Evaluation of Heading Home's Albuquerque StreetConnect

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Qualitative and quantitative analysis of Albuquerque StreetConnect's strategic outreach to people experience chronic homelessness together with mental illness, including three case studies highlighting successes and challenges.

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Introduction

This report evaluates Heading Home's Albuquerque StreetConnect (ABQSC): a specialized outreach team whose mission is to identify, engage, stabilize, and house individuals for whom traditional outreach methods have not worked.

Using qualitative and quantitative methods, this report

- describes ABQSC and the 58 clients it has served since its launch in mid-2017;
- assesses ABQSC's impact, including whether it is associated with changes in the use of healthcare, jail, and emergency medical services; and
- discusses the challenges and opportunities for enhancing this impact.

This report focuses on clients served as part of ABQSC's contract with the City of Albuquerque; it also recently began serving clients as part of a contract with the University of New Mexico Hospital (UNMH). (See Appendix A for the data sources and methods used in this evaluation.)

Whom Does ABQSC Serve?

ABQSC serves people who experience chronic homelessness together with mental illness, typically with co-occurring substance use disorders and physical ailments. Many are high utilizers of the criminal justice system, emergency medical systems (EMS), or emergency departments (ED); just as concerning, some have never or rarely accessed healthcare services.

> *We have never said, "We can't help this person, they are too difficult."*
> *— ABQSC Navigator, Andy*

> *He's been on the streets for a long time. He is cognitively very impaired, has schizophrenia, uses drugs. As an example, he doesn't have the capacity to learn how to use a trash can. — Presbyterian psychiatrist, Dr. Abrams*

Seventy percent of ABQSC's 58 clients are male and, at enrollment, they ranged in age from 23 to 73; just over one-third were over 50 years old. Sadly, 4 clients died since enrolling with ABQSC. Nearly half of ABQSC clients suffer from 5 to 16 chronic conditions each. At the same time, clients have a high prevalence of acute conditions, most commonly in the areas of injury/poisoning, musculoskeletal, skin diseases, and behavioral health. (See Figure 1.) All of ABQSC clients' top ten chronic conditions relate to behavioral health, with schizophrenia being the most common. (See Table 1.) The top ten acute conditions include head injuries, leg fractures, poisoning, and the effects of cold temperatures. (See Table 2.)

The ABQSC Model

ABQSC's mission is to identify, engage, stabilize, and house high-need individuals—those with mental illness experiencing chronic homelessness who have been missed by traditional outreach methods—and to transition them to ongoing supports. It does this by providing clients intensive, individualized, and housing-focused services and by leveraging key relationships and tools. The ABQSC team includes a Program Director, a half-time Clinical Director who is a licensed mental health clinician, and two Navigators; key partners include the Albuquerque Police Department (APD), Presbyterian's Behavioral Health Clinic, and an SSI/SSDI Outreach, Access, and Recovery (SOAR) representative.

Figure 1: Prevalence of Chronic and Acute Conditions (n = 58 clients)

Source: New Mexico's (NM) Health Information Exchange (HIE)

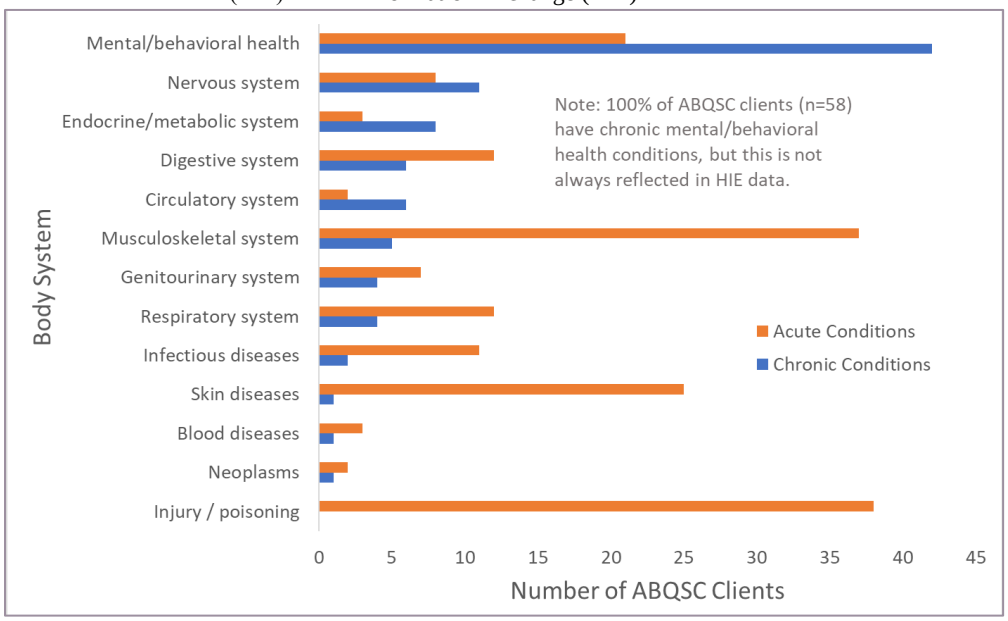


Table 1: Top 10 Chronic Conditions (Source: HIE) (n = 58 clients)

Chronic Condition (first three characters of ICD10 code)	**# of Clients**
Non-mood psychotic disorders: Schizophrenia (F20)	22
Non-mood psychotic disorders: Unspecified (F29)	16
Psychoactive substance use: Other stimulant (F15)	16
Psychoactive substance use: Alcohol (F10)	16
Nonpsychotic mental disorders: Anxiety (F41)	10
Non-mood psychotic disorders: Schizoaffective (F25)	10
Mood disorders: Major depressive disorder, single episode (F32)	9
Psychoactive substance use: Other (F19)	9
Psychoactive substance use: Opioid (F11)	7
Non-mood psychotic disorders: Delusional (F22)	6
Psychoactive substance use: Nicotine (F17)	6

Table 2: Top 10 Acute Conditions (source HIE) (n = 58 clients)

Acute Condition (first three characters of ICD10 code)	**# of Clients**
Musculoskeletal: Other soft tissue disorders (M79)	26
Musculoskeletal: Other joint disorder (M25)	20
Skin: Cellulitis (L03)	17
Skin: Abscess (L02)	14
Musculoskeletal: Upper back pain (M54)	14
Injury/Poisoning: Other head injuries (S09)	11
Psychoactive substance use: Other stimulant (F15)	9
Injury/Poisoning: Other effects of reduced temperature (T69)	9
Psychoactive substance use: Alcohol (F10)	8
Injury/Poisoning: Hand injury (S60)	6
Injury/Poisoning: Fracture of lower leg (S82)	6

Identifying Clients: A Neighborhood-Based Approach

Focusing on a small geographic area is a key component of the ABQSC model and since mid-2017, ABQSC has focused on the downtown area.[1] ABQSC can be scaled up to serve other neighborhoods (as several neighborhood associations have requested), as well as to serve more individuals in the downtown area.

By periodically conducting intensive population surveys, the ABQSC team knows everyone in their target population by name, acuity level, and where they are commonly found. Together with referrals from partner agencies, this information allows ABQSC, at any given time, to maintain a cohort of the 30 highest-need individuals in the downtown area, while also remaining aware of and in communication with past and potential clients whose needs may spike at any time.

Each week, the ABQSC team meets together with key partners—APD, Block-by-Block, and Presbyterian's Medicaid Managed Care Organization—for case conferencing. They review each case, determine the highest priority activities for the upcoming week, and develop an action plan. In addition to day-to-day interactions with clients, prioritization also relies on records regarding healthcare, jail, and EMS use and biopsychosocial and other assessments.

The targeted geographic region means that clients have ready access to Heading Home's downtown office, where they know they are welcome and will find team members who know them and understand their needs. Critically, the ABQSC team also develops and nurtures relationships with other key stakeholders in the neighborhood—APD officers, residents, and business owners—who have often had long, negative histories with ABQSC clients. These neighborhood-based relationships help to shift long-standing dynamics. For example, an APD officer or business owner can directly call an ABQSC team member, who can quickly intervene to support the client and deescalate problematic behaviors. Such an intervention can divert an arrest or a jail booking, or it might simply show the client that APD and the business owner have the client's interests in mind and, thus, increase trust by the client.

Engaging, Stabilizing, and Transitioning Clients

ABQSC uses a team-based approach: the Program Director supervises and supports staff, develops and manages key partnerships, and finalizes decisions about which clients are prioritized and how they are served; the Clinical Director meets weekly—as well as on an ongoing, ad hoc basis—with the Navigators to provide clinical supervision and coordinates clients' care in collaboration with hospitals, guardians, jail, etc. The Navigators provide the bulk of the individualized, intensive, face-to-face client services.

One of the Navigators, Megan, explained, "Our model allows time with clients. Early on, when we're engaging them, we just keep 'offering the tea.' If they refuse, then we come back the next day and gently offer the 'tea' again—which could be water, cigarettes, clothes, transportation to a methadone clinic, whatever it is. Repeatedly engaging clients makes a huge difference in a small trickle kind of way; it's that continuity that is the most impactful."

[1] The downtown area is defined as the blocks between 1st and 12th Streets (east to west) and between Silver and Copper (south to north).

ABQSC is so effective because they understand how to engage folks that are difficult to engage: 'If you need a pair of dry socks, that's what I'm going to do first.' — Presbyterian psychiatrist, Dr. Abrams

Establishing a relationship with a client is a long process, but when ABQSC succeeds, then APD stops getting all those calls about this individual creating problems downtown. — APD Sergeant Peter Silva

Navigators build trust with clients by actively listening, concretely addressing immediate needs, and bringing skills and knowledge regarding trauma-informed care and harm reduction.

Are you going to discharge people because they don't show up for three appointments? Or, are you going to recognize their illness and encourage them to come back and accept care when they are ready? — Presbyterian psychiatrist, Dr. Abrams

Harm reduction principles[2], which are embraced by the ABQSC staff, include

- humanism: valuing and respecting clients; recognizing that harmful behaviors provide some benefit to individuals;
- pragmatism: recognizing that no one can achieve perfect health behaviors and that the ability to change behaviors is influenced by social and environmental factors;
- individualism: understanding that each client presents a unique set of needs and strengths;
- autonomy: embracing that clients make their own choices;
- incrementalism: celebrating any positive change and anticipating backward steps; and
- accountability without termination: not punishing or dis-enrolling clients for not achieving goals.

"By accepting people where they are and building up a rapport with them, we're able to have really frank conversations—like about substance use or criminal activity—and make that a lighter, less threatening conversation than it might otherwise be," Megan continued.

Another key to maintaining engagement and stability is ensuring a "hot transfer" when a client transitions back into the community from a hospital or jail, which means that ABQSC is informed about the discharge and assists the client with their reentry. By building relationship with institutions and their discharge planners, ABQSC is embedding "hot transfers" into their model.

ABQSC is a high-intensity intervention that houses and stabilizes clients and connects them to ongoing services that allow them to maintain stability and improve their quality of life. What clients may need after discharging from ABQSC depends heavily on the types and levels of support that accompany their housing placements, which can range from near-total support (e.g. in a long-term care facility) to minimal support (e.g. in Permanent Supportive Housing). The network of ongoing supports and services that a client may need after discharging from ABQSC include, for example, healthcare providers, payees, guardians, case managers, Comprehensive Community Support Services, Assertive Community Treatment (ACT) teams, etc.

[2] Hawk et al. Harm Reduction Journal (2017) 14:70. DOI 10.1186/s12954-017-0196-4

Transitioning clients out of ABQSC remains a challenge, and several clients have lost their housing once ABQSC services end. One barrier to a successful transition is the lack of appropriate housing placements (such as long-term care facilities and group homes) that will accept ABQSC clients and that clients can afford. Many facilities have banned clients based on their mental health conditions. Although these barriers must be addressed in the long-term, ABQSC is able to mitigate these system issues by welcoming clients back, as needed.

> *Locally, we have various Intensive Case Management programs, but they are designed for higher-functioning folks. They don't address the fact that folks with primary psychotic illnesses, by virtue of their illness, have cognitive impairment. When we start saying that somebody needs to have goals and come to appointments, that's really not accessible to somebody who hasn't had any treatment for their mental health issues and has comorbid substance use. What's different about ABQSC is that they are boots on the ground; they engage folks in care, which means bringing the care to them.*
> *— Presbyterian psychiatrist, Dr. Abrams*

Housing Clients

Placing and maintaining clients in permanent housing, with an appropriate level of ongoing support, is a key goal for ABQSC. As of July 1, 2020, 33 clients (57%) had permanent housing and an additional 5 clients (9%) had housing pending (Table 3).

Table 3: Housing Placements for ABQSC Clients

Type of Housing	**# of ABQSC Clients**	**% of ABQSC Clients**	**Notes**
Group Home	13	22%	1 client is deceased
Nursing Home	3	5%	1 is deceased
Self-housed or housed with family	7	12%	1 moved out-of-state to be close to family
Housing voucher	11	19%	1 is deceased
Housing pending	5	9%	2 are currently staying in a motel, 2 in the streets, and 1 at a shelter.
Motel	5	9%	
Prison/jail	4	7%	
Streets / shelter	7	12%	1 is deceased
Unknown	3	5%	
Totals	**58**	**100%**	

Leveraging Key Partners and Tools

Since its launch, ABQSC has focused on developing relationships with key partners, such as the APD, and honing the use of critical tools, such as Certificates of Evaluation (COE).

> *Building relationships is key, with everyone: the jail, hospitals, police, payees, guardians… — ABQSC Clinical Director, Carol*

While critical gaps still exist, the ABQSC team, together with its partners and tools, create a robust safety net for the vulnerable population they serve.

Healthcare

Outpatient Mental Health and Addiction Services

ABQSC has a crucial relationship with Dr. Swala Abrams, a psychiatrist with Presbyterian's Adult and Geriatric Behavioral Health Clinic. While many in NM must wait months for a psychiatric appointment, Dr. Abrams reserves half a day a week for up to eight ABQSC clients and provides both psychiatric and addiction services (e.g. buprenorphine for opioid use disorder). The ABQSC team decides each week which clients could benefit most from these services and transports and accompanies them to the appointments. Some clients come weekly or bi-weekly for an extended period to stabilize.

> *Having an ABQSC Navigator who can find J and bring him in to get his injection for schizophrenia on time is critical… With ACT teams, the physician goes to the client, spending a lot of time in transit. In the ABQSC model, the team brings in 6-to-8 people and I dedicate a half-day to them; it's a really efficient way to deliver services to a high-need population. — Presbyterian psychiatrist, Dr. Abrams*

Dr. Abram's role extends beyond the medical visit. For example, she fills out forms for payees, guardians, and certificates of evaluation and remains in regular communication with the ABQSC team.

Medicaid Managed Care Organizations (MCOs)

An early step with ABQSC clients is to ensure that they have or to help them obtain Medicaid, and then to work closely with their MCO care coordinators to facilitate access to services. For example, a Presbyterian's care coordinator participates in ABQSC's weekly team meetings. Just over half of clients have Medicaid through Presbyterian and just over one-third via Blue Cross Blue Shield.

Table 4: Distribution of Medicaid MCOs Among ABQSC Clients

Medicaid MCO	**# of ABQSC Clients**	**% of ABQSC Clients**
Blue Cross Blue Shield	19	35%
Presbyterian	29	54%
Western Sky	3	6%
Other*	3	6%
Totals	**54****	**100%**

* This includes Medicare and Veteran Affairs benefits.
** This excludes the 4 ABQSC clients who are deceased.

Certificates of Evaluations and Inpatient Commitments

When a person with mental illness shows a likelihood of seriously harming others or themselves (including grave passive neglect), NM law allows certain providers to issue a COE.[3] A COE compels law enforcement to transport the person to an ED. There, the admitting provider decides whether there are reasonable grounds to detain the person involuntarily for evaluation and treatment. If the person is committed, then they have a right to a hearing within 7 days,

[3] NM Statute Annotated (NMSA) § 43-1-10. The providers include physicians, psychologists, and qualified mental health professionals licensed for independent practice who are affiliated with a community mental health center or core service agency. Under certain circumstances, officers may also issue COEs.

which could lead to a 30-day commitment in a local psychiatric facility or the state-owned facility in Las Vegas, NM Behavioral Health Institute (NMBHI). (See the COE/commitment flowchart in Figure 2.)

He was neglecting himself to the point where, if he continued on that path, he would die… when clients can start medications in the hospital, they can gain the insight they didn't have before. Then we can really start moving forward. — ABQSC Clinical Director, Carol

ABQSC considers COEs and commitments to be important tools for helping some clients avoid harm and begin to stabilize. However, barriers to the effective use of these tools exist at every stage depicted in Figure 2. In a recent example, the ABQSC team gathered on a Saturday to implement a carefully planned COE: the Clinical Director had prepared the COE and an ABQSC Navigator brought the client to Heading Home, where downtown police officers who knew the client well were waiting to transport to the hospital. The team had decided to take the client to Presbyterian's Kaseman Hospital because Dr. Abrams was on call at the inpatient psychiatric facility and aware of the plan. Because the client had medical as well as psychiatric issues, he went to the medical facility first, where he was discharged without consulting the psychiatric facility, even though the ABQSC Clinical Director had informed the attending physician about the client's psychiatric issues and Dr. Abrams' history with the patient.

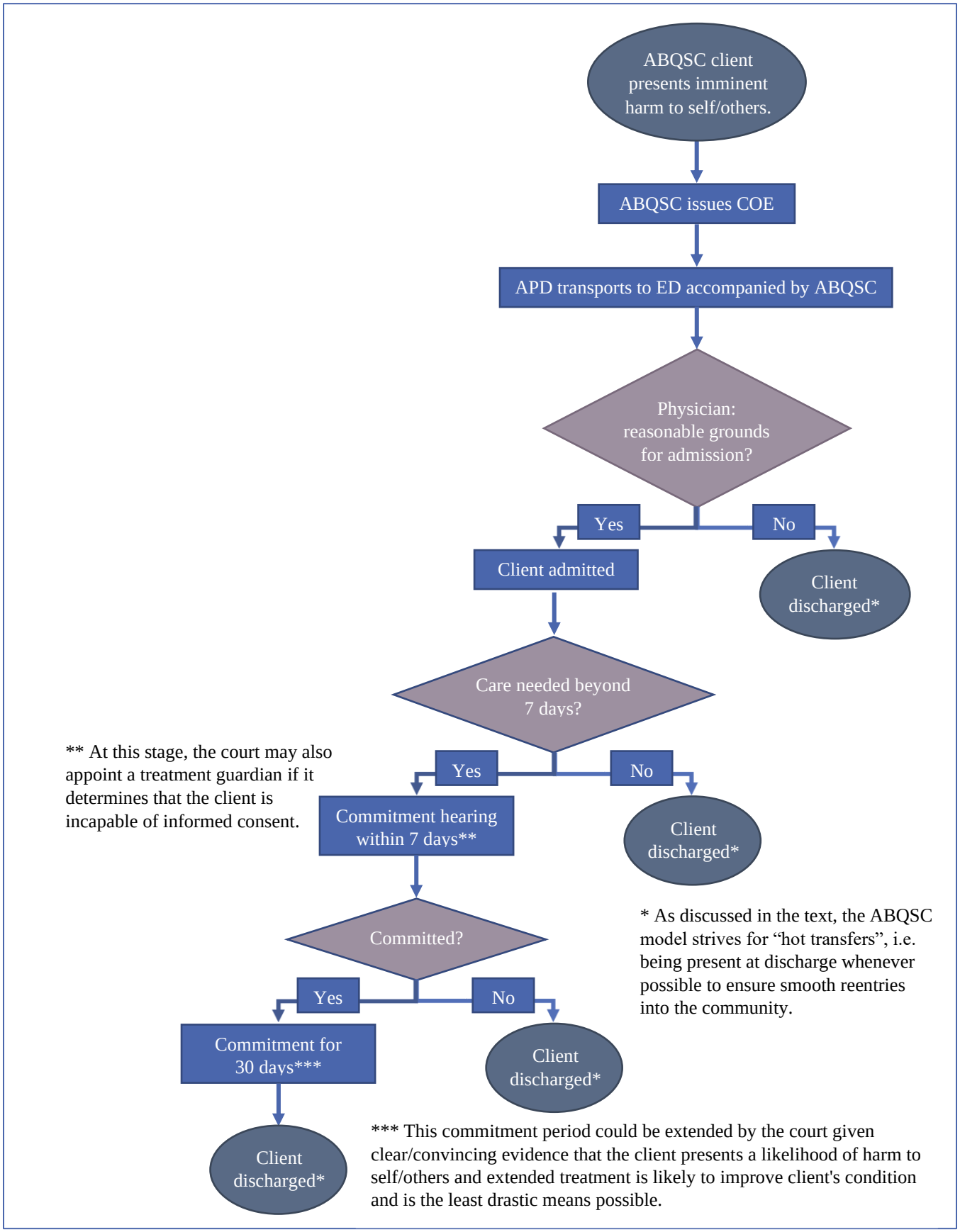
With COEs, a pattern has emerged for ABQSC clients with co-occurring substance use disorders and psychiatric issues: the attending physicians often assume that the psychosis is related to substance use and the clients are discharged without being held long enough to assess their underlying psychiatric issues. As Dr. Abrams explained, "There has to be buy-in from all levels about how best to manage dually diagnosed patients, instead of just triaging them out. That requires a big culture change."

Another challenge is an insufficient number of inpatient beds, which pressures EDs to make difficult decisions about whether to commit clients. "If somebody will [become] clear with Haldol and time, and the urine is positive for methamphetamines, then it's easy to diagnosis with meth-induced psychosis and discharge them, even if you have evidence that this person has chronic mental health issues," Dr. Abrams noted.

ABQSC continues to educate and build relationships with hospital providers and staff, including developing a better understanding of when and why ABQSC pursues COEs and commitments. "We don't do COEs willy-nilly; it's important that hospitals take us seriously when we use this tool," reported the ABQSC Clinical Director. ABQSC's new contract with UNMH will help to accelerate this relationship-building, both with the physicians making admission decisions and with the discharge planners.

While COEs and commitments have the potential to catalyze stability, each of the hospital discharges in the flow through this complex process (Figure 2), if handled poorly, represents a potential setback for a client. In one case, a guardian transported a client to the ED with a COE, but the client was not admitted and the client ended up outside in the cold at 10 pm. Thankfully, the client was able to communicate with an ABQSC Navigator who transported him to a shelter. ABQSC's ongoing relationship-building with discharge planners is critical for smooth transitions back into the community.

Figure 2: Flow Through the Mental Health Certificate of Evaluation and Commitment Process



** At this stage, the court may also appoint a treatment guardian if it determines that the client is incapable of informed consent.

* As discussed in the text, the ABQSC model strives for "hot transfers", i.e. being present at discharge whenever possible to ensure smooth reentries into the community.

*** This commitment period could be extended by the court given clear/convincing evidence that the client presents a likelihood of harm to self/others and extended treatment is likely to improve client's condition and is the least drastic means possible.

People experiencing homelessness, mental illness, and addiction need services, and providing services has just as much of an effect, or more, than writing citations or making arrests. — APD Sergeant Peter Silva

When we started working with APD, they could see that we have tools they don't have, and they have tools we don't have. We can work in tandem. Their objective is to make sure that clients are not a hindrance to other people living and enjoying their life downtown. For us, it's increasing the client's quality of life and decreasing the chances of exploitation and abuse. But it all comes together: increasing the quality of life for the client also means increasing the quality of life for everybody else downtown. — ABQSC Clinical Director, Carol

APD's Downtown Substation works closely with ABQSC. See Box 1 for edited excerpts from an interview with APD Sergeant Peter Silva.

Income Benefits

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Another key tool used by ABQSC is SOAR, a national program that is targeted to individuals who are chronically homeless and struggling with behavioral health issues. It aims to end homelessness by increasing access to federal SSI/SSDI[4] income supports, directly addressing SAMHSA's assertion that "To recover, people need a safe stable place to live." SSI income allows ABQSC clients to fund (partially, if not fully) their own housing; SSI typically provides $783 a month and, per federal rules, $650 of this can go towards housing. ABQSC contracts with Teddi Rivera, a SOAR Representative, who has been involved with SOAR for over a decade.

There is no phone call that is as rewarding as calling the client and saying, "Guess what? You are approved." — SOAR Representative, Teddi Rivera

SOAR helps vulnerable clients get income far quicker than usual by bringing the process to the clients: the SOAR Representative works directly with clients in a familiar environment (Heading Home), as well as with ABQSC navigators, who support with transportation and information gathering. A SOAR Representative spends 20 to 50 hours compiling each application, and these SOAR applications are prioritized by federal Social Security Administration (SSA) and state Disability Determination Services (DDS) staff.[5] In Albuquerque, DDS has adjudicators who specialize in SOAR to help expedite case approvals.

I've started adding the client's picture to the application. I tell their story, why they're on the streets, what traumas they've suffered. The stories are heartbreaking. — SOAR Representative, Teddi Rivera

[4] The main difference between Social Security Disability (SSDI) and Supplemental Security Income (SSI) is that SSDI is for workers who have accumulated enough work credits, while SSI is for low-income individuals who have either never worked or who do not have enough work credits. Reflecting the acuity of ABQSC clients, SSDI is rarely relevant because clients typically do not have a work history.

[5] SSA makes the financial determination—i.e. whether the client has less than $2,000 in assets, then DDS makes disability determination.

A challenge that the SOAR Representative sometimes faces is with clients who have had little to no contact with the healthcare system, even though they have significant mental health and/or substance use issues; they need medical records to establish their disability. ABQSC addresses this issue by helping clients get into the system to establish a medical record. The relationship with Dr. Abrams helps to facilitate this.

The vast majority of ABQSC clients receive SSI benefits; while some used the full SOAR process, others did not, and some had SSI benefits prior to enrolling in ABQSC. (See Table 5.)

Table 5: ABQSC Clients with SSI Income Benefits

Category	# of ABQSC Clients	% of ABQSC Clients
ABQSC used the SOAR process		
Approved	19	33%
In process	6	10%
ABQSC helped client to obtained SSI	15	26%
Client had SSI prior to ABQSC	15	26%
Not applicable*	3	5%
Totals	**58**	**100%**

* 1 client has income, another is incarcerated, and the remaining client died before the SSI application was completed.

Challenge: Expanding SOAR Across NM

SOAR is a fundamental service that, if implemented more broadly, could bring a substantial amount of federal dollars to NM. These dollars would not only directly benefit some of our most vulnerable residents but also free up scarce local housing dollars.

SOAR was originally geared towards individual agencies adding SOAR work to their case managers. Over two hundred staff across NM agencies have been trained in SOAR, but it quickly became clear that the model required dedicated SOAR representatives to accomplish the intense engagement (20–50 hours) that each application requires. If a program wants to include a dedicated SOAR representative, then they must build this cost into their budget. Consequently, only a handful of SOAR representatives are active in NM. A statewide SOAR Steering Committee continues to look for funding streams, such as House Bill 98, which was first introduced during the 2020 Legislative Session but did not pass. This legislation would have put $750,000 a year towards a statewide SOAR program with centralized operations and trained and dedicated SOAR Representatives across the state. ABQSC budgets for dedicated SOAR services and this is part of the reason for the program's success.

Box 1: Excerpts from Interview with APD Sergeant Peter Silva

Law enforcement is only part of the solution. Without the support of something like ABQSC, we would still just be arresting the same people over and over. It would be whack-a-mole. These are individuals who would often panhandle or sleep in front of businesses. So APD is getting these really low-level calls on a regular basis. And, other than arrests and citations, we really didn't have any other avenue: **ABQSC has given us this other avenue.**

One of the **real success stories** has been Barb, an older woman, addicted to narcotics. Because of her age, there's a lot more to worry about if we got into a force encounter with her. But she would do violent things—throw rocks, spit at people, argue with people. We've had to charge her with battery on a police officer. It didn't matter if we arrested her or cut her a citation. **Law enforcement wasn't working. You're just waiting for that moment when things go really wrong**—for example, she pulls a weapon on me. It could get really dangerous.

We got her connected with ABQSC. They started engaging her and getting her into services; what I've learned is, **this can be a long process**. She's now connected with a guardian and a group home. She looks like a different person; you wouldn't recognize her. From where she's come from to where she is now, she's a completely different person. It's hard to quantify because you're thinking, 'This is just one person.' But in reality, this one person was responsible for so many arrests, so many calls to APD, so much time and money prosecuting cases that weren't going anywhere. **None of this was as valuable as getting her what she really needed**.

We've seen results like this with several people. Another one, J, was getting into a lot of trouble: he would display these really violent behaviors, so we would have to take him into custody. Since he's been enrolled with ABQSC, this behavior has gone way down. **He's still downtown, but he's not a problem.** In fact, he's been helpful to people. He's doing really well.

In the **weekly ABQSC briefings**, we get updates and strategize on the highest priority clients. For example, ABQSC had a COE on somebody, but they needed help finding him. My guys knew where to find him. Or I learn that somebody was placed in a group home; so now when my officers are having a problem with him, instead of or citing or arresting him, they can say, "Hey, would you like a ride home?" The client is often like, "Sure, I would actually." Or we can say, "Hey, let's go talk to Jodie at ABQSC." A lot of times, that's all it takes.

Sitting in on these briefings has really been eye-opening. I never saw these issues in the light that I see them now. We all have our biases. Quite honestly, the bias is usually, "Why are you giving free things to people?" **What you don't realize, is how much these ABQSC services are saving the community.**

I like a private organization being involved—the flexibility that provides; fewer restrictions than APD. With the ABQSC model, if Jodie doesn't feel like she needs us, she's not going to call. Nine times out of ten, she's like "No, we're good Sarge. You guys go do your thing. We'll take care of it from here." But she knows that if she needs us, we'll be there. ABQSC does what they feel is the right thing to do, and I trust them to do the right thing. There's a lot of trust there.

Each area command has its own target areas, where crime and homelessness are higher. **Why wouldn't we have an ABQSC team in each of these areas?** There's the perception: you're a cop, you're supposed to be arresting people. But no, I'm a peace officer; I'm restoring the peace. If that means helping somebody get into a program, that's a win to me.

Representative Payees

SSA can appoint a representative payee if it determines that an individual cannot manage their SSI. Although family or friends can serve as payees, many ABQSC clients do not have anyone to fill this role; instead, a qualified local organization, such as Bridge to Success, serves as the payee.

As part of the SOAR application, the SOAR representative makes recommendations to SSA about whether the client would benefit from having a payee. Additionally, judges, doctors, or Adult Protective Services can formally request a payee for a client; ABQSC often turns to Dr. Abrams or its Clinical Director for this. "SSA wants a letter from somebody who has known the client for a while," explained Bridge to Success. Ultimately, SSA makes this important decision based on a brief interview with the client. Of the 49 ABQSC clients who have SSI benefits, about half have a payee (Table 6).

Table 6: Payee Status of ABQSC Clients with SSI Income Benefits

Payee Status	**# of ABQSC Clients (with SSI Benefits)**	**% of ABQSC Clients**
Organizational payee	19	39%
Organizational payee pending	2	4%
Family payee	2	4%
No payee (client manages income on their own)	22	45%
Unknown	4	8%
Totals	**49**	**100%**

As payee, Bridge to Success meets with their clients weekly, reloading their prepaid Visa cards, reviewing their budgets, discussing what they want to save money for, etc. When Bridge to Success and ABQSC share a client, they collaborate closely.

> *There are things that we can't do that ABQSC can do and vice versa… it's coming together as a family. [ABQSC Navigator] Andy just called me; Megan called earlier… There are very few organizations that go above and beyond like ABQSC. — Payee, Bridge to Success*

Challenge: Many ABQSC Clients Need a Payee, But SSA is Reluctant to Assign One

The ABQSC Clinical Director explained, "If they have a payee, there's a greater likelihood that they will have money to pay their rent. If they don't have a payee, then they will spend all their money, or someone will exploit them. They can't pay the rent; they can't buy food…"

> *I can tell SSA, 'They need a Payee; otherwise, they'll drink themselves to death.' They can be dead in 2 months because they suddenly have income but no help to manage it. — SOAR Representative, Teddi Rivera*

"Because SSA has had problems with fraudulent payees, their goal now is to make everyone their own payee," explained a Bridge to Success payee. "SSA can make any decision; they can override doctors. They talk to the client for 5 minutes—who might say, 'I'm going to put my

money in the bank'—and decide they don't need a payee. It's a huge problem." SSA has closed 5 local payee organizations during the past 3 years.

Changes in Service Utilization Associated with ABQSC

Healthcare

Data shows that after clients engage with ABQSC, their healthcare utilization shifts. The biggest change was in the use of outpatient behavioral health (BH) visits, which, for each client, increased by 3.1 visits per year on average, from 1.7 to 4.8 visits. (See Table 7.) Dr. Abrams (discussed above) was responsible for just under one-third of these visits before clients enrolled in ABQSC; this increased by almost half after enrollment, reflecting the system that ABQSC, in partnership with Dr. Abrams, has put in place to increase access to BH services.

As outpatient BH visits increased, BH visits to the ED decreased, by 3.0 visits per year, on average, for each client. However, inpatient BH visits increased an average of 0.4 visits per year (or by 1 visit every 2.5 years). When necessary, ABQSC staff use inpatient care (by pursuing COEs) as a method to stabilize their clients' mental health issues. It is expected that BH inpatient utilization will eventually decrease and stabilize. This will be verified once there is longer post-engagement trend data.

Across all three settings (outpatient, ED, and inpatient), the shift in healthcare utilization for medical visits was smaller than the BH shift, showing slight increases in outpatient and inpatient visits and a slight decrease in ED visits. As seen in Table 8, ABQSC was also associated with a sizeable shift in utilization from Lovelace to UNMH.

Table 7: Healthcare Visits Before and After Enrollment in ABQSC (n=53, see Table 14)

Type of Visit		**Average Number of Visits per Year per Client**		
		Before ABQSC	**After ABQSC**	**Change (After – Before)**
Emergency	Behavioral Health	6.8	3.8	-3.0
	Medical	6.9	6.5	-0.4
Outpatient	Behavioral Health	1.7	4.8	3.1
	Medical	1.8	2.6	0.8
Inpatient	Behavioral Health	0.7	1.1	0.4
	Medical	0.33	0.47	0.14
All Visits		**18.2**	**19.3**	**1.1**

Table 8: Shift in Utilization by Healthcare Facility Owner (n=53, see Table 14)

Facility Owner	**% of Visits**		
	Before ABQSC	**After ABQSC**	**Change (After – Before)**
Lovelace	20%	11%	-9%
Presbyterian	38%	38%	0%
UNMH	41%	51%	10%
Other	1%	0%	-1%
Totals	**100%**	**100%**	

While the average number of healthcare visits per year was 18 prior to ABQSC enrollment, 12 clients averaged 1 visit or less annually. Interviews conducted for this report also revealed that underutilization of healthcare services is a major concern:

> *When we enroll clients, it's clear that many have never accessed services at all, not even emergency care; they are slipping through even those cracks. This is a population whose significant health needs have never been addressed.*
> *— ABQSC Navigator, Megan*

> *She never goes to the doctor, never ever. So there are no records on her. She's in her fifties but looks 80 years old. Delusional, psychotic… the trauma is so severe. Social security may deny her SSI application because we can't prove her condition.*
> *— SOAR Representative, Teddi Rivera*

Overall, clients' shift in healthcare utilization likely reflects more appropriate and beneficial use. ABQSC clients have significant BH and medical issues, and many of these issues have gone unaddressed for long periods of time. The analysis suggests a shift away from the ED and toward outpatient care for both medical and BH issues, as well as a (possibly temporary) shift toward inpatient care as ABQSC works to stabilize clients' BH issues.

Emergency Medical Services

Data also shows that clients' EMS contacts decreased substantially after ABQSC enrollment. Prior to ABQSC enrollment, clients averaged 6.6 EMS contacts per year; this dropped to 0.8 EMS contacts per year following ABQSC enrollment (Table 9).

Table 9: EMS Contacts Before and After Enrollment in ABQSC (n=40, see Table 14)

EMS Contacts	**Average Number of Contacts per Year per Client**		
	Before ABQSC	**After ABQSC**	**Change (After – Before)**
	6.6	**0.8**	**-5.8**

Of the 40 clients included in this analysis, EMS contacts decreased for 24 clients, ranging from a decrease of 0.1 EMS contacts per year to a decrease of 65.9 contacts per year; 4 clients decreased by more than 5 contacts per year. (The mean decrease was 6.9 contacts per year and the median was 1.5.) One client saw no change in the number of EMS contacts and 15 clients saw increases, ranging from an increase of 0.2 to 26.6 EMS contacts per year. (The mean increase for these 15 clients was 2.8 contacts per year and the median was 0.8.)

Jail Bookings at Metropolitan Detention Center (MDC)

Our analysis does not show that ABQSC is associated with substantial changes in jail bookings. Prior to ABQSC enrollment, clients averaged 1.73 MDC bookings per year; this dropped to 1.67 MDC bookings per year following ABQSC enrollment (Table 10).

Table 10: MDC Booking Before and After Enrollment in ABQSC (n=41, see Table 14)

MDC Bookings	Average Number of Bookings per Year per Client		
	Before ABQSC	After ABQSC	Change (After – Before)
	1.73	1.67	-0.06

Of the 41 clients included in this analysis, MDC bookings decreased for 21 clients but increased for 20 clients. (For the former, the mean decrease was 2.4 bookings per year and the median was 1.2; for the latter, the mean increase was 1.8 bookings per year and the median was 1.0.)

Clients' Stories

The client names used below are pseudonyms.

Abe's Story

Abe, who is in his sixties, is very ill, even by ABQSC standards. He suffers from dementia, schizophrenia, alcohol use disorder, anxiety, hypertension, and diabetes. Some of the acute conditions he has had during our study timeframe include protein-calorie malnutrition, pneumonitis, an open head wound, hypothermia, hernias, and a leg fracture.

> *He presents as calm, polite, and interactive… has a history of low educational achievement… He has a significant inability to care for himself and is at an extremely high risk of exploitation and victimization. He doesn't have contact with his family. His longest period of sobriety has been less than a year. His father also had alcohol use disorder and first took him to a bar at the age of 16. He has been homeless for many years and has a history of incarceration. — Outpatient Clinical Note*

The ABQSC intervention with Abe was short, intense, and effective: ABQSC successfully placed Abe in a nursing home with an appropriate level of care (Princeton Place), connected him with a full guardian, and began his SSI application (which is still in progress). At the same time, Abe's new stability is precarious.

As is typical, Abe became an ABQSC client because he was in a heightened state of instability. During the 4 days prior to Abe's enrollment, he had six ED visits (across the three local healthcare systems—UNMH, Presbyterian, and Lovelace).

As is also typical, enrollment in ABQSC was not an immediate panacea. During the 220 days since Abe's enrollment (i.e. up to the present time), he has experienced four very different periods, alternating between instability and stability. Abe was in the hospital every day for his first 17 days as an ABQSC client, for either an inpatient hospitalization or an ED visit, often visiting multiple EDs on the same day.

Within the last week, the client has been admitted to multiple hospitals and discharged to the streets… This has been unsuccessful. The client has severe mobility issues and is unable to make decisions. High likelihood of imminent death…
— Affidavit for Emergency Guardian from ABQSC

Some of this hospital activity was initiated by ABQSC via COEs, with the goal of accessing inpatient psychiatric care to stabilize Abe. Princeton Place would not accept Abe until he was more stable. In the interim, ABQSC invested heavily in engaging and building trust with Abe, pieced together housing to keep him off the streets (hotel room, shelters, and group homes), and began the lengthy processes of securing both SSI income and a full guardian.

Remarkably, the 17-day hospital marathon was followed by 118 days with no hospital visits. Abe received outpatient BH treatment about twice a month from Dr. Abrams during these 4 months, and, a month into this stable period, he met with his full guardian for the first time and moved into Princeton Place. The ABQSC Navigator helped Abe settle into Princeton Place and continued to stay in touch, but without the intensity or frequency required during Abe's first two months as a client.

Abe is doing extremely well. He stated that he would like to stay at Princeton Place permanently. — Navigator Note

Abe then hit a 16-day period in which all but 3 days were spent in the ED. ABQSC was quickly looped in and shifted Abe back to a top-priority client; Abe also proactively reached out to ABQSC during this difficult time, reflecting the relationship that had been carefully built. Currently, Abe is back in a stable period with over two months with no hospital encounters and with regular outpatient care.

Daniel's Story

Although ABQSC first met Daniel about a year and a half ago, he remains on the streets without consistent treatment for his schizophrenia and other mental health conditions. He illustrates the challenges with achieving positive outcomes for individuals who suffer from both chronic homelessness and chronic mental health issues, as well as the gaps in the safety net that exacerbate these challenges.

ABQSC first learned about Daniel, who is in his early fifties, via a referral from the city, who had received an email from a resident: "[We have an] escalating neighborhood situation involving a mentally ill homeless man who is well known to APD… he grew up on our street… [and has] been sleeping in various yards, carports, alleys, and driveways for well over a decade." ABQSC first made contact with Daniel during a week-long inpatient psychiatric stay, but he landed in jail soon afterward with a charge of battery on a police officer. After his release from jail, ABQSC coordinated with APD and others to find and engage Daniel; he was first noticed by Block-by-Block, who immediately called ABQSC.

ABQSC continued to efforts to engage Daniel but often lost contact with him for weeks at a time. Finding Daniel "largely incoherent… and increasingly agitated," the ABQSC team and APD coordinated on a COE with the goal of stabilizing Daniel's mental health status; however, these efforts failed because the ED provider did not find reasonable grounds to admit Daniel for

an inpatient stay. Soon afterward, Daniel walked into moving traffic, resulting in a 2-month inpatient stay and significant chronic disability.

Over the course of a year, ABQSC worked on four additional COEs, with only the last leading to an inpatient admission. ABQSC coordinated with UNMH on Daniel's discharge and helped him to settle into a motel afterward. The Navigator recorded that "[Daniel] requested shoes and cigarettes. He was clear and articulate." In addition to the difficulties with COEs, ABQSC was also unable to convince the court of Daniel's need for a plenary guardian. Other strategies used to construct the support that Daniel needed included working to engage Daniel's treatment guardian and MCO care coordinator in his care, obtaining SSI benefits via the SOAR process, identifying appropriate group homes, and supporting and coaching Daniel in succeeding in these new environments. Daniel often returned to living on the streets soon after a group home placement. ABQSC understood that a group home likely would not meet Daniel's needs and continued to work with the MCO on an assisted living or long-term care placement.

> *[Daniel] continues to be resistant to housing … he reports that he wants to be at his auntie's house (a street corner he likes to stay at). — Navigator Note*

ABQSC actively continues to engage Daniel and piece together the resources required to support him.

Barb's Story

We introduced Barb above, in the interview with Sergeant Silva: "From where she's come from to where she is now, she's a completely different person." Barb is in her late fifties and has schizophrenia and substance use disorders.

> *She has suffered significant cognitive decline over the past 10 years due to untreated mental disorders, substance use, polytrauma, and psychosocial instability, including homelessness. — Physician note on COE application*

During the 4.5 months before Barb enrolled in ABQSC, she had a spike in ED use, spending almost 30% of these days in the hospital. Just as concerning, Barb had a longer history of underutilizing healthcare services—for example, she received little to no outpatient services during the 2 years before ABQSC enrollment. (See Table 11.)

> *[Client] reports she has been on several antipsychotic medications but does not recall which… she's at risk of being exploited due to her lack of recognition of others' motives and intents. — Note from ABQSC Clinical Director*

Table 11: Barb's Use of Healthcare Services Before and After ABQSC Enrollment: Four Phases

Phases	# of days	% of days without healthcare services	% of outpatient days	% of hospital days	% of hospital days that were	
					ED	inpatient
Pre-Enrollment						
Two-year period prior to ABQSQ enrollment (excluding the period below): Underutilization of healthcare services.	597	97.7%	0.3%	2%	100%	0%
4.5 months prior to enrollment: A spike in ED use.	133	71%	0%	**29%**	**85%**	15%
Post-Enrollment						
5.5 months after enrollment: Inpatient stays were used as a tool to stabilize Barb's psychiatric conditions.	170	44%	2%	**54%**	16%	**84%**
The remaining post-enrollment period: A shift to outpatient services and away from hospital use.	333	90%	**8%**	2%	100%	0%

Barb's post-enrollment period had two distinct phases: During the first 5.5 months, ABQSC worked aggressively to stabilize Barb's mental health conditions, primarily thru voluntary and involuntary inpatient admissions. As seen in Table 11 above, Barb spent over half of these days in the hospital, mostly in an inpatient setting. When not hospitalized, ABQSC strived to keep her off the streets, focusing simultaneously on short and long-term solutions; the flow of her housing during this time was:

motel → inpatient → group home → streets → westside shelter → inpatient → Barrett shelter → inpatient.

The second post-enrollment phase began about a year ago, after this last inpatient hospitalization, and built on the mental health stability created during the first phase. In addition to a significant shift from hospital-based to outpatient care, this second phase was characterized by intensive engagement by the ABQSC team that operated on several parallel paths:

- leveraging available resources (Medicaid, SSI and SNAP benefits, a representative payee);
- providing tangible supports to the client;
- building a respectful and sincere relationship with the client;
- coaching the client towards as much self-reliance as her conditions allow; and
- ultimately, transitioning the client to sustainable and ongoing supports. (Barb has remained stably housing in a group home with the support of a plenary guardian.)

In baby steps, Barb transformed her life, overcoming barriers related to her underlying behavioral health conditions as well as related to clunky and under-resourced systems for supporting vulnerable populations. During this time, the ABQSC Navigator accompanied Barb to healthcare appointments—e.g. ensuring that she received her monthly antipsychotic injections—and helped her to obtain, for example, haircuts, shoes, glasses, and dentures. The dentures took months longer than usual as the Navigator worked to reinstate Barb's Medicaid. The Navigator, SOAR Representative, and payee also spent months getting Barb's SSI benefits reactivated due to a long-standing overpayment to a Wells Fargo account that Barb was unaware

of; even the simple task of closing the bank account proved tricky because Barb initially lacked identification.

The SSI delays caused a concrete problem: the group home manager threatened to evict Barb due to unpaid rent. However, it also created an opportunity:

> *[Barb] reported feeling out of control, very worried about losing housing… Navigator's crisis intervention was successful… [Barb] was able to engage in the coping skills that we'd been working on. — Navigator Note*[6]

Nearly all the ED visits during this second post-enrollment phase resulted from Barb exhibiting seizures in the face of a new, stressful situation—e.g. an appointment with SSA, with UNM's Psychosocial Rehabilitation (PSR) program, and with a medical specialist. Again, the Navigator treated each of these "failures" as an opportunity:

> *[Barb] has some awareness around the connection between her anxiety and the seizure episodes… Navigator continues to engage in coaching and motivational interviewing… Navigator called [Barb] to walk her through the process of using medical transport to go PSR … [Barb] called to say that she successfully made it to PSR and then called again to say she enjoyed PSR. — Navigator Notes*

> *[Barb] continues to become more independent; seems to be thriving. — Navigator Note*

Conclusions, Challenges, and Opportunities

This evaluation demonstrates that the ABQSC model has tremendous potential to:

- improve the lives of people who experience chronic homelessness paired with mental illness;
- reallocate resources more appropriately: shifting from ED to outpatient visits, decreasing EMS contacts, and using inpatient stays as needed to stabilize mental health crises; and
- build collaborative, cross-sector relationships—across APD, healthcare systems, and other organizations—to form an essential and effective safety net for the vulnerable population served by ABQSC.

The ongoing, successful relationship between APD and ABQSC, for example, demonstrates that the ABQSC model, in addition to improving clients' lives, can lead to a cascade of positive outcomes: from boosting APD morale by providing officers access to effective tools that decrease their burden and frustration to enhancing the environment downtown for residents and businesses.

As a community, we have made significant strides to better serve certain target populations via tailored services and dedicated resources, including, for example, our community's commitment

[6] Navigators document each encounter, providing a narrative (What did you do with the client?), an assessment (How did the client behave? What do you think the client needs?) and a plan (What are going to do next with the client?).

to behavioral health and reentry services. This clear commitment has helped to improve lives, shift attitudes, reduce stigma, and increase compassion.

At the same, this evaluation also exposes significant gaps in the required safety net for this vulnerable population.

While the target population for the ABQSC model is relatively small, its needs are unique and the barriers it faces in accessing services and resources are staggering. This population requires tailored services, skilled services providers, dedicated resources, and compassion—just as with other special populations such as our children, elders with dementia, or residents with developmental disabilities.

An example of an existing tool that could be tailored to meet the specific needs of the homeless population with significant behavioral health issues is the Vulnerability Index and the Service Prioritization Decision Assistance Tool (VISPDAT), a useful assessment tool to prioritize housing and service needs, but that relies on self-assessment. Our community could develop a brief screening to determine who does not have the capacity to accurately complete this self-report tool together with an alternative tool to better capture this subgroup's needs.

Many organizations face challenges when serving this target population, which is reflected in ABQSC clients being banned from a range of organizations from health centers to social service agencies to long-term care facilities. The root cause of being banned typically stems from clients' behavioral health issues. As a community, we need to both better support the organizations providing services to this target population and ensure that people with behavioral health issues that are aggravated by chronic homelessness are not facing systemic discrimination that limits their access to services.

For example, the policy of one national corporation with a large market share of long-term care facilities in NM is to permanently ban a client from all facilities statewide if they exhibit behaviors that get them banned from one facility. This exacerbates the shortage of housing placements with the appropriate level of ongoing support such as skilled nursing facilities, long-term care facilities, and group homes. One consequence of this shortage is that hospitals lack appropriate options for discharging patients who require post-acute and ongoing support.

Another way in which the ABQSC population is effectively banned from essential services is through program requirements that are inconsistent with their chronic mental health conditions (such as managing Activities of Daily Living or consistently attending meetings/appointments). More subtlety, some programs also have a resistance to working with such a high-need population due to inexperience or insufficient training. For example, historically, the guardianship program has primarily served housed individuals with independent funding, including, for example, elders with dementia; learning to effectively serve the ABQSC population will take time, training, and resources.

Through detailed case studies, interviews with a variety of stakeholders, and quantitative analyses of service utilization, this evaluation described and assessed the impact of ABQSC. Overall, ABQSC clearly benefits its clients. Notably, the use of (non-ED) outpatient BH visits increased by an average of 3 visits per year per client, while BH visits to the ED decreased by 3 visits per year. Additionally, the number of EMS contacts with ABQSC clients decreased by nearly 6 visits per year per client. At the same time, however, average annual MDC bookings

remained at 1.7 both before and after ABQSC enrollment and inpatient BH visits increased an average of 0.4 visits per year. (When necessary, ABQSC staff pursue inpatient care to stabilize clients' mental health issues; further research, with longer post-engagement trends, will be needed to determine whether BH inpatient utilization will eventually decrease.) Taken together, these utilization outcomes suggest that the ABQSC model—in addition to improving clients' lives—may also reduce community-wide costs in the long term.

Our community could benefit from an expansion of ABQSC into additional neighborhoods. This could be facilitated by diversifying the ways in which ABQSC is funded. For example, state funding for SOAR could offset the funding needed for ABQSC; additionally, certain stakeholders, such as Medicaid MCOs, might benefit from reimbursing ABQSC to serve beneficiaries who have experienced chronic homelessness together with serious mental illness.

At the same time, further monitoring and evaluation of ABQSC are needed both to make ongoing improvements to the model and to accurately quantify its long-term impacts. The ability to monitor and evaluate ABQSC, as well as other programs, could be improved in several ways. First, a more universal adoption of the NM HIE would improve both direct client services (by facilitating data-informed decision-making), as well as the ability to assess the impact of programs. State funding and support for federally qualified health centers, NMBHI, and other healthcare organizations to use HIE could accelerate universal adoption. Similarly, developing community-wide information sharing protocols for MDC and other criminal justice data that protect privacy and improve both continuity of care and evaluation capacity is also needed.

To learn more about ABQ StreetConnect,
Heading Home's vision, mission and additional programs,
please visit www.headinghome.org.

Appendix A: Data Sources and Methods

Heading Home contracted with an external evaluator (Judy Bartlett, owner of Bartlett Evaluation) to create this report using a broad range of quantitative and qualitative data sources. The qualitative work included 7 semi-structured interviews of key stakeholders (see Table 12), ongoing conversations with the ABQSC Director, and detailed chart reviews of 3 purposively selected clients.

Table 12: List of Interviews Conducted

Organization	Name	Title/Role
Albuquerque Police Department	Sgt Peter Silva	APD liaison with ABQSC
Bridge to Success	Brenda Barela Phyllis Tabet	Representative Payees
Heading Home	Andy Lopez	Navigator
Heading Home	Carol Brusca	Clinical Director
Heading Home	Megan Brown	Navigator
Presbyterian	Swala Abrams	Psychiatrist
SOAR	Teddi Rivera	SOAR representative

Quantitative Analyses of Changes in Service Utilization Associated with ABQSC

This evaluation used a pre/post analysis to assess whether ABQSC is associated with changes in clients' use of three types of services: healthcare, EMS, and jail. The data sources were, respectively, NM's Health Information Exchange, Albuquerque Fire Rescue's (AFR) EMS data, and booking data from the MDC provided by UNM's Institute for Social Research. ABQSC clients fill out a Participant Authorization that allows personal information, including individually identifiable health information, to be shared between ABQSC and our community partners.

For all three types of services, the pre/post analysis assessed a 3.5-year period: 2 years before enrollment to 1.5 years after enrollment. Not all clients had complete data across this full 3.5-year period, primarily because some client's enrollment dates do not allow a full 1.5-year look-forward period. For example, if a client enrolled at the end of February 2020 and data collection went thru the end of May 2020, this client would only have 1 quarter of post-enrollment data. (See Table 13 for the distribution of clients' enrollment year.) In addition, sadly, four ABQSC clients died before the end of the 1.5-year post-enrollment period.

Table 13: Distribution of Clients' Year of Enrollment

Year	# of Clients	% of Clients
2016*	1	2%
2017	7	12%
2018	27	47%
2019	16	28%
2020	7	12%
Totals	**58**	**100%**

* This was ABQSC's pilot year.

The pre-enrollment periods for the healthcare and jail analyses were handled somewhat differently than the EMS analysis because, for the former, we had dates associated with each encounter; in contrast, for the EMS data we only had total counts for both the pre- and post-enrollment periods. In addition, we had no access to EMS data prior to July 1, 2017, which shortened many clients' lookback periods to less than 2 years.

To determine each client's pre-enrollment period for healthcare and jail data, we first determined whether there were any encounters at least 2 years before enrollment; if so, we collected all encounters during the full 2-year lookback period. However, if a client's first healthcare or jail encounter was, for example, only 6 months prior to their ABQSC enrollment, then we assumed that was their first opportunity to use either jail or healthcare services—e.g. that the client had just moved into the Albuquerque area. This assumption provides a more conservative estimate of the utilization of services prior to ABQSC enrollment (because rather than assuming zero use of healthcare or jail services prior to a client's earliest encounter, the client is excluded from the analysis until their earliest encounter).

The inclusion criteria for each of the three analyses were that the client existed in the data system, had at least one encounter during the analysis timeframe, had both lookback pre-enrollment and look-forward post-enrollment periods of at least 3 months. Table 14 provides descriptive information for each of the three utilization analyses. Additionally, Tables 15 and 16 breakdown the healthcare encounters by visit type and by healthcare facility owner.

Main Pre/Post Outcome Measure: For each type of encounter, the average number of encounters per year per client was calculated for both the pre- and post-enrollment periods to assess the size and the direction of changes in service utilization associated with ABQSC.

The pre-enrollment outcome measure is calculated as

$$\frac{\text{(\# of encounters during the pre-enrollment period)}}{\text{(\# of clients) * (average pre-enrollment period in years).}}$$

Similarly, the post-enrollment outcome measure is

$$\frac{\text{(\# of encounters during the post-enrollment period)}}{\text{(\# of clients) * (average post-enrollment period in years).}}$$

Limitations of the Utilization Analyses

These analyses have several limitations. The most significant limitation is likely that HIE does not include all healthcare encounters in NM, providing only a limited picture of clients' healthcare utilization. This likely does not impact the inpatient or ED results substantially because UNMH, Presbyterian, and Lovelace participate in HIE. However, the (non-ED) outpatient results may be skewed because key players, such as the local federally qualified health centers, are not included.

The AFR EMS data had notable limitations: First, we did not have access to any data prior to July 1, 2017; second, AFR is not able to collect contact information for each EMS contact—e.g. when they are not able to locate the individual or AFR's involvement is canceled due to Albuquerque Ambulance Service's involvement.

Finally, long-term, these analyses could be improved—and stronger conclusions could be drawn—using more sophisticated (experimental or quasi-experimental) approaches applied to longer-term trends from a larger number of clients.

Table 14: Summary Information for the Three Utilization Analyses

Type of Service	Start of Data Availability	End of Data Collection	# of Clients (n=58) Included in Analysis	Number and Reasons for Excluding Clients	Average pre/post enrollment period among clients (years)		Total # of Encounters
					Pre	Post	
Healthcare	N/A	5/31/2020	53	2 clients: not found in HIE 2 clients: pre-enrollment period < 3 months 1 client: post-enrollment period < 3 months	1.8	1.1	2,825
EMS	7/1/2017	6/30/2020	40	15 clients: not found in AFR's system 2 clients: pre-enrollment period < 3 months 1 client: post-enrollment period < 3 months	1.4	1.2	582
Jail (MDC)	N/A	6/30/2020	41	9 clients: not found in MDC system 7 clients: no encounters pre- or post-ABQSC 1 client: post-enrollment period < 3 months	1.8	1.2	215

Table 15: Number of Visits Used in the HIE Analysis, by Visit Type

Type of Visit		# of Visits	% of Visits
Emergency	Behavioral Health	868	31%
	Medical	1,019	36%
Outpatient	Behavioral Health	436	15%
	Medical	320	11%
Inpatient	Behavioral Health	124	4%
	Medical	58	2%
Totals		**2,825**	**100%**

Table 16: Number of Visits Used in the HIE Analysis, by Facility Owner

Facility Owner	# of Visits	% of Visits
Lovelace	471	17%
Presbyterian	1,043	37%
UNMH	1,280	45%
Other	31	1%
Totals	**2,825**	**100%**