Final Step: The pathway is completed when the individual has reliable transportation for 1 month.



UTILITIES

Step 1. Assess the need for assistance and eligibility to include personal and situational factors leading to the need.

Step 2. Apply for Low Income Home Energy Assistance Program (LIHEAP) at Human Services Department if LIHEAP eligible. Help the individual prepare for a meeting with referral agency. Locate and copy required documentation, arrange childcare, secure transportation, review hours of operation, request for bills from utility companies. Confirm that the individual attended the appointment and has a potential solution.

Step 3. If not eligible or LIHEAP is unavailable:

- Seek assistance from other organizations, city and county resources

Use Flexible Funds for:

- Pellets
- Firewood
- Propane
- Fan
- Gas, Electric, Water Bill, Phone, Internet payment (up to 3 months)
- Flashlight
- Fees for identification needed to obtain utilities
- Smoke and Carbon Monoxide detectors

Step 4. Create goals in a navigation plan with the individual to address ongoing utility needs. What is the root cause for not having utilities? Could the individual benefit from life skills for budgeting, problem solving, follow up? Would enrollment in PNM's budget billing program or heating season shut off protection be helpful?

Final Step: The pathway is completed when the individual secures and maintains utilities for 3 months.



INTERPERSONAL SAFETY

Step 1. Is there a safety issue based on the SDOH Screening Tool?

If yes, assess for immediate safety needs.

Is the individual injured? (Call 911)
Where is the person who inflicted harm?
Are there children or others in danger?

Step 2. Review resources for needs unique to the individual and family. If the individual or family has an immediate safety need ask the individual if you can assist to make a referral to Esperanza Shelter (800-473-5220). Ensure a warm hand-off that includes arranging or providing transportation to the emergency shelter coordinated with staff at the shelter.

Use Flexible Funds for:

- Train, bus fare for safe destination
- Court fees such as filing fees for new birth certificate, social security card,
- and ID/Driver's License
- Asylum application fee
- Fee for name change needed for safety

Step 3. Ask the individual if they want to report the abuse to the police. Review mandatory reporting requirements and report if there is reasonable cause for neglect or abuse of a child or vulnerable adult. If you aren't sure if there is a reasonable cause, call the numbers below to ask a hypothetical question to help determine if there is reasonable cause.

REPORTING CHILD NEGLECT AND/OR ABUSE: Any person must report if a person "knows or has a reasonable suspicion that a child is an abused or a neglected child." New Mexico law allows confidential reports of child abuse and/or neglect to be made to a local law enforcement agency, the Department of Children, Youth and Families (CYFD) Statewide Central Intake (855-333-7233) or a tribal law enforcement or social services agency for and Indian child residing in Indian Country. [NMSA section 32A-4-3 A]

REPORTING ADULT NEGLECT AND/OR ABUSE: New Mexico has a "Duty to Report" provision in the Adult Protective Services Act (27-7-30) which states: "Any person, or financial institution, having reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited shall immediately report that information to Adult Protective Services." Adult Protective Services remains on call for emergent reports of adult abuse, neglect, and exploitation 24 hours a day, 7 days a week.
If you suspect an adult is being abused, neglected, or exploited, call Adult Protective Services Statewide Intake, toll-free at **1-866-654-3219 or 1-505-476-4912**.

Step 4. Provide your contact information to the individual to encourage continuation of navigation services relating to the Navigation Plan.

Final Step: The pathway is completed when the individual or family feels safe, free from abuse and sustains mental and physical health for one month.

FLEXIBLE FUND

A Flexible Fund is available to respond to an enrolled person's emerging or immediate crisis involving housing, transportation, utilities, access to food, personal safety, or other unmet SDOH, and activities related to achieving the goals documented in a navigation plan. A list of pre-approved uses is provided in Exhibit A.

Other uses may be allowed by prior written approval of the contract managers for the City and County. Flexible Funds are intended to serve as the *payor of last resort*, not to supplant other available funding sources. Flexible Funds can be used for episodes that are time limited. The navigator must demonstrate a source of ongoing funding to avoid repeated use for the same request and document in a navigation plan.

When distributing Flexible Funds, navigators are encouraged to exercise discretion and be innovative. To extend the available funds, navigators should seek community partners to donate or partially fund the purchase and encourage the individual to contribute to the extent possible.

Any person enrolled is eligible to receive Flexible Funds. There is no limit on the number of items or frequency per contract year of Flexible Funds that an individual may receive except as specified in Exhibit A where expenditure caps are listed. A person may not receive funds for the same item more than once from the same partner organization, and the navigation service cannot expend or commit more funds than are present in the account for Flexible Funds at the time of the request. There is a cap of $25,000 per individual in their lifetime and caps on specific items as listed in Exhibit A. Exceeding caps on certain items may be allowed with prior written approval of the contract managers for the City and County.

A navigator may obtain an item with Flexible Funds and give it to the individual or accompany the individual and pay for an item with Flexible Funds but cannot give Flexible Funds to the individual to pay for an item.

Flexible Funds cannot be used for any purpose not specified in this policy. The disbursement of Flexible Funds is tracked in the Unite Us System by adding Social Care Coverage and documenting using the payments feature. Receipts must be uploaded onto the platform and correspond with the invoice submitted to the City or County. The receipts must be titled with the name of the individual, the date and the service category of the expenditure and uploaded within the reporting term that the purchase is made.

Best practice for documenting Flexible Fund expenditures is within 24 hours. Please refer to the Network Standards for a detailed description of how to document expenditures in the Unite Us platform.

It is the responsibility of each organization to review these protocols regularly. Terms are subject to change.

If you have any questions regarding this policy, contact the contract managers:
COUNTY: Jennifer Romero, jnromero@santafecountynm.gov
CITY: Christa Hernandez, chernandez@santafenm.gov

EXHIBIT A

HOUSING:
Rent (up to 3 months per calendar year)
Sleeping mat
Sleeping bag
Mold remediation
Pest removal
Housing repairs, appliance replacement or safety modifications related to plumbing and water leaks, electrical, heat, oven, hot water heater, smoke detectors or grab bars ($2,000 max)
Fees for identification needed to obtain housing
Hotel (up to 3 months per calendar year)

NO:
Security Deposit
Tent

TRANSPORTATION:
Bus pass
Fuel for vehicles
Uber and Lyft gift cards
Fees for Driver's License or identification needed to obtain license
Vehicle repairs and parts to keep vehicle roadworthy ($1,500 max per vehicle)
Car seat
Vehicle insurance (up to 6 months)
Bicycle parts and repair
Gas card (identification required for use)

UTILITIES:
Pellets
Firewood
Propane
Fan
Gas, Electric, Water Bill, Phone, Internet payment (up to 3 months)
Flashlight
Fees for identification needed to obtain utilities
Smoke and Carbon Monoxide detectors

FOOD:	Groceries Hot meal MoGro membership Baby formula Breastfeeding supplies Prenatal vitamins Fees for identification needed for SNAP application Grocery card (identification required for use)
INTERPERSONAL SAFETY:	Train, bus fare for safe destination Court fees such as filing fees for new birth certificate, social security card, and ID/Driver's License Asylum application fee Fee for name change needed for safety
OTHER:	Weather-appropriate clothing Expenses related to education and securing employment (e.g., registration fees, clothing for work, computer, cap and gown for graduation, certifications, education/vocational tuition (max $1,000) Childcare assistance (up to 3 months)

Medical bills, prescriptions and durable medical equipment will not be paid for.

REPORTING and INVOICING REQUIREMENTS

The fiscal year is broken into four reporting quarters for both the County and City.

FISCAL YEAR SCHEDULE:	**Invoices Due:**
Quarter 1: July - September	October 15th
Quarter 2: October - December	January 15th
Quarter 3: January - March	April 15th
Quarter 4: April - June	June 15th (City) July 5th (County)

DATA

For County Contractors: The Unite Us platform collects and reports data. For each person enrolled, **a Client Record** will be created in the Unite Us platform to provide contact information and demographic data. In addition, the **SDOH Screening Tool** and **Evaluation Screening Tool** and **signed consents (2)** will be completed for all people enrolled by the end of the quarter. In order to invoice for navigation services per person, a **case or referral** in the Unite Us platform must be created for new individuals. Individuals can only be invoiced for services provided one time within the contract year.

For City Grantees: The Unite Us platform collects and reports data. For each person enrolled, **a Client Record** will be created in the Unite Us platform to provide contact information and demographic data. In addition, the **SDOH Screening Tool** and **Evaluation Screening Tool** and **signed consents (2)** will be completed for all people enrolled by the end of the quarter. In order to invoice for navigation services per person, a **case or referral** in the Unite Us platform must be created for new individuals. Individuals can only be invoiced for services provided one time within the contract year. Additional reports may be requested by the City for data not captured in Unite Us. Every effort by the CONNECT leadership team (a combination of City and County administrators) to reduce duplication of data entry, streamline processes, and increase consistency throughout the network despite funding source will be made.

REPORTS

For County Contractors: Data in Unite Us is exported by the County for all quarterly reports for contractors. At the end of the contract year (fiscal and contract years may differ) an **Annual Report** is due and should be emailed to Jennifer Romero by July 15. The annual report template is attached.

For City Contractors:

Grantees shall submit Biannual Reports on the programmatic accomplishments made toward the goals of the grant agreement. Biannual reports are due to the assigned Program Manager by the 15th of the month. If this date falls on a weekend, reports will be due the following Monday by close of business. If Monday is a holiday, reports will be due by close of business on Tuesday.

Reports are due by:

Report 1: July-December	**January 15th**
Report 2: January-June	**June 15th**

Reports should be emailed to:

Christa Hernandez,
chernandez@santafenm.gov
Justin Gonzales,
jmgonzales@santafenm.gov

Natalie Skogerboe,
natalie@aspensolutions.consulting
Ana Coghlan,
acoghlan@aspensolutions.consulting

INVOICES

For County Contractors:

An invoice template has been created for County contractors. The invoice includes payment per person served and Flexible Funds expended. *Please note that Navigation Services should be documented and Flexible Funds receipts must be uploaded to the Unite Us platform and must correspond with the amount invoiced to the County*. The receipts must be titled with the date, name of individual and the service category of the expenditure. The County will audit using the Unite Us platform throughout the year. **Invoices should be emailed to:**

Health Services Division Director
Jennifer N. Romero, jnromero@santafecountynm.gov

For City Grantees:
Invoicing is completed on a cadence agreed upon by the grantee and the City. The invoice template has been provided to all City Grantees. All contracts are deliverable based contracts and reimbursement is based on the people served at a per person rate outlined in the agency's contract with the City. **Invoices should be emailed to:**

Youth and Family Services Program Manager
Christa Hernandez, chernandez@santafenm.gov

Youth and Family Services Project Specialist
Justin Gonzales, jmgonzales@santafenm.gov

NAVIGATION MONTHLY MEETINGS

To strengthen communication, foster strong navigation teams, network identity, and increase navigation knowledge, navigation meetings are offered on the fourth Tuesday of every month for 1-2 hours. **Attendance is required for each organization.**

Meetings are virtual and one in person meeting will be held per year. The following components are consistent elements of the monthly meetings.

Introductions and Updates: Given the continued growth of the network, introductions and updates provide the latest information about new attendees, recent organizational and network changes.

Educational Series- Education, Resources and Professional Growth: Topics include learning about resources that address social determinants of health, best practices and educational opportunities for professional growth.

Networking: Time to network is built into face-to-face meetings.

PROFESSIONAL DEVELOPMENT

The CONNECT leadership team is committed to providing ongoing professional development to strengthen and expand navigator's skill sets. Professional Development Classes will be offered on a quarterly basis. Continuing Education Units (CEU) will be available for trainings and topics are based on suggestions from navigators. All trainings will be conducted by Mikahla Beutler, LPCC. Emails will be sent out with information about each training and registration information one

month prior to the training date. Below is a listing of possible trainings that happen throughout the year.

Trauma-Informed Care
This course on Trauma-Informed Care is designed as a broad overview of best practices in recognizing, assessing, and treating trauma. This includes a review of SAMHSA's TIP 57, an exploration into countertransference and self-regulation, and an opportunity for resource development. As an accommodation for COVID-19, this course will be available online. A didactic teaching method will be the main source of content with the opportunity for experiential and collaborative engagement. This course provides 3 continuing education credits. Participants must attend the entire course to receive a certificate.

Building Resilience
This experiential course on Building Resilience is designed to offer providers a personal practice in self-care and burnout prevention. This includes many self-regulatory practices that can be applied in work with clients. Participants will leave feeling refreshed and renewed, as well as retooled. As an accommodation for COVID-19, this course will be available online. Experiential learning will be the main methodology of content delivery with the opportunity for collaborative, and inquiry-based discovery. This course provides 3 continuing education credits. Participants must attend the entire course to receive a certificate.

Shared Decision-Making in Treatment Planning
This course on Treatment Planning will focus on the shared decision-making model wherein providers and clients work together to form a course of action. Through psychoeducation, goal setting strategies, and tracking tools, providers and clients can monitor the successes and challenges of treatment. As an accommodation for COVID-19, this course will be available online. Inquiry-based teaching methodologies will have participants building appropriate treatment models for their specific practices. This course provides 3 continuing education credits. Participants must attend the entire course to receive a certificate.

Considerations for Effective Communication
This course on Communication is designed to examine a range of meta-communications and influences. Explorations in self-talk, communication styles, and effective communication techniques will offer participants strategies they can utilize with clients and coworkers alike. As an accommodation for COVID-19, this course will be available online. Highly experiential in nature, this course will have plenty of opportunities for practice! This course provides 3 continuing education credits. Participants must attend the entire course to receive a certificate.

CLINICAL GUIDANCE

CONNECT embraces person-centered planning and navigation services that support the person to identify and achieve their goals relating to unmet social determinants of health. Engaging

individuals to participate in the network and navigation services can be difficult when working with individuals who have in the past or are currently experiencing trauma. Trauma is often unrecognized and is widespread. According to SAMHSA "trauma occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation."

Navigators work every day with people who are vulnerable and are most likely experiencing trauma if they have screened positive for the need for housing, transportation, utilities, food or personal safety. This puts navigators at risk of experiencing what is known as secondary trauma, which can lead to overwhelm and emotional burnout.

With a spirit of meeting people where they are both literally and figuratively, navigators must have a varied skill set. Navigators are not required to have a clinical background, nor are they necessarily supervised by clinicians. The complexity of challenges they face could benefit from a clinician's guidance to create a safe environment for themselves and the individuals they serve. In order to mitigate the effects of secondary trauma navigators may access additional support from CONNECT in the form of Clinical Guidance.

Navigators and their agencies may access individual support, team development facilitation, and clinical training through the CONNECT clinical guidance program. Clinical Guidance will be provided by a licensed professional. Topics and areas of interest may vary to include trauma-informed care, individual engagement, person-centered planning, maintaining professional boundaries, and other identified areas of development. The provider will articulate, model, and mentor a standard of care for navigators. Clinical guidance and professional development activities may provide current practice standards, peer-to-peer engagement, debriefing of difficult situations, and personal support among other things.

As part of the CONNECT orientation, each navigator is introduced to Ms. Beutler to learn more about ways to integrate self-care and clinical best practices into their work life.

Team Development, Meeting Facilitation, Case Consultation

To further support individual navigators and interdisciplinary team development, navigators may request the assistance of the clinician for phone consults, to facilitate interdisciplinary navigation meetings when the needs of the individual receiving services, or the dynamics of the team are complex. The clinician will also provide **follow-up** with individual team members to debrief and troubleshoot next steps in difficult situations.

Office Hours are available by appointment every Tuesday and Thursday from 9 to 11 am, or at a time that is mutually agreed upon, for individual Case Consultation. Please email requests to Mikahla Beutler with "Clinical Guidance Request" in the subject line. Ms. Beutler will respond by email within 48 hours of receipt of the request and can be reached at (505) 663-6464 or emergesantafe@gmail.com.

COMMUNITY ENGAGEMENT

Community Engagement is*: "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices."* (Centers for Disease Control and Prevention)

Advisory Committee

Lived experience drives innovation. Identifying, assessing and improving CONNECT and community policy from the perspective of the individual receiving services and resources is the goal. In Fiscal Year 2020, an Advisory Committee of people who have been or are enrolled in CONNECT was initiated. What's working, what's not and how to improve CONNECT and influence public policy is the emphasis of facilitated discussions. Quarterly meetings identify challenges and co-create solutions that affect CONNECT operations and city, county and state policies. Recruitment of individuals to serve is ongoing and meetings will be adapted to accommodate pandemic and social distancing orders, as necessary. We strive for equality in stakeholder recruitment and representation.

Meetings are structured to provide a comfortable and safe environment for individuals to share their experiences from the moment of enrollment to navigation completion. A first-hand account will capture individual experiences with CONNECT. A facilitator from Chainbreaker Collective will guide the discussion to identify ideas for improvement. The insight and recommendations of people who have experienced the program will create solutions.

Through participation in the Advisory Committee, past and current participants of navigation services help inform the program and shape future program enhancements and revisions. Participant's voices help ensure that CONNECT incorporates feedback as part of lessons learned, ensure the effectiveness of the program and augment its impact.

To address and remove barriers to participation due to a number of obstacles that are common challenges to engaging low-income and underserved participants, food, transportation, on-site childcare and stipends are provided when public health orders allow. Meetings are held at

locations that are accessible and on bus routes at times that are convenient for the majority of the membership.
During the pandemic virtual meetings will be scheduled. Tablets and internet connection will be provided to Advisory Committee members. CONNECT leadership will provide operational support of in-person or virtual meeting coordination and facilitation. Every effort is made to create safe spaces that facilitate honest discussion, collaboration and meetings are solution driven.

Applications for the Advisory Committee are accepted year-round and we rely on navigators and current Advisory Committee members to recruit new members. Navigators will forward names and contact information of interested individuals to contract managers or assist individuals to answer and submit the application electronically. The application is included in the CONNECT Digital File. Email completed applications to Tomás Rivera tomas@chainbreaker.org at Chainbreaker Collective.

Empowerment, Collaboration and Feedback
The Gap Analysis conducted in 2017 identified trends in changing demographics and current needs of Santa Fe County residents and community stakeholders. Continued consultation with stakeholders and the broader community provides opportunities for collaboration to create opportunities for city, county and state policy change.

Individuals who receive CONNECT services, navigators and other stakeholders in the community can be partners in changing public policy. Stakeholder buy-in, grass roots organization and continued collaboration to bring people together to identify the needs of the community, coalesce stakeholders around prioritized issues and actions, and identify and support leaders and decision-making structures is essential to move identified public policy changes forward.

The cry of “Nothing for Us Without Us” still rings true in the realm of public policy change. Identifying stakeholders who are interested and want to create policy change is key to any organized effort. Membership of the Advisory Council, navigators and other stakeholders will identify priorities for policy change. Feedback loops will include sharing information between CONNECT Navigators, Planning and Advisory Committee members, City of Santa Fe stakeholder and policy groups, Santa Fe County Health Policy and Planning Commission and Board of County Commissioners.

CONTACT US

CONNECT is committed to improving the experience of all stakeholders. Feedback helps tailor standards and protocols to the strengths and needs of our community and is encouraged and welcomed.

Please direct questions, concerns or suggestions for improvement to:

Santa Fe County Community Services Department, Health Services Division Director
Jennifer N. Romero
(505) 995-9526
jnromero@santafecountynm.gov

City of Santa Fe Youth and Family Services Program Manager
Christa Hernandez
(505) 955-6728
chernandez@santafenm.gov

COMMUNITY
is our Greatest Resource

CONNECT Network Standards

June 2023

A SANTA FE COUNTY + CITY OF SANTA FE
COMMUNITY PARTNERSHIP

CONNECT – NETWORK LEVEL AGREEMENTS (STANDARDS FOR NETWORK BEHAVIOR)

The Unite Us (UU) platform links CONNECT In-Network providers (those organizations with navigators who have licenses to utilize Unite Us) as well as assisting in referring to and coordinating resources and services with Out-of-Network providers across Santa Fe City and County. The Unite Us platform supports the daily work of the navigators and allows for consistent data collection of social determinants and related outcomes.

As stated in the FY23 CONNECT Navigation Protocols, *Santa Fe County and the City of Santa Fe recognizes the need to address Social Determinants of Health* (SDOH*) that impact health outcomes for County residents. Social Determinants include access to health care, interpersonal safety, housing, healthy food, transportation, and other social and material supports*. Navigators connect residents to these services and deliver needed resources that will address these unmet needs. The UU platform provides a user-friendly way to identify needs, create referrals, track connections to those referrals, guide individuals to services and track outcomes. The City and County Community Services Departments, the CONNECT hub, and programs and organizations have the ability to analyze the data and outcomes, which in turn help to identify gaps in services.

IMPORTANCE OF HAVING NETWORK STANDARDS

With the implementation of the Unite Us platform, the CONNECT community agrees to operate within the following network standards. Network standards are critical to promote strong, open and timely communications and data security as well as to assure accurate data collection. Members of the Network agree to respond to referrals within the recommended timeliness guidelines defined in these standards. The standards also address keeping organizational data up to date, entering individual data in a timely fashion, maintaining individual records with services, outcomes and closing the loop of each referral.

BEST PRACTICES

Providers: programs and organizations are set up in the platform using descriptions from the submitted Partner Registration Form. This group makes up the network of platform users. Organizations will be added to the network as they are ready to join. Each of these providers will be considered the In-Network providers. There will be a larger group of providers who will accept referrals via email or phone but will be part of the Out-of-Network group. The UU

platform will also connect to SHARE New Mexico on-line resource directory so that all possible referral resources are available to address an individual's needs.

In-Network Providers:

- Must serve residents of Santa Fe County or City of Santa Fe who meet income requirements
- Must screen for social determinants using the designated screening tool
- Must enter the results or perform the SDOH screening in the platform
- Must search for and send referral/s (external and/or internal) to identified needed services within response standards (see below) to one or more In-or Out-of Network providers.

1. As new providers join the network, the following steps will be employed.
    a. Identify/contract for navigators if applicable
    b. Complete Partner Registration Form
    c. Introduce provider to other Network members to assure knowledge of services offered at new member organization
    d. Provide training on the UU platform for any new navigator/platform user.
2. All In-Network organizations and programs are responsible for maintaining accurate information in their online UU platform profiles. It is extremely important to maintain accurate information concerning capacity of any programs that have limits so that navigators can make appropriate referrals to each organization. Review your profiles once a month to assure that the following information is up to date:
    a. Full description of all services
    b. Accurate listings of key personnel
    c. Clear descriptions of any specific needs for the referral process
    d. Clear description of any required criteria or qualifications for any service – What determines an individual's eligibility for a service?
    e. Up-to-date location information
    f. Up-to-date contact information

    Use the Organization Update Form to update the organization profile and program descriptions.

3. **User Licenses** - Each In-Network provider will identify the staff (typically the navigator/s) who will be trained to use and have a license to use the UU platform. Each user must

have his/her/their own user license. Each user license has individually designated privileges that dictate what the user can see and do in the platform. *No user license may be shared with another person*. Each user will have his/her/their own unique log-on name and password. This is critical to maintain data security and be HIPAA compliant.

When a license is no longer needed by a navigator it is the navigator's responsibility to contact the CONNECT Program Manager of their funding source and provide the last day of use and the name and email of the new license holder if that is known. Leadership at the organization should ensure that this happens.

COUNTY: Jennifer Romero jnromero@santafecountynm.gov
CITY: Christa Hernandez chernandez@santafenm.gov

DATA STANDARDS – as per the FY23 CONNECT Navigation Protocols

In-Network Providers have agreed to report certain data via their contracts. These contractual items are reiterated in the FY23 CONNECT Navigation Protocols.

- Agree on for whom data is to be reported/entered
- Agree on minimum data set
- Timeliness of data entry – whether by integration or manual entry into platform

EXPECTED PROCESS WORKFLOW

It is understood that some of this maybe via paper at first depending on access to computer at time of service request. It may be necessary to capture minimal demographic information and do the screening on paper and perform the search and data entry afterwards.

1. Search for the person to see if he/she is already in the platform – first and last name and date of birth.
2. Use the existing record if found or create new record if person is not found (you do not want to create duplicate records in the platform).
3. If a SDOH screening exists for this person, you can:
    a. Use the information from the previously completed screening
    b. Complete a partial screening that reflects the new information that you have gathered from the person that was not reflected in the earlier screening
    c. Or, do a new screening if circumstances have changed or screening is old
    d. Each screening will be kept in the person's history so that you can see what issues were identified over time.

4. Enter as much information as you have for this person during the intake. Information concerning how to contact him/her/them is critical – telephone, address/location, email.
5. Address is particularly helpful so that the referral sources are as geographically convenient as possible. The platform will use address information to help identify close resources.
6. A field to capture Social Security number will show on the screen but is **NOT** required.
7. There is a field to enter Medicaid number if the person is eligible for Medicaid. It is not a required field but may be useful to capture if the person is willing to provide the number.
8. **SDOH Screening** - Perform the SDOH screening with the individual. This can be done on paper or directly via the platform with the individual, but results need to be entered into the UU platform either way. This should be completed one time and every 12 months or at a life changing event.
9. Complete the **Evaluation Screening** at intake and through-out service with the individual. This should be completed at every encounter. For navigators who meet with individuals daily or frequently, complete the evaluation screen no more than once a month.
10. **COVID-19 Screening** should be completed every time an individual will be receiving COVID-19 relief funds (CARES Act, ARPA, etc.).

Per Navigation Protocols:

The Navigator shall proceed to enroll the individual if an individual:

1. Screens positive for any of the Social Determinants of Health on the SDOH screening and,
2. Is a Santa Fe County or City of Santa Fe resident and,
3. Qualifies for the Santa Fe County Health Care Assistance Program if a County resident.

A person will be considered enrolled if he/she:

1. Screens positive for any of the Social Determinants of Health on the SDOH screening and,
2. Would like assistance to address unmet needs and,
3. Signs a Unite Us consent form and a paper copy of a consent for program evaluation. If a person declines signing the consent for Unite Us their information will not be in the platform and referrals will need to be done via email or phone.

Navigation Plan Tier 2 navigators will be required to develop a navigation plan with the individual. The plan will include the following components:

- Name of primary navigator and organization developing the plan
- Measurable goals
- Date of plan development
- Review date of Navigation Plan

Initially, the plan can be developed as it is currently using the templates provided in digital form in the Digital File as the recommended format. Once a plan is developed, it should be uploaded in pdf format to the individual's case record in the UU platform. This should be done within 24 hours of plan development so that it can be shared with anyone else working with this person.

The Navigation Plan may also be completed in the UU platform. There is an assessment called Navigation Plan. The assessment format is similar but not identical to the paper form. The assessment has a series of drop down options from which to select:

1. Goals based on the needs identified in the SDOH screening
2. Level of intensity of each identified need – low, moderate, high
3. Steps for achieving each goal – based on the Need related Pathways
4. Ability to indicate that the time frame for the Pathway was met
5. Text box for each goal to allow for a brief description of the goal and how you and the person will work towards that goal.

There is also a text box for additional notes for noting achievement of steps and progress towards each goal.

Navigators work with the individual to identify any organizations with whom he/she/they is currently working or getting services. This communication assists coordination and helps to avoid duplication of services. Sharing the Navigation Plan will support this communication. In concert with the plan, notes in the individual's case record will document all steps and movement towards resolving each person's identified needs.

Referrals

1. Any SDOH screening with positive results will lead to suggested/possible referral sources in the platform to help with each identified need.
2. The need for services may be urgent or routine. (see more below)
3. The Navigator will create all appropriate referrals in the platform and submit them to receiving providers.

4. Obtaining an informed consent from the individual is also a key and electronic part of the platform. A consent will be in a Pending status until received.
5. Referral/s will go out electronically to any identified providers who are In-Network.
6. Referrals will go out via email/phone for all Out-of-Network providers.
7. Notes should be entered as needed to document the referral process, individual preferences and any other information critical to the provision of service to address each identified need. It is particularly important to enter details of all Out-of-Network referrals, their hand-off process and related outcomes.

FLEXIBLE FUNDS

The disbursement of Flexible Funds is tracked in the UU platform using the Payments feature. Before closing a case where flexible funds have been utilized, you must add Social Care Coverage to document flexible funds used. Please refer to FY23 Navigation Protocols for the list of approved expenditures.

Receipts must be kept and uploaded into the individual's record and must match what is invoiced on a quarterly basis.

When you provide Flexible Funds for a client, follow these steps:

1. Navigate to the client's Face Sheet and click on the "Profile" tab.
2. Scroll to the bottom and select the blue plus sign "Add Social Care Coverage" (second to last section above Military Information).
3. Select "Santa Fe CONNECT-FLEX, ARPA, Wellness, Navigation" as the Social Care Coverage, and the start date is the day that you distributed the funding. Leave the end date blank.
4. Then click on the "Cases" tab and select "create new case".
5. Select "Santa Fe CONNECT - FLEX, ARPA, Wellness, Navigation" as the program and "emergency/one-time financial assistance" as the service subtype.
6. Fill out the primary worker, case description, and click "next" to create the case.
7. Once in the open case, you can use the "Add contracted service" feature to document the FLEX funding that was previously distributed, including the reason for distribution and the date that you distributed the money. You can add multiple contracted services in one case if funding was given to the client for multiple needs. You don't have to close out the case for one service provided if a client potentially needs many services.
8. Once all funds distributed to that client have been documented, you can then close the case as resolved.

REFERRAL PROCESS & RESPONSE STANDARDS

Routine Referral – the expected response time to routine referrals sent within the network is for Providers to respond to a referral within 2 business days. In-Network Providers have multiple options when responding to a referral. They will indicate the status within the platform:

1. Accept - If the referral is accepted by the provider, they have agreed to serve the individual.
2. Hold for Review - If the provider needs to have an additional conversation with the individual and/or is checking their organization's capacity, they can choose to "hold for review" to let the referring organization know they've seen the referral and are acting.
3. Reject- If the referral is rejected, it is routed back to whomever sent the referral (the navigator, CONNECT hub or other network provider). When referrals are rejected the individual is unaware, however it is the Navigator's or referring provider's responsibility to identify a different provider or communicate to the individual that no services can be identified.
4. Refer On/Send – when one In-Network provider cannot accept a referral but knows of another provider who may be able to assist or be a better fit for, the provider can send their referral on to another provider. Notes about this process should be entered into the person's record to track this onward referral. If the referral is pending after 2 business days, the Navigator should call/email the provider. If the provider cannot be reached within 3 business days, the Navigator should recall the referral and send it to a different provider.
5. Close Case - In networks with provider-to-provider referrals, providers can close cases if they are unable to contact the individual or the individual no longer needs assistance. A referral must first be accepted, which creates a new case in order for the case to be closed.

Out of Network Referral – it is the responsibility of each Navigator to monitor out of network referrals and close the referrals in the platform as appropriate. The Navigator will enter notes to track communications with other providers, manage referrals and maintain to the same timeliness standards as for In-Network referrals.

A **Warm Hand-Off** is the preferred method of referral and can improve communication between the individual and community partner organizations, improve coordination of services, build stronger relationships and increase the experience of the individual being served. (per FY23 Navigation Protocols)

Urgent/Emergent Referral – for all referrals to any/all services that would otherwise jeopardize a person's physical or emotional health – e.g. housing, food services and crisis intervention services), referrals will be sent to ensure all providers able to provide the needed service or care will see the referral as soon as possible.

Referrals received by In-Network providers should be responded to in as close to real-time (within 2 hours) as organizations are able. Once a referral is submitted, the standard of care is for providers to respond to an urgent referral within 1 business day. If no In-Network provider can be reached within 2 business days, the Navigator will recall the referral and either sent to an alternative In-Network or Out-of- Network services providers will be identified. Direct contact will be made with the person on the 3rd business day to provide assurances that services are being identified.

Unresponsive Person – the standard is that there should be a minimum of three attempts over a week to contact a person who has requested services. The Navigator will use all known contact information to try to reach out to the person – phone, email, text. If there is still no response from the person after 10 days and a minimum of three attempts to contact have been made, the Navigator can close this referral. The status of "unable to contact" will be noted as well as each of the attempts to contact. The person's record will remain in the platform and can be reactivated at any time that they reach out for service whether at the first organization or another In-Network provider.

Closing a Case - Once a case is open, it is up to the Navigator to monitor and coordinate resources and services. It is also their responsibility to close a case once the reason for the referral has been addressed and/or needed services have been provided. A case can always be re-opened if further needs are identified in the future. The other reason to close a case is when an individual had become unresponsive after repeated attempts at contacting him/her/them (see above). Typically, a case can be closed after 10 business days of active reaching out (minimum of three attempts) with no result.

Outcomes - When closing a case in the UU platform, it is important to select and capture the appropriate outcome/s. There is a list of drop down options from which to choose the outcome for the referral/case. This is a required piece of data for each closing.

SELF-REFERRAL

A public facing website serves as a self-referral portal. Santa Fe City and County residents are able to go to either website, answer a few questions addressing their current unmet needs, sign a consent on-line and request assistance. The requests will be received, reviewed and managed by CONNECT hub navigators who will then either provide navigation and/or send the referral requests to the appropriate organizations.

To access the self-referral portal for **CONNECT** services visit:

santafecountynm.gov/connect or santafenm.gov/connect

TECHNICAL ASSISTANCE AND FEEDBACK

For technical assistance while using the Unite Us platform please use the chat feature to troubleshoot problems first. If there are issues that are unable to be resolved, please contact erin.willis@uniteus.com.

Feedback on Unite Us and Network Standards is welcome from all navigators and administrators at any time. Time will be devoted to workflow and Unite Us at monthly navigator meetings and meetings with individual organizations within six months of implementation will be scheduled.

If you have questions or comments about the Unite Us software platform or CONNECT please contact:

COUNTY: Jennifer Romero jnromero@santafecountynm.gov
CITY: Christa Hernandez chernandez@santafenm.gov

Quick Links:
Partner Registration Form
Unite Us Login
CONNECT Resource Directory (English)
CONNECT Resource Directory (Spanish)