SANTA FE COUNTY

ACCOUNTABLE HEALTH COMMUNITY

We are building a system that helps residents navigate community services and offers providers access to data and information to better serve residents, improve health and reduce health care costs.

INITIAL RESULTS: One Year of Navigation and Data

John sat at a table with representatives from four community organizations. The group included navigators from a local homeless shelter, a crisis response team, a behavioral health agency and a clinic. John was living on the street. He repeatedly ended up at the emergency room while intoxicated and had ongoing medical issues. Immediate and safe housing and ongoing medical care were identified as short term goals. Admission to medical detox treatment, counseling, and finding sober housing were targeted as intermediate and long term goals.

John is one of 639 Santa Fe County residents who received navigation services between July 2017 and June 2018 (Fiscal Year 2018) as part of the Accountable Health Community (AHC). In this same period, a cohort of over 30 navigators from 13 community organizations, school programs and clinics, all using the same screening tool, identified 1583 unmet social needs relating to health. Where someone lives, if they have access to reliable utilities, transportation and healthy food, and if they feel safe all impact the health and well-being of an individual. These Social Determinants of Health (SDOH) are screened for by each navigator and documented. For the five SDOH on the screening tool, 1367 unmet needs were identified. The remaining 216 needs relate to education, employment, childcare and income support.

"We are working with the Santa Fe County Detention Center to create more supports and connections in re-entry to create a level of prevention for clients at risk of recidivism."

-Navigator

Spreadsheets collect de-identified demographic data, identified and addressed SDOH, Emergency Department and jail use. Written narratives provide anecdotal information about what's working, trends and challenges. Spreadsheets and reports are submitted on a quarterly basis. Data is reviewed each quarter and shared with stakeholders. Lessons learned from quantitative and qualitative data have shaped how data are collected. This, in turn, has informed modifications of the AHC to effectively respond to the needs of the individuals served, navigators and contracted community partners.

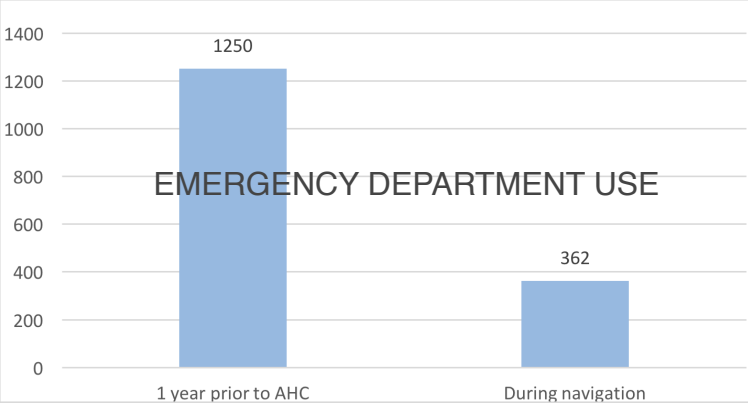
In alignment with the GAP Analysis conducted county-wide in early 2017, annual data shows the need for housing is acute, with 30% screening positive for needing stable housing. Food, transportation, utilities and personal safety follow in that order of need.

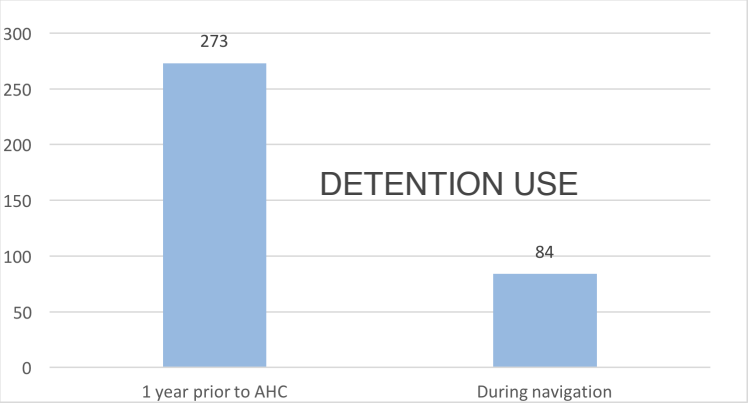
Anecdotal information from navigators suggests that following the initial screening, and after building trust with the individual, additional unmet needs are shared with the navigator. Before building trust, for example, a pregnant young woman who is couch surfing may share that she needs transportation only. After repeated visits the navigator

may learn that safety and housing are more pressing issues, and these additional needs may be addressed.

Does addressing unmet social determinants of health impact unnecessary or non-emergent Emergency Department (ED) use? Individuals who receive navigation are asked to self-report emergency use for the year prior to receiving AHC navigation. There were 1250 self-reports for ED use. In FY 2018, with AHC navigation, people reported using the Emergency Department 362 times—a 71 percent reduction in ED use.

Does the AHC impact jail use? Preliminary data indicates that the year prior to receiving navigation individuals were in jail 273 times. In FY 2018, with AHC navigation, individuals reported going to jail 84 times—a 69 percent reduction in incarceration.





The cohort of navigators and AHC partners is anticipated to grow in Fiscal Year 2019 and the "reach" of the Accountable Health Community into the County will increase. It is anticipated that 2000 Santa Fe County residents will receive navigation this year. We look forward to the implementation of a software system that will track referrals and provide the AHC network updates on-line and in real-time. Unmet social needs, Emergency Department and jail use will continue to be tracked. Data will inform improvements to the Accountable Health Community. A Story Telling Project will highlight individual experiences with the health and human services system generally and the AHC in particular.

In the meantime, John has completed detox treatment, is living in stable housing and continues to attend counseling and AA meetings. His Emergency Department utilization has decreased and his health has stabilized.

For more information on the Accountable Health Community please contact:

Elizabeth Peterson, MPH
Project Manager
elizabethpetersonmph@gmail.com