



Closed-Loop Referral System

Progress & Insights

Toni Grinstead, MPA

Community Health CLRS Program Lead

Presented to NMSDOH-C

12/09/2025

PRESBYTERIAN COMMUNITY HEALTH

How Presbyterian Uses Our CLRS

Three defined uses:

- Automatic lists of recommended resources are created for patients who disclose needs during clinical visit (appx. 500K annually).
- Community Health Worker refer patients for Housing, Food, Transportation, Utilities and Violence & Abuse services.
- Peer Support Specialist refer patients for Substance Use Disorder & Harm Reduction services.

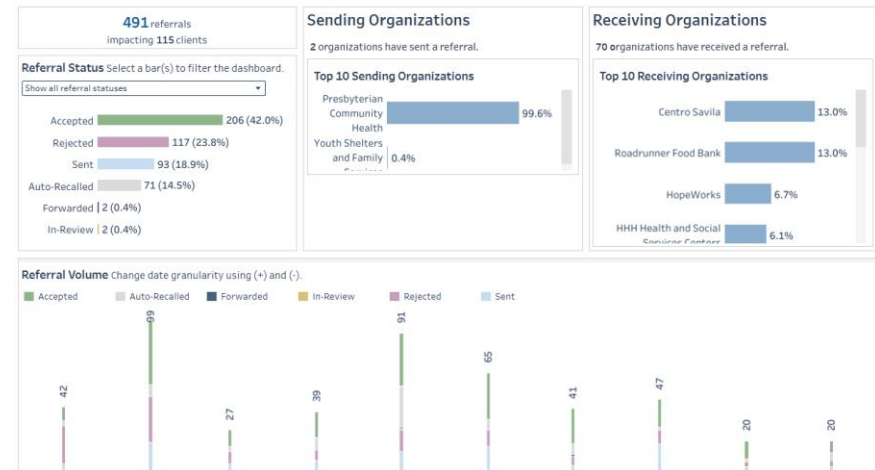
What's Going Well in 2025

Actionable Baseline Data

- **Handoff success** (referral acceptance vs rejection): Are patients connected with organizations?
- **Baseline infrastructure:** Which community orgs are we most commonly referring patients to?
- **Monthly referral volume trends:** Is the CLRS being used consistently w/in Presbyterian? When and why does referral activity change?

Referrals

Learn more about the referral activities between network organizations.



Looking Ahead

Opportunities to use our CLRS data to:

- Monitor CLRS process health
- Spot when referral workflows drop off or spike unexpectedly
- Goal refresh and support where use declines
- Improve match quality
- Use acceptance/rejection patterns to refine where we send referrals
- Focus on appropriate referrals that partners can realistically accept
- Strengthen partnerships and advocacy
- Identify high-volume community partners and engage them intentionally
- Use patterns in rejection and gaps to inform regional + statewide planning

How NMSDOH-C Can Support the Work in 2026

Convene Referral Network Participants to Review Data Across All Platforms

- Bring together users of Unite Us, FindHelp, and other CLRS platforms
- Regularly review referral outcomes, successful handoffs, dropped handoffs across systems
- Create shared interpretation: what is this data telling us about the ecosystem?

Lead Process & Quality Improvement Across Networks

- Shift the statewide focus from volume to process reliability
- Use data to identify where referral pathways are breaking down
- Facilitate structured QI problem-solving (A3, SIPOC, fishbone, whatever format resonates)
- Document shared wins and replicable practices

Identify and Escalate System-Level Breakdowns

- Metrics to review at the coalition level:
 - Successful vs. unsuccessful handoffs
 - Time to referral acceptance
 - Capacity constraints / saturation
 - Needs with no receiving partners
 - Referral pathways that fail no matter the platform

Questions

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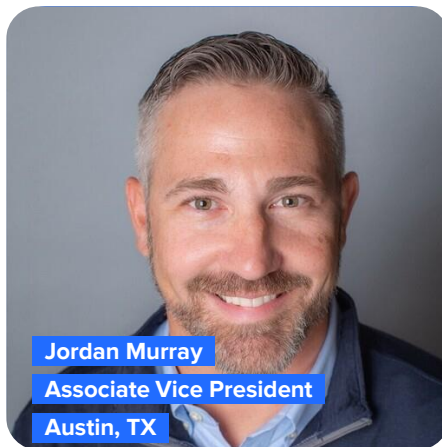
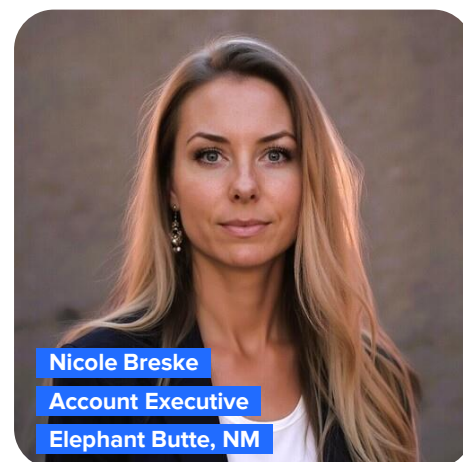
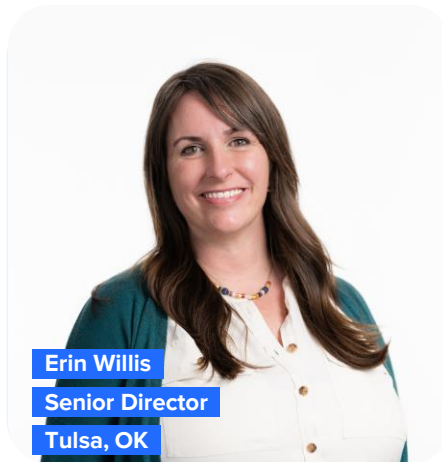
Closed-Loop Referral System New Mexico

Nicole Breske, Account Executive, Unite Us
Erin Willis, Senior Director, Unite Us

Our Team

A diverse team that brings:

- Backgrounds in Public Health, Non-Profit Leadership, System Design, & Customer Success
- Local presence, leadership, and cultural competency
- Stable presence with combined over 15 years serving and supporting New Mexico partnerships and communities





Network Strategies that Scale



Anchor



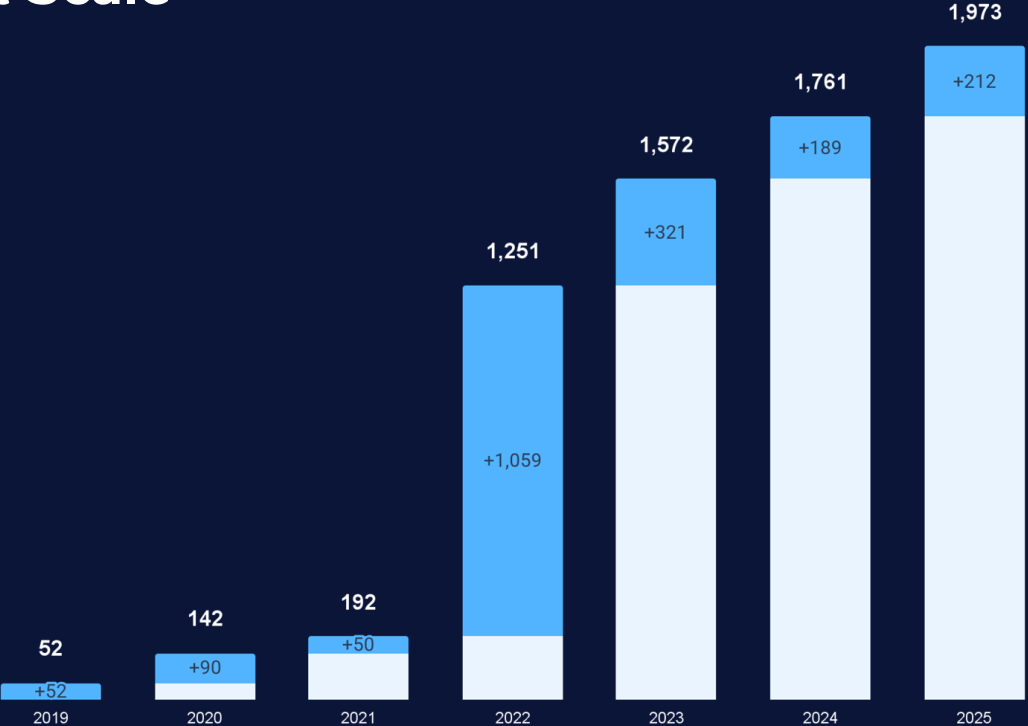
Opportunity



Community



Optionality



Anchor

Santa Fe County
+ City of Santa
Fe

Presbyterian
Healthcare
Services

NCNMEDD

CABQ +
BernCo

Los
Alamos
County

Rio
Arriba
County

Opportunity

AHC Grants

CA?RES Act &
ARPA Funds

Community

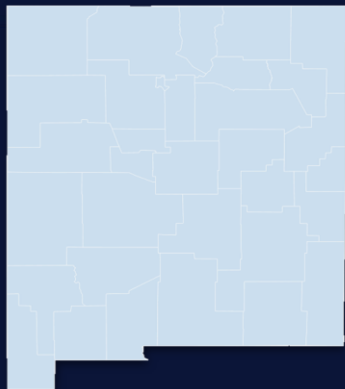
Time-limited
incentives

Build, Ramp, Strengthen

Optionality

Diverse workflow options for the spectrum of interventions and efficiencies

New Mexico Closed-Loop Referrals



17,038 Clients Served by Network Partners

52,884 Cases Created to Provide Services

1,845

Participating
Programs

83%

Case Resolution
Rate

1.0

Median days to
case acceptance

Top Service Types Requested



Income
Support



Housing &
Shelter



Benefits
Navigation



Individual &
Family Support



Food
Assistance

Top Outcomes

Received Emergency/One-time Financial Assist..	7,132
Receiving Social Services Case Management Se..	3,624
Obtained Emergency Housing	949
Received Assistance Paying for Rent	808
Received Housing Case Management Services	601
Received Gift Cards/Financial Assistance to Pu..	471
Received Supplemental Food from Food Pantry..	414
Receiving Social Services Case Management	387
Received Pregnancy/Birthing/Postpartum Sup..	360
Received ID/Documentation Assistance	247
Received Prepared Meal(s)	183
Received Peer Support Services	173
CARES Act - UTILITIES - Funding provided for G..	127
Received Hotel Voucher	126
Signed Up to Receive Food Pantry Distribution	123

What's Next

Looking Ahead to 2026

- Expanding opportunities to support rural communities
- Developing & strengthening tribal partnerships
- Interoperability for a cohesive statewide network
- Elevate efficiencies and capacity gains

Supporting CLRS Efforts

- Shout your impact data, demand impact data
- Share feedback in abundance
- Measure expectations
- Embrace change management



Get in touch

Nicole Breske

Account Executive

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[Meet with me here!](#)

Follow us





COMMUNITY
is our Greatest Resource

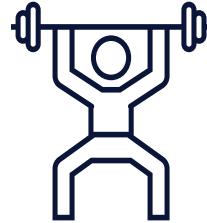
CONNECT

A SANTA FE COUNTY + CITY OF SANTA FE COMMUNITY PARTNERSHIP

Successes and Support



Training



Growing &
Strengthening
the Network



Join us!

Navigators & CONNECT Network Growth

78

New Navigators

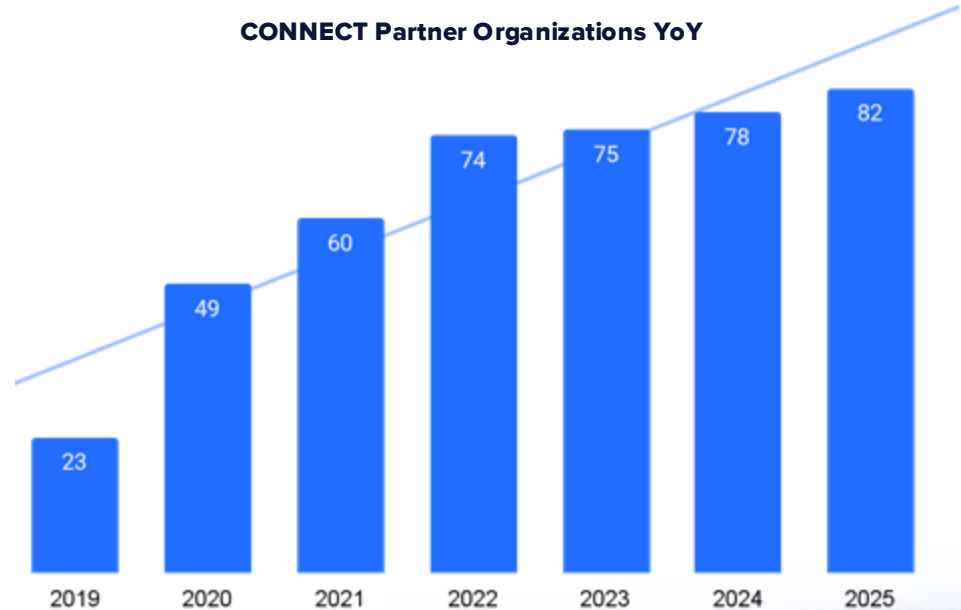
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Trained Navigators

4

New CONNECT Partners

CONNECT Partner Organizations YoY



Source : Unite Us Platform Data 1/1/2025-12/1/25

Proprietary and Confidential

Measurable Impact

Top Requested Services Types & Resolution Rates*

1

Income Support

Top sub-service type: Emergency/
One-Time Financial Assistance

92%

Top Outcome:

- ✓ Received Emergency One-Time Financial Assistance

2

Housing & Shelter

Top sub-service type: Emergency
Housing

75%

Top Outcomes:

- ✓ Received Emergency Housing
- ✓ Received Housing Case Mgmt
- ✓ Received Rent Payment Assistance

3

Individual & Family Support

Top sub-service type: Social Service
Case Management

91%

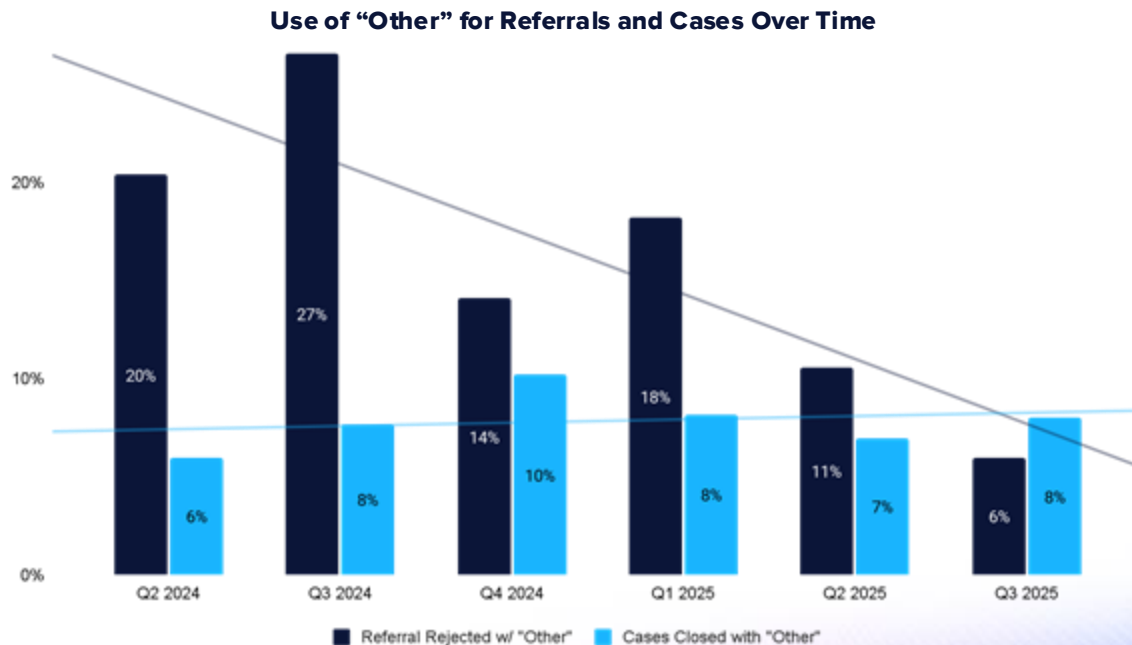
Top Outcomes:

- ✓ Receiving Social Service Case Management
- ✓ Received Pregnancy/Birthing/Postpartum Support

Optimizing Workflows for Precise Outcomes

Through focused support efforts, the CONNECT Network has [significantly reduced the use of “Other” for both referrals and case closures](#). Over the past year, our team has partnered closely with network providers to ensure users understand and select the most accurate outcome pathways.

By **socializing best practices with navigators**, refining workflows, and conducting **targeted outreach to high-volume organizations**, we’ve strengthened consistency across the statewide network. This has resulted in clearer visibility into true outcomes and increased efficiency for frontline staff.



Contact Us or Make a Referral

Christa Hernandez

chernandez@santafenm.gov

City of Santa Fe

Youth & Family Services Program
Manager

Coy Maienza

cmaienza@santafecountynm.gov

Santa Fe County

Health Services Division Manager

City of Santa Fe Self-Referral Portal: <https://www.santafenm.gov/connect>

Santa Fe County Self-Referral Portal:

https://www.santafecountynm.gov/community_services/hhsd/ahc

Dial 211 and enter a Santa Fe zip code or call 505-245-1735



HEALTH CARE
AUTHORITY



Closed Loop Referral System

ROBERTO MARTINEZ || PROGRAM MANAGER

INVESTING FOR TOMORROW, DELIVERING TODAY.

MISSION

We ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.



VISION

Every New Mexican has access to affordable health care coverage through a coordinated and seamless health care system.

GOALS



LEVERAGE purchasing power and partnerships to create innovative policies and models of comprehensive health care coverage that improve the health and well-being of New Mexicans and the workforce.



BUILD the best team in state government by supporting employees' continuous growth and wellness.



ACHIEVE health equity by addressing poverty, discrimination, and lack of resources, building a New Mexico where everyone thrives.



IMPLEMENT innovative technology and data-driven decision-making to provide unparalleled, convenient access to services and information.

“Go to the people. Live with them. Learn from them. Love them. Start with what they know. Build with what they have. But with the best leaders, when the work is done, the task accomplished, the people will say 'We have done this ourselves.'”

Lao Tzu



The Challenge

Finding social and health resources and services in New Mexico can be frustrating and time-consuming, leading to unmet social needs and poor health outcomes.



The Solution

A CLRS is an **ecosystem** of multidisciplinary network partners that use a shared language, resource database, and integrated technology platforms to deliver health related social services. This ecosystem is poised to receive and accountably deliver diversified funding.



Vision & Mission

Vision || All people in New Mexico live in communities with equitable access to the conditions they need to thrive

Mission || Strengthen the coordination of care and inform solutions for resource gaps for those in need by connecting people, service organizations, and community partners more quickly and more effectively – resulting in a healthier, more equitable community for all.



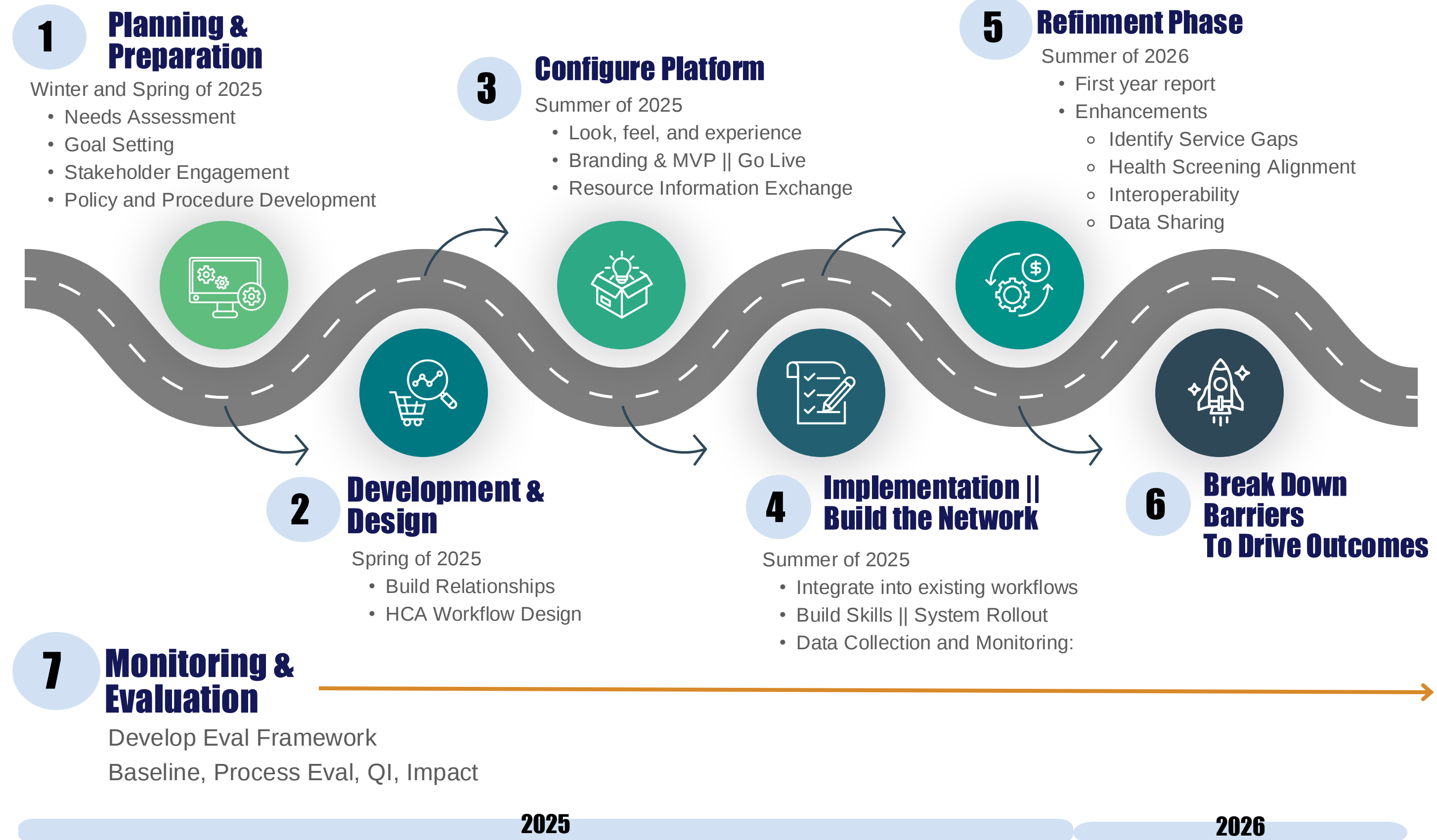
Goal & Key Strategies

Overall Goal: Design and Implement a robust CLRS to strengthen the coordination of care and inform solutions for resource gaps for those in need by connecting people, service organizations, and community partners more quickly and more effectively – resulting in a healthier, more equitable community for all.

- Strategy 1 || Configure, deploy and promote adoption of the CLRS.
- Strategy 2 || Integrated CLRS in the Healthcare System
- Strategy 3 || Foster policy and financial alignment to increase capacity in the Human Service sector



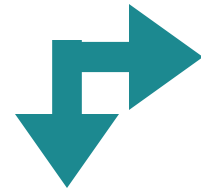
IMPLEMENTATION ROADMAP



Lessons Learned

- **Closed Loop Referral System work is based on relationship building. Engaged Champions and Organizational Buy-in:** Success hinges on securing buy-in at all organizational levels and empowering trusted "champions" within each department to drive the process.
- **Embedding the "Why":** Clearly and consistently articulating the rationale and benefits of the new system to the workforce helps ensure staff understand the purpose beyond just a new process, fostering commitment.
- **Strong Cross-Sector Partnerships:** Formalized relationships (e.g., MOUs, contracts) between healthcare providers, Managed Care Plans (MCPs), and Community-Based Organizations (CBOs) are crucial. This ensures a robust continuum of care and shared understanding of roles and expectations. San Diego specifically saw project timelines shift to accommodate relationship development with new plan partners.
- **Network Accuracy & Adequacy:** Ensuring there are enough qualified partners engaged in the network is critical to meet the demand for services.
- **Plug & Play Approach.** Organizations must have the ability to participate based on readiness.
- **Develop a Logic Model for Success**





BUILD RELATIONSHIPS

Bring people together, exchange ideas, gather information, establish common ground, and identify shared values and interests.

Government Agencies

- HCA
- ECECD, DOH, CYFD, ALTSD
- DWS, Corrections, PED, HED, IAD

Trusted Statewide Networks

- Managed Care Organizations
- Large Healthcare Systems
- 211
- 988 Crisis Line
- Others
- Food Banks
- Housing
- Health
- Others

City, County & Tribal Governments

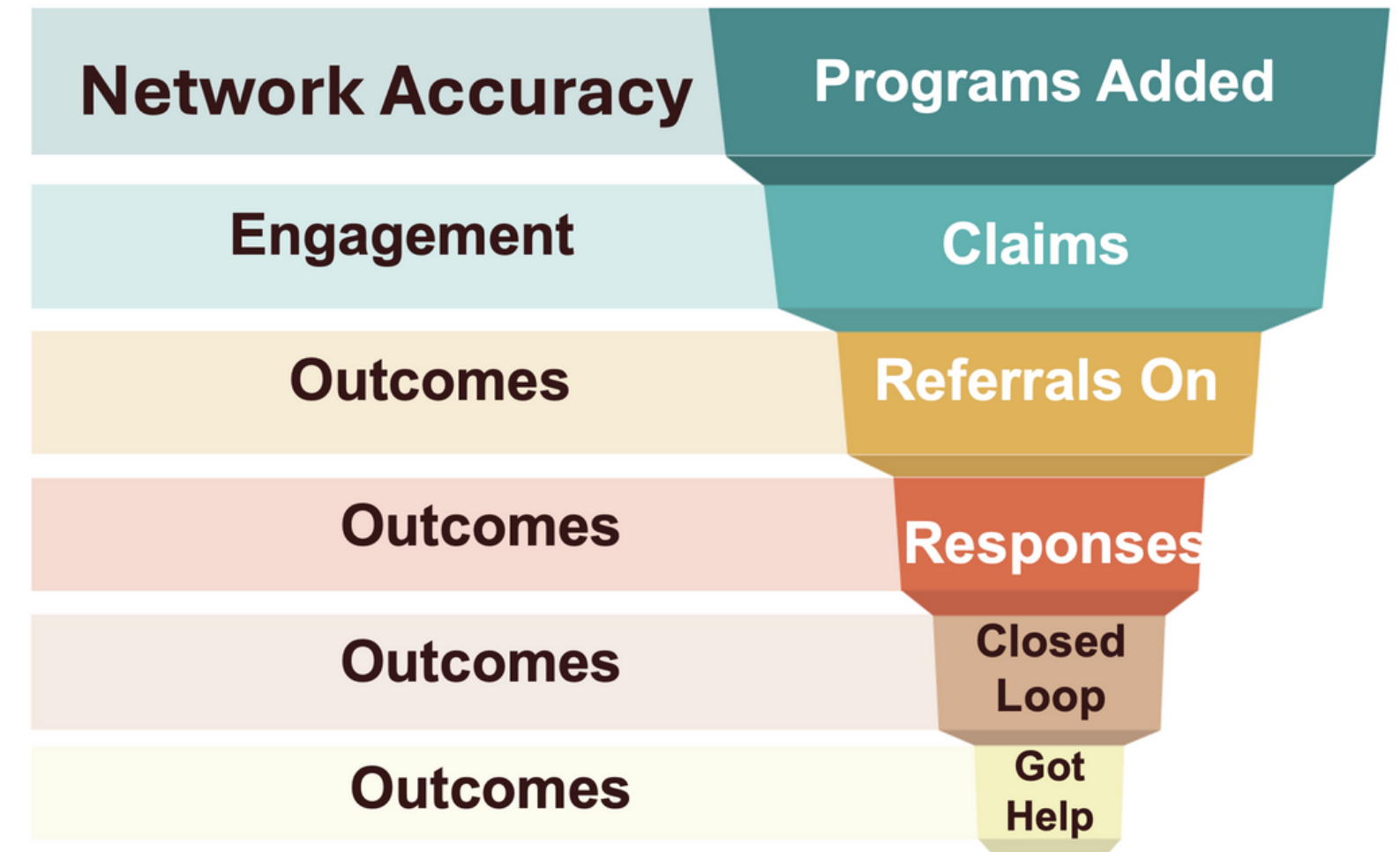
- 33 Counties and
- 24 Tribal Nations

1. Decision to Participate
2. Role Definition
3. User Scoping Sessions
4. Configure Platform
5. Integrate Platform into existing workflows
6. Streamline referral process
7. Data

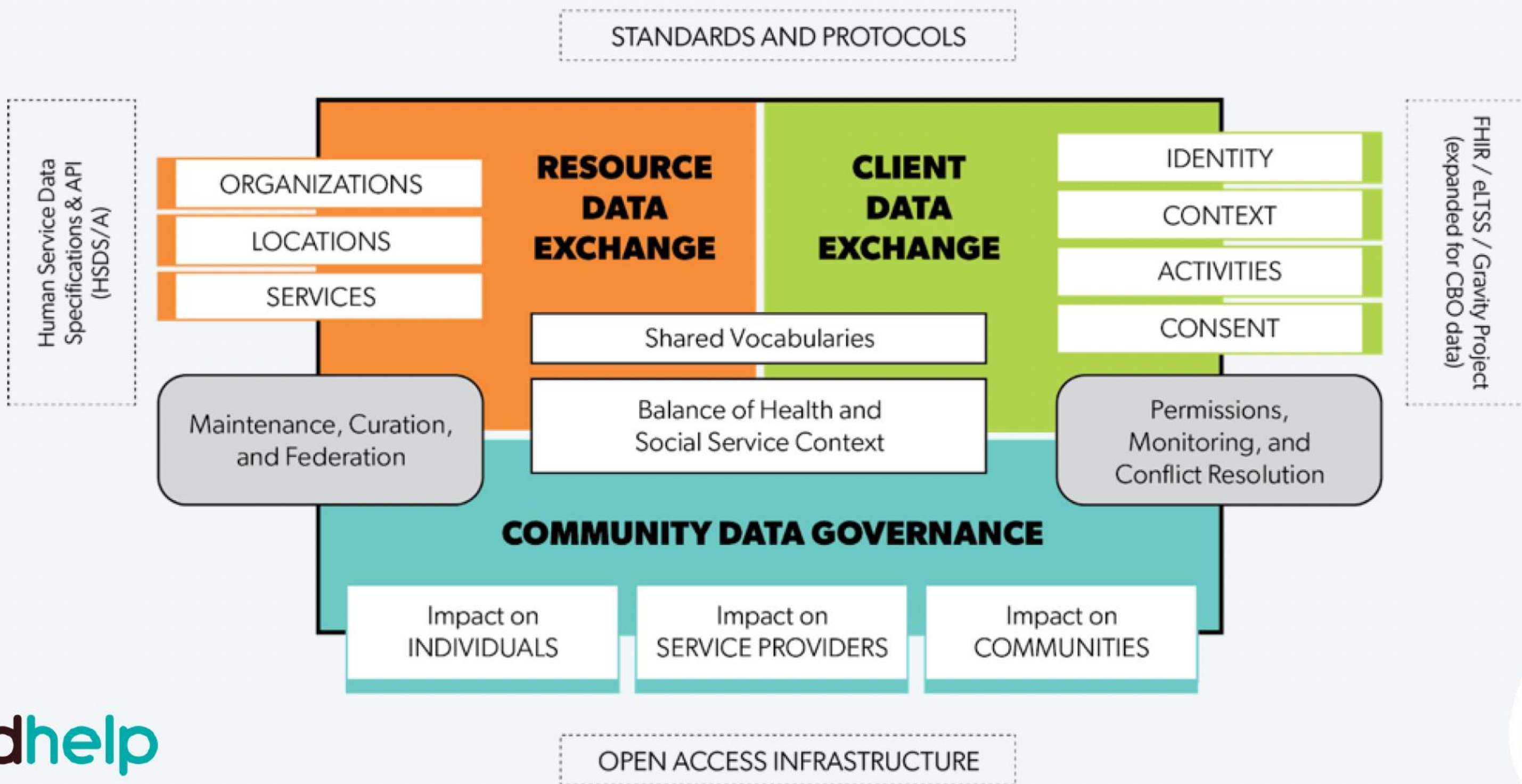
1. Decision to Participate
2. Configure Platform
3. Integrate Platform into existing workflows
4. Streamline referral process

BUILD SKILLS

Nurture ideas, learn the capabilities of others, explore their contributions, foster group decision making, and craft a plan.

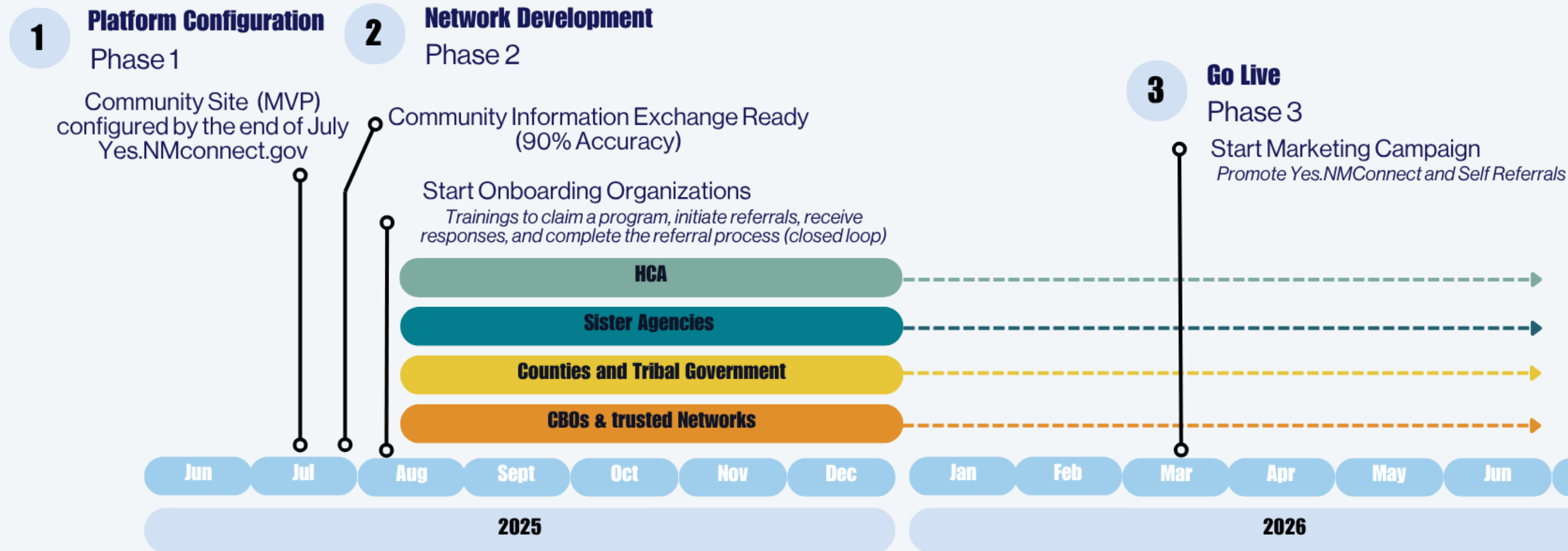


Elements of a CLRS



Partnerships

Strategy 1 Timeline || Configure, deploy and promote adoption of the CLRS



Partnerships

Strategy 2 Timeline || Integrated CLRS in the Healthcare System

Trainings, Technical Assistance and financial incentives for MCOs, fee for Service and waiver programs

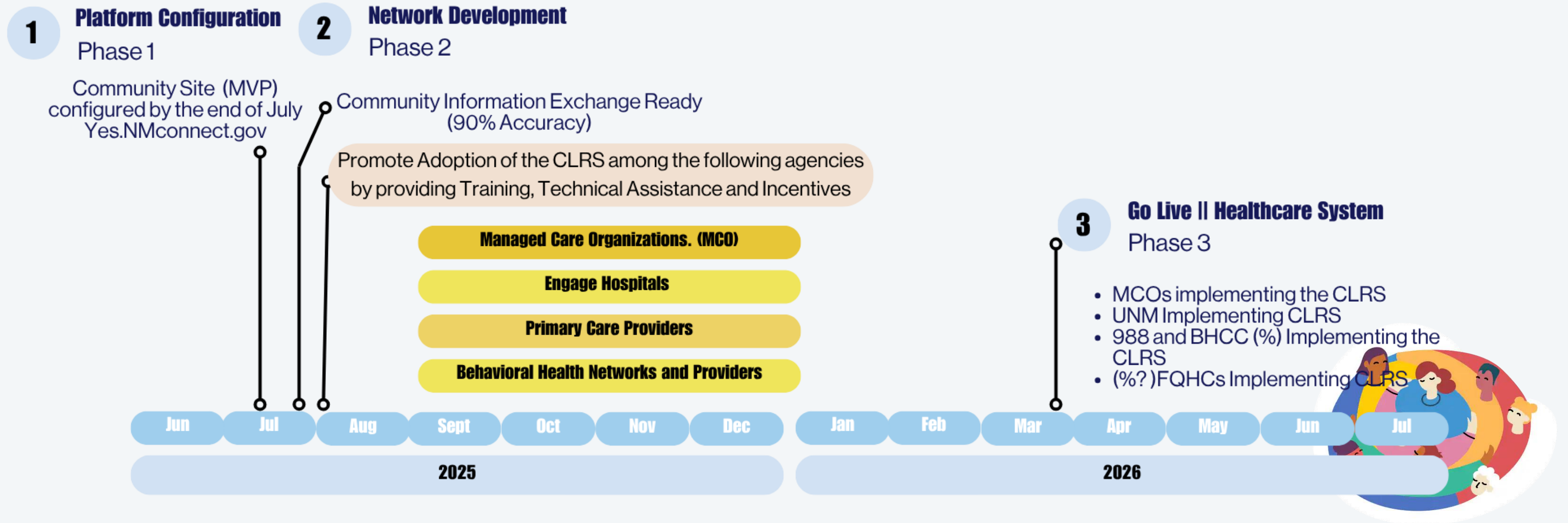
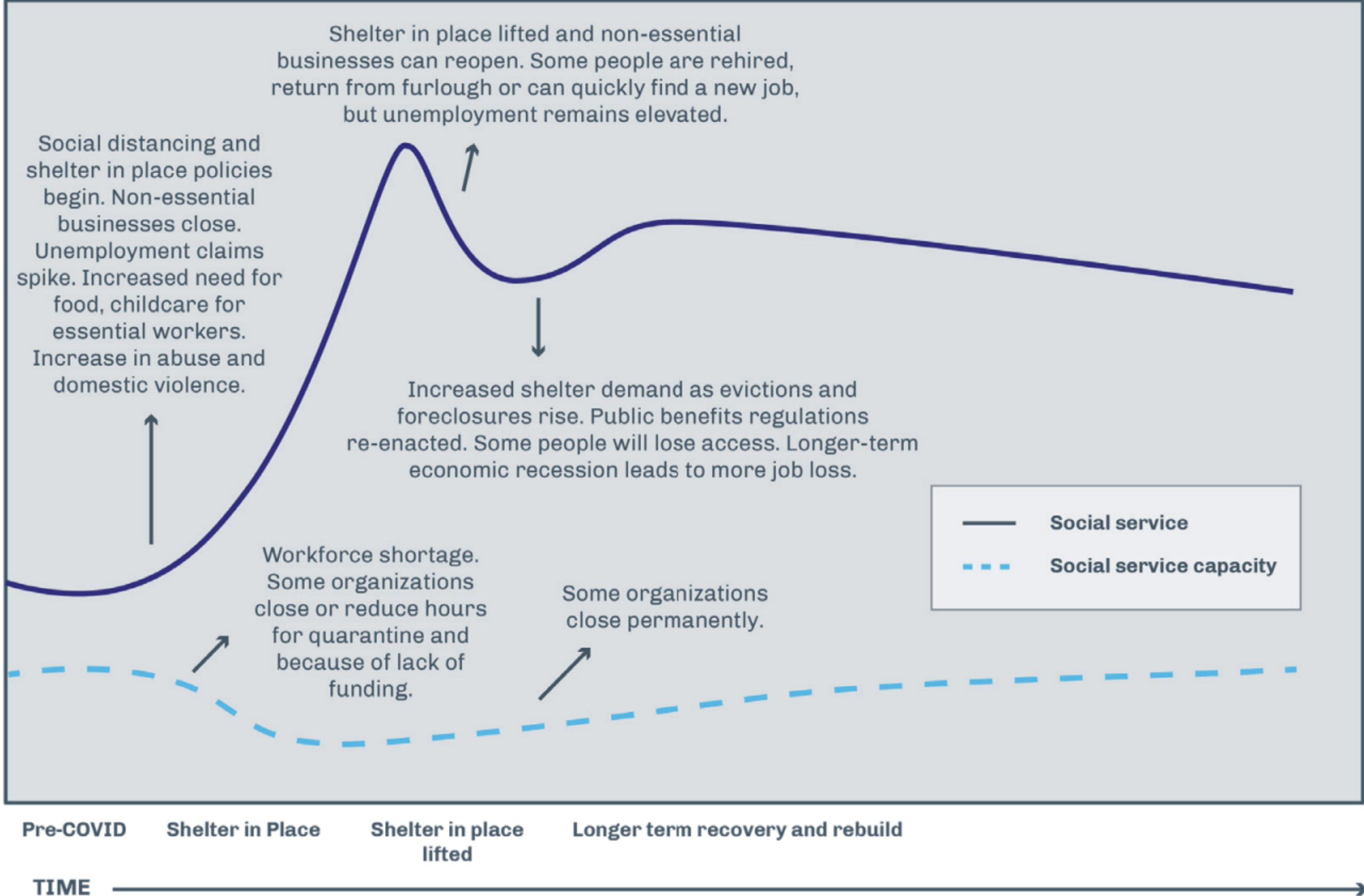


Illustration of total demand for social services as compared to social service capacity over time through the COVID-19 crisis





Training Hub

<https://go.findhelp.com/nm-ce-self-service-hub>

Welcome to Your YesNMConnect Hub!

YesNMConnect (powered by Findhelp) aims to connect people in need and the programs that serve them - with dignity and ease.

This free technology helps New Mexicans find and connect to community resources, and supports local programs' abilities to keep their services up-to-date. Join the movement!



Powered by **Findhelp**



“Go to the people. Live with them. Learn from them. Love them. Start with what they know. Build with what they have. But with the best leaders, when the work is done, the task accomplished, the people will say 'We have done this ourselves.'”
Lao Tzu



Thank you!



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