Priority Area 1: Connections to Care

Determined to provide safe, compassionate, and equitable care.

State & Federal Population Level Goals	PHS Goals	Community Health Strategy	Community Health Programs & Tactics	Level of Influence	Key Objective	Key Performance Measures
All New Mexicans can access healthcare and services they need, when they need it- including behavioral health and social services - to improve overall well-being and quality of life How we measure progress: Drug overdose mortality rate % of Adults reporting 14 or more poor mental health days Food Insecurity Rate Severe Housing Problems	Increase access to behavioral health services and reduce stigma associated with accessing those services. How we measure progress: Drug Overdose ED Visits Would recommend provider/ practice Hospital Experience	Paraprofessional workforce integration and sustainability	Peer Support Services Community Health Worker Services	Institutional	Increase the capacity for paraprofessionals to thrive and provide care for more patients.	# of Peer Support Specialists employed # patients who encountered peer prior to discharge
		Support and collaborate with care teams implementing evidence-based interventions for SUD and BH conditions	Screening Brief Intervention and Referral to Treatment (SBIRT)	Individual	Connect patients experiencing drug use to recovery resources, addiction medicine services, and medication assisted treatment.	SBIRT Completion Rate # patients who accepted/declined follow-up services # & type of linkages to care services
			Substance Use Prevention & Harm Reduction including training, clinical support tools, stigma reduction, and naloxone access	Institutional	Work with specific care teams to integrate harm reduction practices into routine care and emphasize skills to overcome barriers to treatment.	# Patients who received harm reduction educational materials/naloxone kit # of people attending harm reduction trainings
		Enhance safety of babies born with substance-exposure	Connect to behavioral health care, substance use disorder treatment, home visiting, WIC, and more	Individual Family	Peer Support, Community Health Workers, Care Coordinators, and Care teams work as one, coordinated clinical team to plan for infant safety after discharge while providing non-stigmatizing support to infants and families.	# of safety care plans in place
		Provide workforce and community training, presentations, and educational opportunities	Health Equity Training Series	Institutional Community	Increase provider and community knowledge and confidence to deliver equitable, patient-centered, and compassionate care. Reduce stigma, shame, and fear, and increase trust in providers, services, and brand.	# of participants # of tailored trainings

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All New Mexicans can access healthcare and services they need, when they need it- including behavioral health and social services - to improve overall well-being and quality of life How we measure progress: Drug overdose mortality rate % of Adults reporting 14 or more poor mental health days Food Insecurity Rate Severe Housing Problems	Identify and close unfair and avoidable differences in health care access, quality and outcomes for New Mexicans at highest risk in line with standards and requirements set forth by Joint Commission, CMS, and the NM Health Care Authority. How we measure progress: Maternal death or serious injury in low risk pregnancy Death or serious injury of neonate	Support patients to address health related social needs	Connect Individuals to community resources	Institutional Individual	Sustain and improve the data-driven system for identifying, addressing, and tracking health-related social needs across the Presbyterian Healthcare Delivery System.	HRSN Screening Completion Rate HRSN Screening to Encounters Ratio HRSN needs identified through screening Resource Connections
		Standardizing social care in clinical settings	Increase the workforce that can help address social barriers (CHWs, doulas, etc.)	Institutional	Expand access to trusted, relationship-based CHW services that address social drivers of health, strengthen care coordination, and support patients in navigating complex systems.	# Referrals from providers to CHWs % of patients with HRSNs referred to CHWs CHW Case Outcome Success Rate
			Closed Loop Referral Technology and Networks	Community	Adopt and use of an EMR/ integrated closed-loop referral platform (Unite Us). Participate in regional and statewide referral network collaboratives. Use data to inform strategic investments in social care infrastructure.	Unite Us Referral Workflow Process
		Increase access to healthy affordable food where food access is low	Food Is Medicine	Individual Family	Increase the number of patients and members who have qualifying chronic conditions and screen as food insecure who receive immediate nutrition assistance via Presbyterian or other community programs	Improved food security # unique participants # of referrals and referring providers to FIM programs
		Use data to understand how patient needs and outcomes differ based on demographic and other factors	Culturally and linguistically appropriate initiatives for priority populations	Institutional	Interdisciplinary work across departments within Presbyterian to, improve existing, and create new services to better serve people and groups with whom healthcare institutions have broken trust or fallen short.	PHP Postpartum Visit PMG Post Partum depression screening CDS # Individual patients & members supported Workforce resource requests/completed # Consultative Projects Land Acknowledgement Indigenous Healing Policy HEI Survey Score
		Focus action planning on three specific priority populations	Health Equity Quality Improvement Consultation			

Priority Area 2: Healthy Lifestyle Determined to connect individuals and families to tools, skills, and confidence they need to live a healthy lifestyle.

Federal & State Population Level Goals	PHS Goals	Level of Influence	Community Health Strategy	Community Health Programs & Tactics	Key Objective	Key Performance Measures
Improve quality of life for people living with or at risk for chronic disease How we measure progress: Mortality – diabetes and heart disease	Improve prevention and self-management of chronic disease How we measure progress: Diabetes Bundle Preventive Care – Annual Wellness Visits, Well Child Visits	Individual/ Family	Healthy lifestyle opportunities that support the prevention and management of chronic disease	Diabetes Prevention & Self-Management Education and Support	Increase individual knowledge, skills and self-efficacy related to cooking skills, healthy nutrition practices and chronic disease self-management	Pre & post enrollment A1c Pre & post enrollment BP # of Medicare/Medicaid members enrolled and completed # of billable visits # of program participants; demographics
				Diabetes Prevention & Self-Management Education and Support		
				Family Healthy Weight Program		
				Healthy Eating and Active Living Classes	Increase individual knowledge, skills, access, and self-efficacy related to ways to be physically active and manage stress	# of participants in classes, demographics # of HEAL classes, type # of Referrals/ Enrollments
				Wellness Connection Center		
				CHW Model of Care: Health Education	Increase individual access to evidence-based programs and preventative care through resource and care navigation, barrier resolution and education.	# enrolled into evidence-based interventions # of barriers to care resolved # of preventative screening/appointments (e.g. well-child)
		Individual Organizational	Food Is Medicine	Produce Prescriptions Nutrition Education & Counseling	Increase fresh fruit and vegetable consumption. Increase access and use of varied, local produce.	Participation, demographics Improved A1c, BP Self-reported health behaviors Improved food security # of referrals and referring providers to FIM programs
	Prevent communicable disease	Individual	Promote Vaccination	Community Vaccination Clinics	Provide free and accessible vaccination opportunities	# vaccinations administered
		Organizational		Workforce Immunization		# workforce vaccinated

Priority Area 3: Healthy Communities

Determined to do our part to keep our patients and members healthy across New Mexico.

State & Federal Population Level Goals	PHS Goals	PHS Strategy	PHS Programs & Tactics	Level of Influence	Key Objective	Key Performance Measures
Identify meaningful ways healthcare institutions can positively impact the conditions in which people live, work, or play in order to improve their long-term health How we measure progress: Unemployment Rate Poverty Rate Severe Housing Cost Burden Adverse Weather Events Drinking Water Violations	Increase economic opportunities, investments, meaningful engagements, and explore opportunities to impact in the communities we serve How we measure progress: Nursing Time To Fill (Avg. Days) Brand Preference	Proactive Financial Assistance Practices & Policies	Financial Assistance Program: Incl. sliding scale fees, payment plans, & debt relief programs.	Institutional Individual Family	Offer transparent, user-friendly, patient-centered and accessible financial assistance by better utilizing technology and presumptive eligibility, proactive communication, and no-wrong door approaches, and through community partnerships, ensure patients can afford the care they need without sacrificing other basic needs.	Financial Assistance Community Benefit Ratios
		Workforce Development	Internships, Scholarships, etc. for youth	Individual Institutional Community	Increase incentives and opportunities to give youth interest and opportunities to pursue careers in healthcare.	# and types of opportunities by hospital, region
			Nursing Career Pathways		Support current employees with tuition assistance, onsite experience, and job placement to earn a BSN or LPN online.	# of program graduates
			Healthcare Advanced Learning Lab		Provide an innovative, supportive, learning environment where healthcare professionals and students receive hands-on, simulation education and training using advanced technology. Enhance current skills and teach new ones to improve quality of care, experiences and outcomes for the communities we serve.	# and types of requests for use
		Health System Anchor Institution Strategy for Community Wealth Building	Healthy Neighborhoods ABQ Rural Anchor Initiatives	Institutional Community	Increase local purchasing, spending, and procurement. Uplift community conditions through partnerships, and economic investments, including creation of workforce training and living-wage jobs, creating and improving affordable housing, increasing local safety and access to parks, and local spending.	% of food budget used for local food procurement Rank largest employers in Communities # of Employees
Identify meaningful ways healthcare institutions can	Investigate the connection between	Community Engagement & Support	Community Investments & Benefit	Community	Award one-time sponsorships and community grants with priority for community organizations whose missions relate directly to	Dollars Invested by Priority Area; Geography

State & Federal Population Level Goals	PHS Goals	PHS Strategy	PHS Programs & Tactics	Level of Influence	Key Objective	Key Performance Measures
positively impact the conditions in which people live, work, or play in order to improve their long-term health How we measure progress: Unemployment Rate Poverty Rate Severe Housing Cost Burden Adverse Weather Events Drinking Water Violations	organizational opportunities and community-based health improvement efforts: Exploratory and learning measures: Heat/Cold related ED utilization Pediatric Asthma Screenings (PQIP)				improving the health status of individuals within underserved populations, advancing the health equity status of our communities, promoting healthy eating and active living, and enhancing a sense of cultural belonging within New Mexico.	
			Voices for Equity: Community Ambassador Program	Institutional	Deepen the complexity of engagement with the community including through outreach and information, community consultation, participatory involvement, collaboration especially on solving issues, and shared leadership.	# of engagements by county and region
			Community Partnership	Community	Partner extensively with Community Based organizations and coalitions as vendors, subcontractors, and to provide in-kind support for community and coalition based efforts.	# of class instructors # and types of organizations engaged
		Volunteerism & Community Service	Volunteer Program	Institutional	Increase opportunities for adults and youth to connect with others, find sense of purpose, increase wellbeing, utilize skills, explore healthcare careers, and give back to the community.	# of volunteers by hospital, region
		★ **This is a Learning Strategy**				
		Learning & Exploratory Assessment	Learning, planning & capacity building	Institutional	Identify: • 'No-Brainers' for actions healthcare systems can take to respond to adverse weather events/emergencies • Any complex opportunities or interventions within the sphere of influence of healthcare organizations • Potential funding/investment opportunities • Community partnership opportunities Build internal awareness and attention	Report outs