PRESBYTERIAN HEALTHCARE SERVICES COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP)

Plains Regional Medical Center | 2023 – 2025

PRESBYTERIAN

phs.org

Overview

Presbyterian Healthcare Services (Presbyterian) exists to improve the health of the patients, members, and communities we serve. Aligned with our purpose and in compliance with Internal Revenue Services (IRS) regulations, Presbyterian Plains Regional Medical Center completes a Community Health Assessment (CHA) and a Community Health Implementation Plan (CHIP) every three years. The CHA describes 1) the community served: Curry County, 2) the process for conducting the assessment, and 3) a description of assets and resources that already exist in the community. Many of these assets include programs, services, and physical assets that will aid Presbyterian and partners in addressing the identified community health priorities. Plains Regional Medical Center partnered with Presbyterian Community Health to complete a community health assessment and identify significant community health needs.

Through this comprehensive community health assessment process, and in partnership with our community, community-based organizations, and stakeholders, we have identified the following areas as our priorities for 2023-2025:

Behavioral Health

Social Health

Physical Health

These three priority areas are examined and will be implemented using the following lenses: **Access and Equity**.

The full Community Health Assessment can be found on www.phs.org.

This community health implementation plan describes goals and strategies that Presbyterian developed with community partners to impact all of the needs prioritized by the community in the Community Health Assessment. Presbyterian combined all of the significant health priorities into three categories, and each is addressed by goals and strategies within the plan. The goals and strategies detailed in this plan are bold and comprehensive. Through yearly action planning with partners and stakeholders, yearly monitoring of progress, strategic investment, leveraging resources, capacity building, strong partnerships, and quality improvement efforts, Presbyterian Community Health will assist each hospital, community health council, other partners, and our healthcare system to implement and evaluate these strategies.

About Plains Regional Medical Center

Plains Regional Medical Center is committed to the health and well-being of the people and communities of eastern New Mexico and west Texas. In addition to offering comprehensive medical care for every stage of life, Plains Regional Medical Center works for the growth and development of each member of our community. Join us in our commitment to the community.

The people of Plains Regional Medical Center – physicians, nurses, clinicians, support staff, board members, chaplains, and auxiliaries – take great pride in a long tradition of delivering patient care, a wide range of general acute care, and specialty services to residents and visitors.

Plains Regional Medical Center's quality and values are made possible through a partnership between the County of Curry, a local Board of Trustees, and Presbyterian Healthcare Services, which has owned and managed hospital operations since 1975.

Implementation Plan Development

Health Equity Framework

According to the Robert Wood Johnson Foundation, health equity means that "everyone has a fair and just opportunity to be as healthy as possible." This means removing obstacles that contribute to health inequity, such as poverty and discrimination, as well as their consequences including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health equity is essential to Presbyterian's purpose to improve the health of the patients, members, and communities we serve and serves as the foundation for all Community Health strategies outlined in the implementation plan.

In 2019, Presbyterian embarked on a formalized journey to address health equity in our communities and for our patients and members. We adopted a framework developed by the Institute for Healthcare Improvement for health care organizations to achieve health equity, which identifies five practices:

1. Make health equity a strategic priority.
2. Develop structure and processes to support health equity work.
3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact.
4. Eliminate racism and other forms of oppression.
5. Develop partnerships with community organizations.

To achieve health equity, we seek to understand how our patients experience health inequities due to structural and social determinants of health (SDOH). We strive to remove barriers for individuals as we simultaneously seek big-picture, systemic change. This work is carried out across the system and through interdisciplinary, enterprise-wide committees, including the Health Equity, LGBTQ+, and Perinatal Health Equity Committees.

Health Equity Committee Vision: Increase health equity in our healthcare system through: 1) Increased access to high quality health and wellness services; 2) Leadership commitment and accountability to improve health equity; 3) Build a culture of justice, diversity, inclusion, and belonging that addresses structural and institutional racism and oppression; 4) Utilize actionable health equity data to drive and measure change through policies and programs; 5) Increase access to culturally and linguistically appropriate services; and 6) Address the social drivers of health.

LGBTQ+ Committee Vision: Presbyterian is the provider of choice for the Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning, Plus (LGBTQ+) community of New Mexico because of our high-quality compassionate care and through eliminating discrimination and inequities in health care by identifying and advancing opportunities and priorities.

Perinatal Health Equity Committee Vision: Achieve higher levels of health equity for our patients, members, and community through the implementation of a strategy and organizational framework to positively impact perinatal outcomes.

To view our Health Equity report, click here.

The Socio-Ecological Model

Community Health uses the Socio-Ecological Model of Health as a framework to identify and select implementation strategies included in this implementation plan. The success of public health programs requires a broad approach to achieving health improvement, targeting the health behavior itself in the context of the environment in which it occurs. This framework acknowledges there are multiple, complex factors that influence health and are affected by the interaction between the individual, the community and the physical, social and political environments (CDC). Strategies were considered and selected using each level of influence to maximize resources and impact, while acknowledging Presbyterian's sphere of influence, role as an anchor institution in the community, and collaboration with local, state, and federal partners.

Stakeholder Engagement and Alignment: Who was Involved

The 2023-2025 CHA/CHIP cycle engaged in deeper community and stakeholder engagement in order to develop implementation plans that maximize alignment and coordinate assets with Community Health, the healthcare system, and community partners.

Community Stakeholder Engagement

Community Health solicited community feedback on the proposed community health approach, priority areas, and strategies throughout the assessment and planning process. A detailed description of the community engagement approach and methods are detailed in the Community Health Assessment. The Community Health Assessment and Implementation Plan are available on the Presbyterian website and social media as well as disseminated to health council and community partners. Feedback and input are encouraged at any time.

Stakeholder	Method

Community Input Forums (n=39)	2 virtual community forums per county
Community Survey (n=211 responses)	Random Online Surveying
Focus Groups and Key Informant Interviews	Maternal and Child Health Patient Focus Group, COVID-19/Flu Vaccine Equity Focus Group, and local youth
Community Partner Input on Implementation Strategies	Meeting presentations with feedback, email requests for feedback. Forums include individuals from local government, health council, and schools; county commission and county clerk offices, and local nonprofits.

Community Stakeholder Feedback and Input Table 1

Community Stakeholder Alignment

In the development of the Implementation Plan, Community Health reviewed local and state assessments and strategic plans to increase alignment, reduce duplication, and identify new or existing partnerships. In Curry County, this includes: the Curry County health council. Statewide, this includes: the New Mexico Department of Health, the New Mexico Alliance of Health Councils, and tribal and county health councils.

Presbyterian Stakeholder Engagement

Community Health worked closely with Presbyterian stakeholders to seek input on key elements to successful implementation of community health strategies, which includes: existing and planned collaborations, commitments to leveraging assets, alignment with existing systemwide strategic plans, and anticipated impact and evaluation.

Stakeholder	Method
Community Health Department Subject Matter Experts	Management retreat, email request for feedback, team meetings
Presbyterian Leadership Feedback Sessions	3 virtual feedback sessions were held (n= 22)
Community Health Advisory Committee	Virtual meeting. Includes public health, healthcare, and business leaders that represent communities statewide.
Community Health Steering Committee	Virtual meeting. Includes Presbyterian Hospital and System leadership
Hospital Leadership and Clinic Teams	One-on-one meetings, email request for feedback

Table 2 – Presbyterian Stakeholder Feedback and Input

Presbyterian System Alignment

Presbyterian Healthcare Services, the largest, integrated healthcare system in New Mexico, is committed to resources and relationships that address community health needs more broadly in addition to this Community Health Implementation Plan. Community Health will continue to align, support and coordinate with systemwide strategies to maximize impact. The following section includes but is not limited to key system work that addresses some of the health needs prioritized in the community assessment process.

a. **Sustainability**: In 2020, an employee-led Environmental Stewardship Committee (ESC) was established to ensure a safe and environmentally responsible workplace while advancing healthcare without harm to its community. In 2022, Presbyterian hired a Director of Sustainability to launch a Green Health Initiative to develop and implement sustainable business practices to achieve carbon neutrality by 2030 and carbon negativity through a reduction in carbon emission and supplementation through offsets. This will be achieved through implementation of sustainable business practices within purchasing, operations, waste management, community health investments, and facilities design.

b. **Diversity and Inclusion:** In mid-2020, Presbyterian hired its first Chief Inclusion and Diversity Officer. The vision for our Inclusion and Diversity work is to intentionally commit our organization to an inclusive and equitable environment where everyone is valued and empowered to thrive. Our environment reflects the diversity of the community, learns from all perspectives, provides affordable, accessible and culturally appropriate health care and champions health equity for our New Mexico communities. The over-arching strategy is to integrate core inclusive principles that make equity, belonging and connectedness a standard, intentional practice within our culture. Championed by a cross-functional leadership council focused on Inclusion, Diversity, Equity, Accessibility and Social Responsibility (IDEAS), the function drives, influences and supports organization-wide initiatives that increase retention, attract top talent, grow extraordinary leaders and inspire a best place to work where everyone belongs, and everyone thrives.

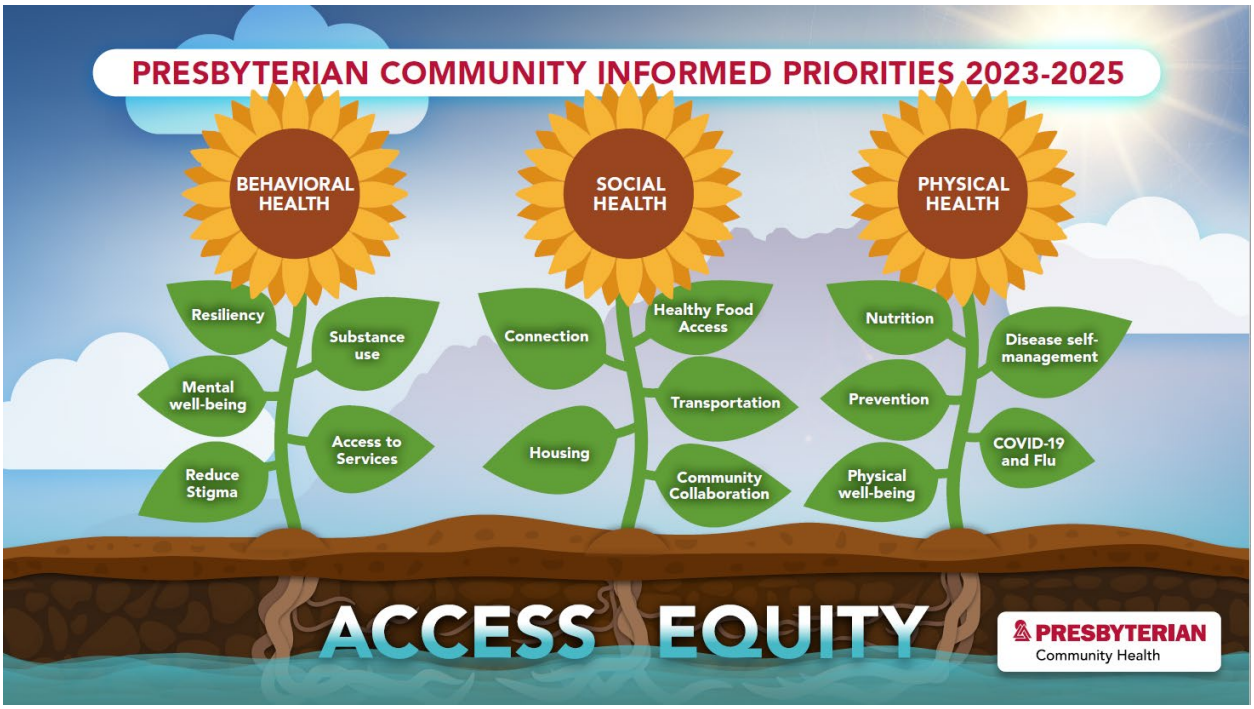
c. **Telehealth**: Presbyterian is making significant investment in telehealth and digital partners to improve access to health care for New Mexicans. Telehealth initiatives include, but are not limited to, implementing an innovative virtual primary care model to provide primary and chronic disease care management, virtual urgent care, and virtual behavioral health for adults and teens; championing to expand broadband infrastructure in rural areas; and an innovative partnership with the Presbyterian Health Plan to provide comprehensive virtual care to older adults.

Community Health is adopting Presbyterian's Elevate A3 strategic planning process and tools in the 2023-2025 CHA/CHIP process which: 1) allows groups of people to actively collaborate on the purpose, goals, and strategy, and 2) serves as a communication tool that aligns the frontline workforce to specific strategic initiatives.

Implementation Strategy to Address Community Health Needs

I. Health Needs Addressed

Presbyterian Plains Regional Medical Center will be implementing activities specific to Curry County and related to the identified health needs of **Behavioral Health**, **Social Health,** and **Physical Health** over the three-year time period of calendar year 2023 through calendar year 2025. These three priority areas are examined and will be implemented using the following lenses: **Access and Equity**. Access refers to access to health care and community-based resources. Health Equity refers to removing obstacles that contribute to health inequity such as poverty and discrimination and their consequences, including powerlessness, and a lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.



II. Implementation Strategy

Presbyterian and community partners will continue to use a Collective Impact and Asset-Based approach for community health improvement planning and implementation. This approach focuses on capacity building and partnership with local health infrastructure to leverage resources and implement broad evidence- and practice–based community health activities to address significant health needs in the county. The follow principles were used to guide the identification and development of implementation strategies:

- Data will be used to drive identification of interventions
- Interventions will be practical, realistic, cost effective, and sustainable
- Resources are available or attainable to address the health need
- Interventions will be based on professional theories and will be consistent with professional and/or best-known evidence or practices
- Interventions will promote equity and will not reinforce inequities in health outcomes
- The plan will be integrated with existing hospital and Presbyterian plans and will leverage health system assets
- Presbyterian will collaborate with existing agencies to strengthen adopted strategies

- Interventions will be evaluated, monitored, and reported

Priority Area: Behavioral Health. The Behavioral Health priority area includes mental and psychological health care, mental wellbeing, and substance use. This distinction allows us to address the complex and multi-faceted topics within this area including stigma, overdose, substance use, access to treatment, social supports, and mental health inequities.

Priority Area: Behavioral Health	
Long Term Goal	All New Mexicans have access to behavioral health services to improve overall well-being
Strategic Goal 1	Improve prevention and treatment of unhealthy substance use including tobacco, alcohol, and illicit drugs for youth and adults.
Strategic Goal 2	Increase access to behavioral health services and reduce stigma associated with accessing those services for youth and adults.
Population Level Outcome Measures	• Prevalence of Adult Frequent mental distress • Deaths of Despair • Youth Sadness and Hopelessness
Community Health Strategies, Activities and Interventions	**(S1)** Support the delivery of Behavioral Health services by expanding the **paraprofessional workforce** (e.g. Peer Support) specializing in substance use and mental health • Expand and sustain Peer Support Worker model in hospitals and clinics to identify substance use and mental health disorders and navigate individuals to harm reduction and treatment support services. • Expand Peer Support Model to different settings, including emergency departments, neonatal intensive care unit, inpatient care, Presbyterian Medical Group, PRESNow, first responders, and partnering healthcare entities across the state. • Develop and expand the Virtual Peer Model to deliver peer support services to regional hospitals and settings using technology. • Collaborate with the Presbyterian Behavioral Health Department and care teams to support individuals with comprehensive, wrap-around services, including collaboration with Community Health Workers to support health-related social needs. • Continue to build, elevate, and strengthen the Peer Support workforce through recruitment, training, retention, and staff wellness, as well as providing technical assistance and best practices to entities implementing Peer Support programs. **(S2)** Increase access to and awareness of available behavioral health services and resources through **referrals, education, and anti-stigma messaging campaigns** • Increase connections to and partnerships with community behavioral health service providers through patient and member referrals • Support coordinated strategies to inform communities about available community and healthcare resources for prevention programming, substance use treatment, and mental and emotional health resources, including state and federal initiatives like the 988 crisis lifeline.

	• Identify and address barriers to accessing behavioral health services through anti-stigma campaigns that educate and address negative attitudes and beliefs around mental health and substance use. • Participate in community events to provide education and increase awareness of available behavioral health resources **(S3)** Support and collaborate with care teams implementing **evidence-based interventions** that identify, treat, and manage patients with substance use disorder (SUD) or behavioral health conditions • Partner across the system to support and pilot evidence-based interventions, including the Primary Care Collaborative Care Model and Screening, Brief Intervention, and Referral to Treatment (SBIRT) • Implement Emergency Department Buprenorphine distribution and education • Increase harm reduction efforts, including naloxone distribution and education • Implement and deploy Opioid Stewardship across the Presbyterian enterprise to ensure appropriate utilization of opiates across the Presbyterian continuum. **(S4)** Provide workforce and community **training, presentations, and educational opportunities** to build skills in culturally responsive and inclusive support of individuals' mental health or substance use disorder • Increase the number of people in New Mexico trained in Mental Health First Aid and Youth Mental Health First Aid • Implement training curriculum that includes trauma-informed care, social and emotional wellness, addressing stigma, cultural humility, adverse childhood experiences (ACEs), implicit bias, and safety. • Provide role specific training, including implementing a Pilot Echo geared towards Community Health Workers, Peer Support Specialists, and Substance Use Prevention Specialists. **(S5)** Support **positive youth development** to build increased resiliency and reduce toxic stress • Provide mentorship opportunities for youth • Invest in youth-oriented community-based programming • Support the implementation of the Perinatal Health Equity Plan, with a focus on increasing access to perinatal and early childhood supports. **(Cross Cutting) Policy Change** – support policies that remove barriers and increase access to services that support behavioral health. **(Cross Cutting) Partnerships, Investment, and Capacity Building** – serve on boards and coalitions, identify strategic community investments, and partner with organizations and health councils working to improve behavioral health.
Curry Specific Strategies	• Implement Regional Community Health model in Southeast New Mexico to assist patients, members, and the community in access to health care services including behavioral health services and overall well-being.
Key Performance Measures	# of patients engaged by Peer Support Program % of people participating in Peer Support Services

	# of referrals to community providers and organizations that support behavioral and social health # of people trained Mental Health First aid and other BH related trainings # of community-based agencies trained on use of naloxone Increased initiation and engagement of Treatment for Alcohol and Other Drug Dependence for patients and members

Priority Area: Social Health. The Social Health priority area is aligned with the Healthy People 2030 definition of social determinants of health, which is defined as: the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality of life outcomes and risks. This priority area comprises health-related determinants including economic stability, housing, food access, transportation, safety/interpersonal violence, and environmental health.

Priority Area: Social Health	
Long Term Goal	All New Mexicans live in social conditions that promote attaining the full potential of health and well-being
Strategic Goal 1	Increase patient and member connections to PHS, community, and government resources and services that address health-related social needs.
Strategic Goal 2	Increase access to affordable, healthy food for households experiencing highest rates of food insecurity
Population Level Outcome Measures	• Severe Housing Cost Burden • Food Environment Index • Transportation
Community Health Strategies, Activities and Interventions	**(S1)** Increase **screening and referrals** to services and interventions that address **health-related social needs** • Implement Universal Social Determinants of Health Screening and Referral across PHS system, which includes screening for Food Insecurity, Housing Instability, Transportation, Financial Instability, Personal Safety, Substance Use, Alcohol Use, and Mental Health • Strengthen connections to health-related social need resources, services, and programs through a robust statewide resource directory, closed loop referral relationships with community-based organizations (CBOs) and identifying and developing interventions for individuals who experience health inequities • Collect and analyze data to understand where health inequities exist and to improve access to and delivery of care, including accurate collection of race, ethnicity, and language (REAL) and sexual orientation and gender identity (SOGI) data **(S2)** Expand and sustain **paraprofessional workforce** (e.g. Community Health Workers) to address social barriers to care

	• Increase number of Community Health Workers who support individuals with health-related social needs through tailored, culturally appropriate navigation. • Expand use of patient flexible funding as an immediate way to respond to a crisis that impacts housing, utilities, access to food, and safety. • Strengthen the Community Health Worker workforce through offering CHW certification and specialty track training opportunities (i.e. chronic disease, vaccine education). • Collaborate with and integrate Community Health Workers in care teams across the healthcare system in different settings (e.g. emergency department, primary care), and with other paraprofessional roles (i.e. Peer Support Specialists, Presbyterian Health Plan CHW teams) **(S3)** Build cross-sector, **coordinated statewide partnerships** that connect individuals to health-related social need resources through closed loop referrals, community capacity building, and investment • Participate in statewide and local SDOH coalitions that strengthen collaboration and build alignment of a statewide strategy to address structural and social determinants, including screening for social needs, referrals to resources, building community capacity and measuring impact • Coordinated investment in local community-based organizations that strengthen systems and resources to address social health. **(S4)** Increase **access to healthy, affordable food** in low food access communities • Implement produce prescription programs that connect individuals experiencing food insecurity with healthy, affordable food, nutrition education, and community food resources. • Connect and enroll individuals in food benefit programs that build food security (e.g. WIC, child nutrition programs, family tax credits, Double Up Food Bucks) • Continue to invest in the local food system to promote economic development and increase access to healthy food in low food access communities. • Partner on statewide and local initiatives to address food insecurity **(S5)** Support **anchor institution strategies** to improve health, social conditions, and economic opportunity inside and outside of Presbyterian facilities. • Partner with high schools, vocational schools, community colleges, and community workforce development programs to support workforce pipeline programs for students interested in healthcare careers with a focus on underrepresented communities • Partner across system to provide opportunities for clinical students to participate in community health projects and training • Leverage spending power to source local and sustainable goods and services • Reduce negative impacts on the environment through supporting system sustainability initiatives • Collaborate with community partners including multi-sector coalitions and local government to support economic development initiatives

	(Cross Cutting) Policy Change - support policies that remove barriers and increase access to services that support social health, including affordable housing, broadband access and local, state and federal benefit programs. **(Cross Cutting) Partnerships, Investment and Capacity Building** - serve on boards and coalitions, identify strategic community investments, and partner with organizations and health councils working to improve social health.
Curry Specific Strategies	• Implement Regional Community Health model in Southeast New Mexico to assist patients, members, and the community in access to health care services including social needs resources
Key Performance Measures	# of patients screened for health-related social needs Increase statewide closed-loop referral partnerships for each social need domain # of patients referred to resources by Community Health Worker # of patients participating in food access programs (i.e. Northern Roots) Decrease in reported food insecurity Increase in access to care measures (i.e. well-child visits, preventative screenings) as a result of participation in produce prescription programs.

Priority Area: Physical Health.

The Physical Health priority area includes chronic conditions and factors that contribute to the development of chronic conditions in addition to other factors that influence our physical health. Some key examples of this priority area include diabetes, hypertension, vaccination for flu, COVID, and pneumonia, healthy eating, and active living.

Priority Area: Physical Health	
Long Term Goal	All New Mexicans have access to health care and healthy environments that promote improved phsyical health
Strategic Goal 1	Improve prevention and self-management of chronic disease
Strategic Goal 2	Improve COVID-19 and Flu vaccination status among high-priority populations
Population Level Outcome Measures	• Diabetes Diagnosis • Heart Disease Mortality • % eligible vaccinated flu/COVID-19
Community Health Strategies, Activities and Interventions	**(S1)** Increase equitable access to **healthy lifestyle** opportunities that support the prevention and management of chronic disease • Offer evidence-based chronic disease self-management programs, including Diabetes ReCHARGE (Diabetes Self-Management Education and Support), Diabetes Self-Management Program, and Blood Pressure Self-Monitoring Program • Collaborate across system to support alignment and integration of chronic disease programs and resources • Offer no-cost, in-person and virtual community healthy lifestyle group classes, including nutrition, cooking, and active living classes taught by experts, including Registered Dietitians • Refer to and partner with community organizations offering evidence-based healthy lifestyle education serving priority populations and/or taught by educators who represent the community served

	• Support and expand Community Health Worker (CHW) workforce specializing in health education, including chronic disease prevention & management • Expand educational opportunities to specific populations, including maternal and child health and people experiencing substance use disorders • Increase access to healthy, safe environments for walking, biking, and hiking **(S2)** Implement **food as medicine interventions** that support chronic disease, pregnancy, early childhood, and older adults • Implement produce prescription programs to increase access to local, affordable food for priority populations • Provide culturally appropriate food skill building and cooking classes tailored for priority populations • Partner with local food and retail organizations that provide fresh, affordable produce, including community gardens, farmers' markets and Community Supported Agriculture (CSA). **(S3)** Increase **equitable access to COVID and Flu vaccines** among high-priority populations • Facilitate and support community-based vaccine clinics in partnership with community-based organizations reaching priority populations • Support and expand Community Health Worker (CHW) workforce specializing in vaccine outreach and education • Create and disseminate culturally and linguistically-appropriate communications to dispel vaccination misinformation and disinformation about viruses and vaccines among priority populations. **(S4)** Implement **enterprise-wide Health Equity strategies** that address access to care barriers among populations that experience health disparities, including perinatal and LGBTQ+ populations • Facilitate, convene, and support enterprise wide Health Equity, Perinatal Health Equity and LGBTQ+ Committees • Help lead and support Presbyterian to become a provider of choice for Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, and Asexual (LGBTQ+) New Mexicans • Support the implementation of a multi-year Perinatal Health Equity Plan • Implement Health Equity curriculum to workforce **(S5)** Improve ability for individuals to access care to manage their health and **navigate healthcare systems**. • Connect and provide patients Presbyterian financial assistance and emergency flex funds to support their access to medical care and services • Collaborate with PHS care teams to increase patient education and access to care support (e.g. Case Management, Pharmacy Clinicians, Clinical Nutrition, Vaccinations) • Support systemwide and local efforts to address access to care barriers, including technology support and literacy, transportation and language access

	(Cross Cutting) Policy Change - support policies that remove barriers to health care and improve the delivery of services **(Cross Cutting) Partnerships, Investment and Capacity Building** - serve on boards and coalitions, identify strategic community investments, and partner with organizations and health councils working to improve phsyical health.
Curry Specific Strategies	• Implement Regional Community Health model in Southeast New Mexico to assist patients, members, and the community in access to health care services including access to physical activity, nutrition, chronic disease self-management, and vaccinations.
Key Performance Measures	Patients referred and program completion, by priority population Health goals met and wellbeing improvement (self-reported) Blood sugar control and incremental improvement in A1C

III. Health Needs Not Addressed

Presbyterian intends to address all of the significant health needs identified in our Community Health Needs Assessment. Presbyterian Community Health understands the issues identified are extensive and complex and take a long-term, comprehensive, multi-sector collaborative approach to address the many aspects of Behavioral, Social, and Physical health needs in each county, including factors that contribute to gun violence, community-wide safety, improving the natural environment, and availability of clothing stores. In areas Presbyterian has less direct influence, we will apply the socio-ecological framework to identify opportunities that impact change through policy, partnerships, and community investment.