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.

Navigation: ***the method of determining position, course, and distance traveled.*** (Merriam-Webster)

In the Third Century BC, the Greeks used stars to navigate. Nowadays, our smart phones locate and provide directions to and from our next meeting. In Santa Fe County, **Navigation Services** assist residents successfully to maneuver local, state and federal health care and social service systems. As part of the Accountable Health Community (AHC), navigators assist individuals who may have limited health literacy, behavioral health issues, or other challenges to access community services and resources that they need to be healthy.

Efforts to address social determinants that improve population health and reduce cost are logical steps in building healthy communities. According to the Centers for Medicaid and Medicare Services, "Many of the biggest drivers of health and health care costs are beyond the scope of health care alone. Health-related social needs often are left undetected and unaddressed."

"Mounting evidence shows that factors ranging from poverty and food insecurity to inadequate schools and unsafe neighborhoods contribute to disease and threaten health."
(The Commonwealth Fund)

Santa Fe County Community Services Department has identified the need to address the social determinants of health as a priority for County government and the community as a whole. To focus on this priority, the Community Services Department sought proposals from community service organizations interested in providing Navigation Services to address social determinants of health, with the goal to make Santa Fe County a healthier community.

The AHC model for screening, referrals and navigation was presented to the AHC Advisory Committee in draft form as a starting point to define the process of how this might work in our community. The model may be adjusted as we receive input from stakeholders when navigators begin to test the model.

Determining position:
Clinical sites will screen for risks including utilization of emergency room and jail. They assess if an individual has safe and secure housing, has access to and eats nutritious food, has reliable utilities and transportation, and other social supports needed to live a healthy life.

Navigation is provided at the clinical site, at a partner organization or with a combination of organizations to address needs that residents have. A primary navigator is identified to ensure that services are tailored to the individual's priorities, are culturally relevant and based on a team approach of service delivery that documents cross-sector collaboration.

Determining course:
A navigation plan is developed with the individual to identify 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 social and community referrals that develop sustainable relationships with community organizations.

Navigators will 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, and provide and document a "warm hand-off." Referrals will be considered complete if a trusting and sustainable relationship is verified by the individual and service provider and documented by the navigator.

A Flexible Fund will serve as a payor of last resort for one-time expenses that address needs related to social determinants of health such as a bus pass to keep a job, a cell phone to communicate with health care providers, or a security deposit for a new apartment for a new mother and her baby. Navigators and partner organizations will collectively draft a protocol that allows for quick access to funds and expenditure accountability.

Determining distance travelled:
Navigators will participate in data sharing with other community and social service organizations on activities related to navigation plans with consent of the individual. On-line and real-time data sharing using a software system that provides case sharing features is hoped to reduce duplication and build an

even stronger community network while improving the health and health outcomes of the resident.

The sharing of aggregate and non-medical data with other Santa Fe County-funded partners, the AHC Advisory Committee and other stakeholders will identify if goals are met, what is working well and what challenges must be addressed. We want to know whether individual and population health have improved, unnecessary utilization of the Emergency Department and jail have been reduced, and if more people have health insurance.

Santa Fe County Community Services Department is pleased to announce the following agencies have been awarded contracts to provide Navigation Services as part of the Accountable Health Community Initiative.

1. **United Way of Santa Fe County**: a half-time navigator to support a home visiting program for pregnant and new mothers
2. **Santa Fe Public Schools**: a full-time navigator for the Teen Parent program
3. I**nterfaith Community Shelter Santa Fe**: a full-time navigator for homeless guests with behavioral health needs
4. **Adelante Program of Santa Fe Public Schools**: a half-time navigator for families with children in facing homelessness
5. **The Life Link**: a full-time navigator to work with residents released from the County Detention Center and State Penitentiary with multiple incarcerations coupled with behavioral health needs
6. **SF City Fire Department (MIHO)**: a part-time social worker to provide clinical supervision to navigators of city residents who are high utilizers of 911
7. **CHRISTUS St. Vincent**: funding to support information-sharing and IT coordination between the hospital and community partners
8. **St. Elizabeth Shelter:** a half-time navigator for homeless guests with medical needs at Casa Familia and the Men's Shelter

For more information on the development of the Accountable Health Community please contact:

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