Priority Area 2: **SOCIAL HEALTH**

"Our vision is that all New Mexicans live in social conditions that promote attaining the full potential of health and well-being" – *Presbyterian Community Health*

Long-Term Goal	Medium-Term Goals	Short-Term Goals	Level of Influence	Strategy	Programs and Tactics	Key Objective	Key Performance Measures
Decrease physical and behavioral health outcome inequities for people with health-related social needs. Population level signals: • Percentage of households with a vehicle • Severe housing cost burden • Food Environment Index (% of Households with limited access to healthy foods AND % of households experiencing food insecurity)	CMS regulatory requirements and TJC accreditation standards are met, measured, and exceeded	All patients are screened	Individual	Increase screening and referrals to services and interventions that address health-related social needs (S1)	Health Related Social Needs Screening	Implement Universal Social Determinants of Health Screening and Referral across PHS delivery system, which includes screening for food insecurity, housing stability, transportation needs, financial resource strain, violence and abuse, substance use, alcohol use, tobacco use, and possible depression	% Screened for HRSN Screen positive rate # of patients linked to services or resources by CHW Volume of patient connection, by community-based organization
						Optimize screening workflows	
	PHS leads in healthcare as a strong intermediary, enabling and increasing access to social services and protective supports	Create infrastructure within the health system to address HRSN	Organizational			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	
		Support community infrastructure to adequately address HRSN for patients and members	Community	Build cross-sector, coordinated statewide partnerships that connect individuals to health-related social need resources through closed loop referrals, community capacity building, and investment (S3)	Community Partnerships	Coordinated investment in local community-based organizations that strengthen systems and resources to address social health	Total funding provided, # of hubs or community networks; # of community partners
			Policy		NM SDOH Collaborative	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	
	Reduce compounding financial barriers to access quality healthcare and increase quality of life	Resolve urgent and unmet social needs to stabilize individuals and families	Individual/Family	Expand and sustain community health workers to address social barriers to care (S2)	CHWs	Expand use of patient flexible funding as an immediate way to respond to a crisis that impacts housing, utilities, access to food, and safety	$ given from flex fund, by category of need ; # of patients receiving flex funds, by category of need; # of individuals in household positively impacted
	Increase trust & satisfaction with healthcare experience	Increase health workforce capacity	Organizational			Increase the number of CHWs available to assist patients on care teams across the healthcare system in primary, specialty, and perinatal care	# of net new CHW positions
			Community			Strengthen the Community Health Worker workforce through offering CHW certification and specialty track training opportunities (i.e. chronic disease, vaccine education)	# of CHWs certified
	Reduce patient and member food insecurity	Increase consumption of nutritious food	Individual/Family	Increase access to healthy, affordable food in low food access communities (S4)	Food is Medicine Produce prescription & subsidy programs: Food Farmacy Northern Roots FreshRx	Increase patients and members who receive immediate food assistance through Food Is Medicine Programs	# of participants # referring providers and practices Lbs. of food distributed
						Increase consumption of fruits and vegetables	Self-reported behavior changes
						Increase patient, member, and family connections to food assistance programs like SNAP and WIC	# of patients linked to services or resources by CHW % PHP membership
		Use spending power to bolster local food economy	Organizational	Support anchor institution strategies to improve health, social conditions, and economic opportunity inside and outside of Presbyterian facilities. (S5)		Increase the proportion of locally sourced food purchased at PHS	% of food budget used for local food procurement
			Cross-cutting	Policy Change	Advocacy	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.	