



# Presbyterian Healthcare Services Community Health Implementation Plan

**2026-2028**

**Presbyterian Central New Mexico**

Presbyterian Hospital

Presbyterian Kaseman Hospital

Presbyterian Rust Medical Center

 **PRESBYTERIAN**

[phs.org](https://phs.org)

## Overview

Presbyterian exists to ensure all of the patients, members and communities we serve can achieve their best health. Aligned with our purpose and in compliance with Internal Revenue Services (IRS) regulations, Presbyterian Hospital, Presbyterian Kaseman Hospital, and Presbyterian Rust Medical Center complete a Community Health Assessment (CHA) and a Community Health Implementation Plan (CHIP) every three years. The CHA describes 1) the community served: Bernalillo, Sandoval, Tarrant, and Valencia Counties. This region is also characterized by the following tribal communities: Cochiti Pueblo, To'Hajiilee, Santa Ana Pueblo, Kewa Pueblo, Sandia Pueblo, Isleta Pueblo, Jemez Pueblo, and San Felipe Pueblo. 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. These hospitals as well as the Department of Health and a widespread coalition of other community-based and healthcare organizations partnered with Presbyterian Community Health to complete a community health assessment and identify significant community health needs. Learn more about this partnership at [www.chipsandsalsanm.com](http://www.chipsandsalsanm.com).

Through this collaborative community health assessment process in partnership with our community, community-based organizations, and stakeholders, we have identified the following areas as our priorities for 2026-2028:

### **Connections to Care**

### **Healthy Lifestyle**

### **Healthy Communities**

The full Community Health Assessment can be found on [www.phs.org](http://www.phs.org).

This community health implementation plan describes goals and strategies that Presbyterian developed, informed by community partners to impact needs prioritized by the community in the Community Health Assessment. 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 partners, and our healthcare system to implement and evaluate these strategies.



**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
<p>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</p> <p>How we measure progress: Drug overdose mortality rate % of Adults reporting 14 or more poor mental health days Food Insecurity Rate Severe Housing Problems</p>	<p>Increase access to behavioral health services and reduce stigma associated with accessing those services.</p> <p>How we measure progress: Drug Overdose ED Visits Would recommend provider/ practice Hospital Experience</p>	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	<a href="#">Health Equity Training Series</a>	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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State & Federal Population Level Goals	PHS Goals	Community Health Strategy	Community Health Programs & Tactics	Level of Influence	Key Objective	Key Performance Measures
<p>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</p> <p>How we measure progress:            Drug overdose mortality rate            % of Adults reporting 14 or more poor mental health days            Food Insecurity Rate            Severe Housing Problems</p>	<p>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.</p>	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
	<p>How we measure progress:            Maternal death or serious injury in low risk pregnancy            Death or serious injury of neonate</p>	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	
<p>Improve quality of life for people living with or at risk for chronic disease</p> <p>How we measure progress: Mortality - diabetes and heart disease</p>	<p>Improve prevention and self-management of chronic disease</p> <p>How we measure progress: Diabetes Bundle Preventive Care - Annual Wellness Visits, Well Child Visits</p>	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	<p>Pre &amp; post enrollment A1c</p> <p>Pre &amp; post enrollment BP</p> <p># of Medicare/Medicaid members enrolled and completed</p> <p># of billable visits</p> <p># of program participants; demographics</p>	
				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
				Wellness Connection Center	# of HEAL classes, type		
	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.	# of Referrals/ Enrollments				
	Individual Organizational	Food Is Medicine	Produce Prescriptions	Increase fresh fruit and vegetable consumption. Increase access and use of varied, local produce.	Participation, demographics		
Prevent communicable disease	Individual	Organizational	Promote Vaccination	Community Vaccination Clinics	Provide free and accessible vaccination opportunities	# Improved A1c, BP	
				Workforce Immunization		# Self-reported health behaviors	
						# Improved food security	
						# of referrals and referring providers to FIM programs	
						# vaccinations administered	
						# 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	Increase economic opportunities, investments, meaningful engagements, and explore opportunities to impact in the communities we serve	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
How we measure progress:  Unemployment Rate Poverty Rate Severe Housing Cost Burden Adverse Weather Events Drinking Water Violations	How we measure progress:  Nursing Time To Fill (Avg. Days)  Brand Preference		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
		<a href="#">Health System Anchor Institution Strategy for Community Wealth Building</a>	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	<a href="#">Community Engagement &amp; Support</a>	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



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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				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
	Pediatric Asthma Screenings (PQIP)	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
		<b>★ This is a Learning Strategy</b>				
		Learning & Exploratory Assessment	Learning, planning & capacity building	Institutional	Identify: <ul style="list-style-type: none"> <li>'No-Brainers' for actions healthcare systems can take to respond to adverse weather events/emergencies</li> <li>Any complex opportunities or interventions within the sphere of influence of healthcare organizations</li> <li>Potential funding/investment opportunities</li> <li>Community partnership opportunities</li> </ul> Build internal awareness and attention	Report outs

## About Our Hospitals

The Presbyterian Central New Mexico delivery system includes the following hospitals: Presbyterian Hospital (Albuquerque, NM), Presbyterian Kaseman Hospital (Albuquerque, NM), and Rust Medical Center (Rio Rancho, NM). These three hospitals serve the Albuquerque Metro Area and surrounding communities.

### Presbyterian Hospital

As a not-for-profit health system, Presbyterian's purpose is to improve the health of the patients, members, and communities we serve. As the needs of our community continue to evolve, we've increased access to care with the opening of a new 11-story patient care tower. Once remodels to existing buildings are complete, Presbyterian Hospital will have a 600 private room capacity - the largest in New Mexico.



Presbyterian Hospital offers a wide range of specialized care, including heart health, women's health, children's health, and neuroscience care.

To learn more about Presbyterian Hospital, visit <https://www.phs.org/presbyterian-hospital/about>.



### Presbyterian Kaseman Hospital

Located in Albuquerque, Presbyterian Kaseman Hospital serves the greater Albuquerque area and the East Mountain communities.

Presbyterian Kaseman Hospital is a satellite medical campus providing a wide range of outpatient medical care. Our facility features:

- A multidisciplinary cancer program that includes gynecologic oncology, breast surgical oncology, radiation oncology, surgical oncology, and supportive care services.
- A physician office building offering a wide variety of outpatient services, including primary care, surgical care, endocrinology, pulmonology, rheumatology, pain and spine, and more.
- Sleep medicine services, including consultations and sleep studies, to accurately diagnose sleep problems.
- Inpatient hospice care, providing end-of-life physical, emotional, and spiritual support to patients and their families.
- Inpatient adult and child behavioral health services offering a team approach to care.
- An emergency department designed to decrease treatment time and triage patients to help them receive the most appropriate care.
- A variety of support services, including a sample pharmacy, nutrition counseling, and on-site lab and radiology services.

To learn more about Presbyterian Kaseman Hospital, visit <https://www.phs.org/kaseman-hospital/about>.

### **Presbyterian Rust Medical Center**

Presbyterian Rust Medical Center is in Rio Rancho in Sandoval County. Presbyterian Rust Medical Center is conveniently located for patients and members living on Albuquerque's west side, offering patient-centered, environmentally friendly, and technologically innovative care. Our facility features:



- A family birthing unit offering midwifery and obstetrics services, including triage for pregnant patients. Our private and spacious labor and delivery rooms each feature an infant warmer for delivery, tubs for water therapy, birthing balls, and necessary equipment, as well as a fold-out couch for overnight guests.
- The Ted and Margaret Jorgensen Cancer Center, part of a multidisciplinary cancer program that includes gynecologic oncology, breast surgical oncology, radiation oncology, surgical oncology, and supportive care services.
- Presbyterian Breast Care, for both malignant and benign breast disease, where patients with new cancer diagnoses can receive a same-day consultation with a breast radiologist, breast surgeon, medical oncologist, and radiation oncologist, depending on their clinical needs.
- A physician office building offering a wide variety of outpatient services, including cardiology, surgical care, orthopedics and podiatry, neurology, OB/GYN, bariatric and weight loss services, and more.
- An emergency department designed to decrease treatment time and triage patients to help them receive the most appropriate care.
- An intensive care unit (ICU) that combines the latest technology with skilled physicians and nurses who are both onsite and connected 24/7. Utilizing sophisticated, real-time video feeds and communication tools, our ICU offers an additional layer of care to critically ill patients.
- Patient rooms designed for any level of care, including in-room procedures.

To learn more about Presbyterian Rust Medical Center, visit <https://www.phs.org/rust-medical-center/about>.

## **Implementation Plan Development**

The Presbyterian Healthcare Services Community Health Implementation Plans are rooted in the needs identified in the Community Health Assessment process and the community-informed priority areas developed subsequently. This includes both epidemiological data collected and analyzed as part of the assessment and community input into the needs and priorities Presbyterian should adopt in the 2026-2028 CHA/CHIP cycle.

The Community Conversations conducted in May 2025 followed community-based participatory action frameworks and fundamentals, highlighting the community-informed root causes of health and inequities in each priority area. These sessions strategically and intentionally elicited input from the community on potential interventions/strategies they would like to see implemented in their community especially in conjunction with known assets and accounting for known barriers.

### **MAPP Process - adapted for New Mexico**

The New Mexico Community Health Improvement Plan and System Alignment for Sustainable Action (CHIPS & SALSA) created a collaborative to work on shared needs assessments and planning activities.

This collaborative has agreed to reference and loosely follow guidance from the National Association of County & City Health Officials or “NACCHO” and their published guide to assessment and planning called “Mobilizing Action through Planning and Partnership 2.0” or “MAPP 2.0”. This is a common framework used by public health entities, healthcare organizations, and community coalitions to conduct health assessment and planning in partnership with each other and the community. Our stakeholders have adapted the steps in the framework to meet our needs and also to incorporate our understanding of community participatory action approaches and activities.

## Results Based Accountability - Adapted

To help us frame our approach to community health improvement, we have adapted and adopted various aspects of Results Based Accountability (RBA). Of note, we conceptualize key performance measures in the strategies noted below in the following areas: how much did we do (quantity), how well did we do it (quality), and is anyone better off (impact). We conceptualize our work as being action-oriented and with a partnership focus, understanding that working within a collective impact model may help accelerate community health improvements while maintaining a strong community engagement. Many agencies and organizations in New Mexico, including NM Health, follow and utilize principles of Results Based Accountability, so this provides a shared language and understanding among our collaborative and communities.

## 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 requires removing obstacles that contribute to inequity—such as poverty and discrimination—and addressing their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

In 2019, Presbyterian formally embarked on its health equity journey to better serve our patients, members, and communities. Guided by the Institute for Healthcare Improvement’s framework for achieving health equity, we focus on five core practices:

- Making health equity a strategic priority.
- Developing structures and processes to support equity work.
- Deploying strategies that address the multiple determinants of health on which health care organizations can directly act.
- Eliminating racism and other forms of oppression.
- Building and sustaining partnerships with community organizations

As described on our [Health Equity page](#), this commitment is both systemic and patient-centered. We work to understand how structural and social determinants of health (SDOH) shape the lived experiences of our patients, and we strive to remove barriers at the individual level while also advancing broader, systemic change.

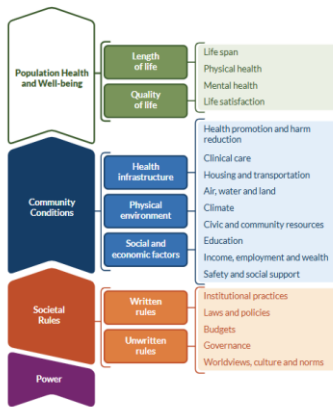
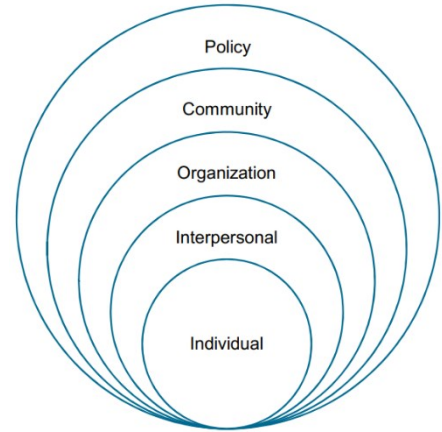
We are deeply committed to **equity, safety, and compassionate care**, recognizing that equitable care directly enhances patient safety, quality, and outcomes. Recent research underscores that embedding equity into health care delivery is essential for preventing harm and achieving better results for all.

To advance this work, Presbyterian leverages interdisciplinary, enterprise-wide committees—including the Health Equity Committee, the Perinatal Health Equity Workgroup, the LGBTQ+ Care Program Committee, and the Native American and Indigenous Advisory Workgroup—to ensure that equity is

integrated across strategies, services, and clinical priorities. These efforts demonstrate our dedication to creating a health system where every person has the opportunity to thrive.

## 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.



University of Wisconsin Population Health Institute Model of Health © 2020

This model expands on the 2014 County Health Rankings Model of Health.

## County Health Rankings Model of Health

This [model](#), which was created by the University of Wisconsin Population Health Institute, describes the intersection of community conditions, societal rules, power, and population health and well-being. Through this model we conceptualize our interventions and implementation plans, understanding that complex health issues require intervention at multiple levels within society and different stages of disease processes. Additionally, understanding how social conditions shape physical and mental health is paramount in creating lasting improvement for key health outcomes and needs identified in the CHA.

## Our Approach to Community Health Improvement

At Presbyterian, we recognize that good health goes beyond the actions individuals take, but that systems and services can impact

the actions individuals are able to take to improve their health. System change can be slow and hard to quantify and much of the community health department’s efforts are focused on slowly changing healthcare and social systems over long periods of time to better serve community and individual needs.

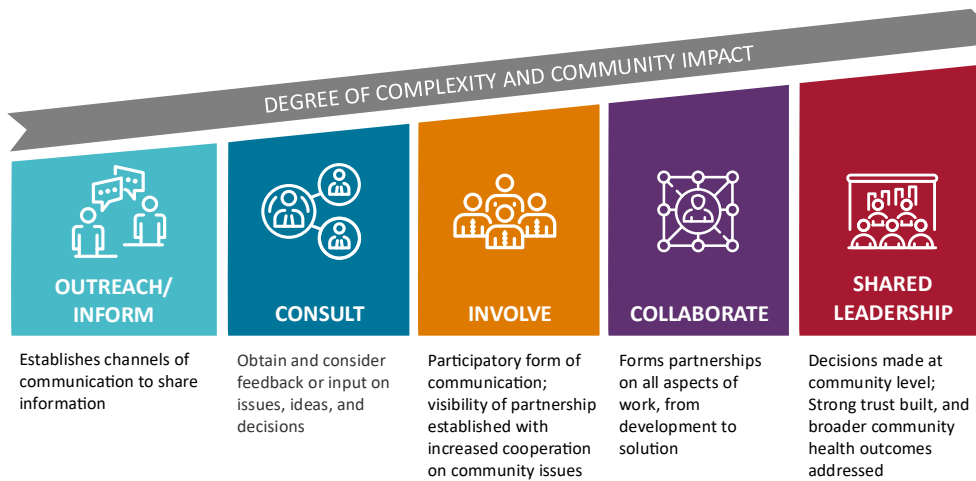
At the individual level, we are committed to supporting patients, members, and community in accessing the services and resources needed by increasing connections to equitable and linguistically and culturally safe care: through varying staffing structures- connecting patients, members, and community to needed behavioral/mental health care and resources to address health-related social needs.

At the interpersonal and organizational levels, we work to ensure professionals and providers (both in Presbyterian and among our community partners) are well equipped to deliver services in a variety of languages and communication modalities with an emphasis on culturally safe and trauma-informed approaches.

At the community level, we aim to address systemic issues around stigma as it relates to care-seeking behaviors for mental/behavioral health, substance use, and accessing community resources for health-related social needs.

Below are some of the frameworks that inform our approach to some of the strategies across priority areas.

## Continuum of Community Engagement



Anchor Institution Strategies for Hospital and Health Systems can differ based on urban or rural settings and needs of the community. The below image from the [Communities In Action Pathways to Health Equity -Opportunities for Hospitals and Health Systems Report from the National Academies of Sciences, Engineering and Medicine](#) helps us understand and act on the fundamental drivers of an anchor strategy.








Drivers	Community Wealth Building	Traditional Approach
 Place	Develops under-utilized local assets of many kinds, for benefit of local residents.	Aims to attract firms using incentives, which increases the tax burden on local residents.
 Ownership	Promotes local, broad-based ownership as the foundation of a thriving local economy.	Supports absentee and elite ownership, often harming locally owned family firms.
 Multipliers	Encourages institutional buy-local strategies to keep money circulating locally.	Pays less attention to whether money is leaking out of community.
 Collaboration	Brings many players to the table: nonprofits, philanthropy, anchors, and cities.	Decision-making led primarily by government and private sector, excluding local residents.
 Inclusion	Aims to create inclusive, living wage jobs that help all families enjoy economic security.	Key metric is number of jobs created, with little regard for wages or who is hired.
 Workforce	Links training to employment and focuses on jobs for those with barriers to employment.	Relies on generalized training programs without focus on linkages to actual jobs.
 System	Develops institutions and supportive ecosystems to create a new normal of economic activity.	Accepts status quo of wealth inequality, hoping benefits trickle down.

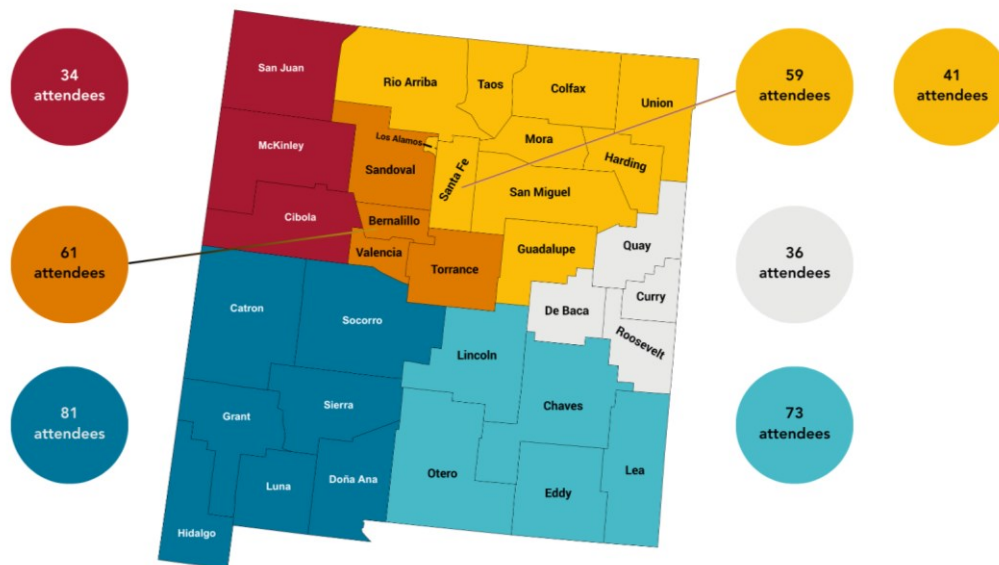
Image Attribution: FIGURE 7-3 Approaches to and drivers of community wealth building to improve economic development. SOURCE: Kelly and McKinley, 2015. Retrieved from <https://nap.nationalacademies.org/resource/24624/anchor-institutions/2.26.26>

Additionally, while published after the publication date of Presbyterian’s community health assessments, the United Way’s groundbreaking report on Asset Limited, Income Constrained, and Employed people and households in New Mexico ([ALICE in New Mexico](#)) contains valuable information about needs and circumstances of workers and their families and recommendations for employers and services providers on how to address needs of this population.

## Stakeholder Engagement and Alignment: Who was Involved

The 2026-2028 CHA/CHIP cycle involved intentional and meaningful community and stakeholder engagement to develop implementation plans that maximize alignment and coordinate assets with Community Health, the healthcare system, and community partners.

Conversation Date	Region	Attendees primarily live, work, or learn in these counties/communities
May 6, 2025	Central	Bernalillo, Cochiti Pueblo, Isleta Pueblo, Kewa Pueblo, Jemez Pueblo, To'hajiilee, Torrance, Sandia Pueblo, Sandoval, San Felipe Pueblo, Santa Ana, Valencia
May 8, 2025	Northeast	Ohkay Owingeh, Los Alamos, Rio Arriba, San Ildefonso Pueblo, Santa Clara Pueblo, Santa Fe, Taos, Taos Pueblo, Tesuque Pueblo
May 13, 2025	Northwest	Acoma Pueblo, Cibola, Mckinley, Navajo Nation, San Juan, Other
May 14, 2025	Northeast	Colfax, Guadalupe, Harding, Mora, San Miguel, Union, Other
May 15, 2025	Southwest and Southeast	Eddy, Chaves, Lea, Lincoln, Mescalero Apache Tribe, Otero, Other
May 20, 2025	Southwest	Catron, Dona Ana, Grant, Hidalgo, Luna, Sierra, Socorro, Other
May 21, 2025	Southeast	Curry, DeBaca, Roosevelt, Quay, Other



## 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. Statewide, this includes: the New Mexico Department of Health, the New Mexico Alliance of Health Councils, 100% Communities, 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 Advisory Board	Regular implementation updates presented for feedback/input
Community Health Steering Committee	Regular implementation updates presented for feedback/input

### Annual Action Planning

Community Health is adopting Presbyterian’s action planning and process excellence tools in the 2026-2028 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.

One page action plans (referred to within Presbyterian as an “A3”) will serve as the high-level communication technique for tracking key programmatic information including key performance indicators, partners, and how the strategies/programs align with Presbyterian goals, strategies, KPIs and must-dos.

### Addressing Community Health Needs

#### Health Needs Addressed

Presbyterian Hospital, Presbyterian Kaseman Hospital, and Presbyterian Rust Medical Center, in conjunction with the Presbyterian Community Health Department will be implementing activities specific to Central New Mexico and related to the identified health needs of Connections to Care, Healthy Lifestyle, and Healthy Communities over the three-year time period of calendar year 2026 through calendar year 2028 as identified through community conversations and assessment of epidemiological data during the Community Health Needs Assessment process.

#### Activities and Intervention Identification

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 community. The following 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: Connections to Care

We are determined to provide safe, compassionate, and equitable care

Our population-level goal is that 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. At Presbyterian, we aim to increase access to many specialty services including behavioral health and birthing services and address the social barriers that prevent people from seeking those services.

### Community Assets and Gaps

Through collaborative conversations, in partnership with NM Department of Health, community-based organizations, Health Councils, and community members, we identified the following assets and gaps related to the Connections to Care priority area.

Our Central New Mexico community identified a plethora of services related to access to health care and wellbeing including organizations who provide specialized recovery services (NM Leaders in Recovery), sources for traditional healing (Horse Medicine at First Nations Community Health Source), virtual and telehealth options for both primary health care and behavioral health care access, increasing accessibility to racial and ethnically appropriate and safe services, and an increase in providers. Additionally, there are local coalitions and non-governmental organizations working to increase access to health services through strategies like continuing education for providers, navigation to services, spaces for support groups, and systemic coordination of services to increase connections to care.

These assets are key in framing our implementation plan both from understanding what others are doing and how we can support what is already happening. There are, however, still gaps our communities identified. These include the need for expanded access to broadband, continuing to ensure and progress efforts in accessibility of services (i.e. language, culturally responsive and inclusive services), continued need for more providers, housing, more support for youth in schools, and the need for reduction of waitlists.

### Key Strategies

Our community identified areas organizations engaging in community health improvement should focus on. These include addressing stigma, increasing access to primary prevention of substance use, increasing providers in both mental/behavioral health and primary and specialty care, increase trauma-informed care practices and training, support for people working in this field, early intervention, more and better access to detox centers, support for people exiting incarceration, increase in self-help and other social groups for adults and youth, and more wrap-around care to include addressing health-related social needs and whole-person treatment.

Our community identified the following approaches/interventions that may work in the community or that they would like to see to address Connections to Care:

- Population-specific support including programs for people who are unhoused, veterans, victims of emotional/physical abuse, people exiting incarceration, and families

- Increasing community knowledge around awareness and availability of services
- Youth program and interventions: increasing youth programming to prevent and disrupt substance use, school-based mental health programs and supports, free lunches, free after school programs, positive youth development
- Behavioral/Mental health treatment including substance use treatment: integrated behavioral health in primary care clinics and physical health offices, access to substance use treatment programs including increasing SBIRT and harm reduction services and resources, primary prevention of substance use, alternative therapies (music, art, dance, animal therapies), increasing trauma-informed care through training, stigma reduction, increasing medication assisted treatment in Sandoval and Valencia counties, and better/more jail diversion programs
- Universal screening of health-related social needs and building referral networks
- Increase and improve the use of culturally tailored and safe care through increasing accessibility, language and interpretation options, and inclusive resources
- Increase education for providers on health equity topics

A vast array of organizations currently support work in this area including Presbyterian Healthcare Services, University of New Mexico Health Sciences Center, public libraries, city and county governments, and community-based organizations including First Nations Community Health Source, Transgender Resource Center of New Mexico, Hopeworks, Albuquerque Health Care for the Homeless, Centro Savila, Endorphin Power Company, NAMI New Mexico, Running Medicine/Native Health Initiative, Santa Fe Mountain Center, Enlace Comunitario, Native American Community Academy, Roadrunner Food Bank, Housing New Mexico, and many, many others. Presbyterian will continue to develop its relationships with these organizations for alignment of interventions and programs for this implementation cycle.

*Presbyterian will implement the following interventions and strategies:*

### Strategy 1: Build paraprofessional workforce integration and sustainability

Presbyterian will support and collaborate with care teams in implementing evidence-based interventions for substance use disorders (SUD) and behavioral health (BH) conditions. We will do this through strategic hiring and expansion of Certified Peer Support Workers (CPSWs) and Community Health Workers (CHWs) to support clinical teams in connecting patients to needed resources.

#### Program/Tactic 1: Peer Support Services, Community Health Worker Services

Presbyterian will increase the institution's capacity for paraprofessionals (Certified Peer Support Workers and Community Health Workers) to thrive and provide care for more patients

Key Performance Measures:

- Number of Peer Support Specialists employed
- Number of patients who encountered Peer Support Specialists prior to discharge

#### Program/Tactic 2: Screening, Brief Intervention, and Referral to Treatment

Presbyterian will continue to connect patients experiencing drug use to needed recovery services including addiction medicine services and medication assisted treatment. We will do this through maintaining and expanding (where appropriate) Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Key Performance Measures:

- SBIRT Completion Rate
- Number of patients who accepted/declined follow-up services

- Number and type of linkages to care services

### Program/Tactic 3: Substance Use Prevention & Harm Reduction

Presbyterian will work with specific care teams to integrate harm reduction practices into routine care and emphasize skills to overcome barriers to treatment. We will do this through maintaining and expanding (where appropriate) training, clinical support tools, stigma reduction work, and increasing and improving naloxone access through the system and within the community.

Key Performance Measures:

- Number of patients who received harm reduction educational materials
- Number of patients who received naloxone kits
- Number of people attending harm reduction training

### Strategy 2: Enhance safety of babies born with substance exposure

#### Program/Tactic 1: Connect to behavioral health care, substance use disorder treatment, home visiting, and WIC

Presbyterian will continue to support and expand (where it makes sense) CPSWs, CHWs, care coordinators, and other care teams to work as one coordinated clinical team to plan for infant safety after discharge while providing non-stigmatizing support to infants and their families.

Key Performance Measure:

- Number of safety care plans developed

### Strategy 3: Provide workforce and community training, presentations, and educational opportunities

#### Program/Tactic 1: Health Equity Training Series

Presbyterian will increase provider and community partner knowledge and confidence to deliver equitable, patient-centered, and compassionate care. We will do this through health equity topics that will focus on reducing stigma, shame and fear while increasing trust in providers, our services, and our brand.

Key Performance Measures:

- Number of training participants
- Number of tailored training modules developed and implemented

### Strategy 4: Support patients to address health-related social needs

#### Program/Tactic 1: Connect individuals to community resources

Presbyterian will sustain and improve the data-driven system for identifying, addressing, and tracking health-related social needs (HRSN) across the Presbyterian Healthcare Delivery System. Through this strategy, patients will be screened for social needs once every six months with key emphasis on measuring the following needs: food insecurity, housing stability, transportation needs, personal safety needs, and utility needs. Patients with identified needs will be connected to a CHW who will help patients connect to resources to resolve those needs.

Key Performance Measures:

- HRSN screening completion rate
- HRSN screening to encounters ratio
- HRSN needs identified through screening

- Resource connections

## Strategy 5: Standardizing social care in clinical settings

### Program/Tactic 1: Increase workforce to address social barriers

Presbyterian will expand access to trusted, relationship-based CHW services that address social drivers of health, strengthen care coordination, and support patients in navigating complex systems.

Key Performance Measures:

- Number of referrals from providers to CHWs
- Percent of patients with HRSNs referred to CHWs
- CHW case outcomes success rate

### Program/Tactic 2: Closed-loop referral technology and networks

Presbyterian will adopt and use an electronic medical record (EMR)/integrated closed-loop referral platform to track outcomes associated with HRSN navigation and associated resolution statuses. We will participate in regional and statewide referral network collaboratives and use data to inform strategic investments in social care infrastructures.

Key Performance Measures:

- Referral workflow process maps for closed-loop referral system

## Strategy 6: Increase access to healthy affordable food where food access is low

### Program/Tactic 1: Food is Medicine

Presbyterian will increase the number of patients and members who have qualifying chronic conditions and who screen positive for food insecurity who receive immediate nutrition assistance by way of Presbyterian programs or other community programs. This strategy involves developing a sustainable and comprehensive “triage” process to determine what resources patients need, what they qualify for, and how they get connected to those resources.

Key Performance Measures:

- Improved food security
- Number of unique participants in Food is Medicine programs
- Number of referrals and referring providers to Food is Medicine programs

## Strategy 7: Patient needs disparities

### Program/Tactic 1: Culturally and linguistically appropriate initiatives for priority populations

Presbyterian will use data to understand how patient needs and outcomes differ based on demographic and other factors. We will work across departments within Presbyterian using an interdisciplinary team to improve existing and create new services to better serve people and groups with whom healthcare institutions have broken trust or fallen short. We will focus action planning on three specific priority populations to improve health equity and quality: Indigenous Americans, LGBTQIA2S+ community, and perinatal populations.

Key Performance Measures:

- PHP postpartum visits – percent of pregnant patients who access postpartum visits and services
- PMG postpartum depression screening within the delivery system (prevalence of postpartum depression and frequency of completed screenings)
- Number of unique patients and members supported through various health equity initiatives

- Number of workforce resource requests completed
- Number of consultative projects
- Land Acknowledgement established
- Indigenous Healing Policy established
- Health Equity Index (HEI) survey score

Presbyterian will not implement the following interventions and strategies identified by the community:

- Youth program and interventions: increasing youth programming to prevent and disrupt substance use, school-based mental health programs and supports, free lunches, free after school programs, positive youth development
- Animal therapy, art therapy
- Diversion Programs

While Presbyterian regularly provides care for youth and many of Presbyterian's classes are youth-inclusive, there are many community-based organizations who specialize in this area including NACA, school-based health centers, local nonprofits, and community groups. Additionally, we will not be implementing animal therapy or systematically adding art therapy in Community Health at this time because it is outside the scope of our staffing priorities and expertise. Finally, while we may still participate in community coalitions for substance use that may include organizations working to improve drug diversion programs, we will not be spearheading any of that work due to the fact it is outside of our scope as a health care organization.

### Region Specific Programming, Interventions and Partnerships

Presbyterian Community Health, with support from federal, state, and other grant funding, is focused on substance use and overdose prevention activities in Bernalillo County and the Albuquerque Metro area. Prevention programming includes training community and frontline workers how to recognize and respond to overdose, about stigma and how to combat it, and about substance use first aid and safety first approaches. These activities also include partnering with and supporting organizations and coalitions in their efforts to maximize distribution of naloxone and provide other substance use prevention and treatment services including partnerships with Women in Leadership, the New Mexico Healthcare Authority, The Office of Substance Abuse Prevention, NM Health, The Health Equity Council, The Albuquerque Coalition to End Homelessness, Albuquerque Community Safety, The New Mexico Dream Center, The ABC Prevention Coalition, ABQ DWI Program, Local Behavioral Collaboratives, Keep New Mexico Alive, Frontline Resurrection, The New Mexico Community Planning and Action Group, The Children's Law Institute, and many others.

In 2025, Presbyterian EMS teams at Albuquerque Ambulance Service (AAS) performed 940 naloxone administrations and partnered with fire departments, Albuquerque Community Safety, the new Medical Sobering Center at Gateway Center and others to address behavioral health needs including to provide a "golden opportunity" to patients who want to immediately begin substance use treatment. AAS remains a committed partner to equitably address behavioral health gaps in Central New Mexico.

Additionally, to promote increased and more equitable access to care, Presbyterian through AAS maintains a Community Paramedic Program and Mobile Integrated Health Unit providing care for those unhoused, with transportation issues, or with medication reconciliation issues.

AAS also operates a comprehensive Mobile Integrated Healthcare (MIH) program in collaboration with healthcare systems and insurance providers to expand access to care, support high-risk populations,

reduce emergency department and acute care utilization, and help patients achieve optimal health outcomes.

The MIH team includes four MIH paramedics, a licensed social worker, and a Commander. AAS MIH paramedics manage patients with complex, high-risk clinical needs through specialized training developed in collaboration with clinical specialists. This training includes expanded skill sets beyond the traditional New Mexico paramedic scope of practice, along with dedicated clinical shifts designed to maintain competency and foster strong collaborative partnerships.

During 911 or interfacility transports, AAS providers who identify patients with unmet social needs may initiate referrals through the electronic patient care reporting system to the community health specialist and social worker. With patient consent, the MIH team conducts assessments and connects patients to appropriate community based resources and services.

### The Evidence

There is some evidence to suggest that developing and implementing paraprofessional workforce members, specifically CHWs, may increase patient knowledge, access to care, and improve the adoption of healthy behaviors and mental health, and potentially decrease health disparities.<sup>1</sup> Screening and brief interventions for alcohol use is recommended by the United States Preventive Services Task Force (USPSTF) for adults in primary care settings.<sup>2</sup> This tactic is scientifically supported, may help to reduce alcohol use, excessive drinking, underage drinking, and alcohol-related harms.<sup>3</sup> Additionally, recent work Presbyterian Community Health participated in - the Accountable Health Communities project - shows that screening for and connecting patients to community resources to address health related social needs improved the quality of care and reduced expenditures.<sup>4</sup>

## Priority Area: Healthy Lifestyle

We are determined to connect individuals and families to tools, skills, and the confidence they need to live a healthy lifestyle.

Our population-level goal is to improve quality of life for people living with or who are at risk of developing chronic disease. At a population level, we measure success by analyzing the change in prevalence of diabetes and heart disease-related mortality. At Presbyterian, our goal is to improve the prevention and self-management of chronic diseases, especially diet-related chronic conditions such as heart disease, hypertension, diabetes, and gastrointestinal conditions. At the system level, we will measure success using system quality metrics for diabetes and hypertension and measuring preventive care access (annual wellness visits, well child visits). Additionally, we seek to prevent the spread of communicable diseases both in our facilities and in the community.

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<sup>1</sup> County Health Rankings and Roadmaps. (2026). Community health workers. Retrieved from

<https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/community-health-workers>

<sup>2</sup> USPSTF. (2018). Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions.

Retrieved from: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions>

<sup>3</sup> County Health Rankings and Roadmaps. (2026). Alcohol Brief Interventions. Retrieved from

<https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/alcohol-brief-interventions>

<sup>4</sup> Beil, H., He, F., Parish, W., Renaud, J., Rojas Smith, L., Sussman, L., & Toth, M. (2026). Accountable Health Communities

(AHC) Model Evaluation Final Report. Retrieved from: <https://www.cms.gov/priorities/innovation/data-and-reports/2026/ahc-final-report>

## Community Assets and Gaps

Through collaborative conversations, in partnership with NM Department of Health, community-based organizations, Health Councils, and community members, we identified the following assets and gaps related to the Healthy Lifestyle priority area.

Our Central New Mexico community identified services, places, and policies that support individual health and wellbeing. Some of these assets include public pools, free gyms at community centers including multigenerational and senior centers, bike paths, organizations who provide direct health care services, community gardens, evidence-based chronic disease self-management programs, running/walking groups, parks, telehealth, schools, recreational facilities, community health fairs, academic medical centers, and farmers markets.

These assets are key in framing our implementation plan both from understanding what others are doing and how we can support what is already happening. There are, however, still gaps our communities identified. These include transportation to walking trails/bike paths/hiking trails/recreational facilities, the need for more access to dietitians, the cost of healthy food, more recreational facilities needed, more community vaccine events and distribution of evidence-based knowledge about vaccines, employer support of employee wellness, and more funding allocated to parks/recreation/open space.

## Key Strategies

Our community identified areas organizations engaging in community health improvement should focus on. These include expanding existing walking paths and developing more, systemic issues including insurance coverage for visits with nutritionists/dietitians and for gym memberships, holistic views on health, and funding robust community wellness initiatives and fairs.

Our community identified the following approaches/interventions that may work in the community or that they would like to see to address Healthy Lifestyle:

- Farmers' markets programs (like DoubleUp Food Bucks)
- Senior centers food sites
- Mobile wellness units
- Produce prescription programs
- Education about resources/services
- Expanding walking paths/developing new walking paths
- Increase in community gardens as a healthy lifestyle intervention
- Vaccine events
- Healthy eating classes
- Education on Dental Health
- Establish new farmers' markets in Valencia County
- Increase affordability of fitness programs

A vast array of organizations and coalitions currently support work in this area including Presbyterian Healthcare Services, Health Councils, the Healthy Here Coalition, the International District Healthy Communities Coalition, University of New Mexico Health Sciences Center, public libraries, city and county governments, and community-based organizations including First Nations Community Health Source, Transgender Resource Center of New Mexico, Albuquerque Health Care for the Homeless, New Mexico Farmers' Marketing Association, New Mexico State University Extension Services, Running Medicine/Native Health Initiative, Casa de Salud, Native American Community Academy, Roadrunner Food Bank, Together for Brothers, Kids Cook, The Agricultura Network and many, many others.

Presbyterian will continue to develop its relationships with these organizations and participate in relevant coalitions for alignment of interventions and programs for this implementation cycle.

## Presbyterian will implement the following interventions and strategies:

### Strategy 1: Healthy lifestyle opportunities

Presbyterian will increase individual knowledge, skills, and self-efficacy to support patients, members, and communities in achieving their best health in alignment with personal goals, evidence-based programming, and connections to classes and resources.

Presbyterian will increase individual knowledge, skills, and self-efficacy related to cooking, healthy nutrition practices, and chronic disease self-management through offering healthy lifestyle opportunities that support the prevention and management of chronic diseases, especially diabetes. We will do this through supporting diabetes prevention and self-management techniques and evidence-based approaches.

### Program/Tactic 1: Diabetes prevention & self-management

Key Performance Measures:

- Pre & post enrollment A1c
- Pre & post enrollment blood pressure
- Number of Medicare/Medicaid members enrolled and completing programs
- Number of billable visits
- Number of program participants, demographics

### Program/Tactic 2: Family Healthy Weight

Key Performance Measures:

- Pre & post enrollment A1c
- Pre & post enrollment blood pressure
- Number of Medicare/Medicaid members enrolled and completing programs
- Number of billable visits
- Number of program participants, demographics

Presbyterian will increase individual knowledge, skills, access, and self-efficacy related to ways to be physically active and manage stress by offering healthy eating and active living (HEAL) classes and assisting in the connection to those classes.

### Program/Tactic 3: Healthy Eating and Active Living Classes

Key Performance Measures:

- Number of participants in classes, demographics
- Number of HEAL classes, by type

### Program/Tactic 4: Wellness Connection Center

Key Performance Measures:

- Number of referrals and enrollments in HEAL classes

Presbyterian will increase individual access to evidence-based programs and preventive care through resource and care navigation, barrier resolution, and education.

### Program/Tactic 5: CHW Model of Care

Key Performance Measures:

- Number of people enrolled into evidence-based interventions
- Number of barriers to care resolved
- Number of preventive screening/appointments completed

## Strategy 2: Food is Medicine

Presbyterian will work to increase fresh fruit and vegetable consumption among patients, members, and community through connections to programs, both internally and externally. We will work to increase access and use of varied local produce by leveraging institutional buying power to support local farms. We will work to improve nutrition and food insecurity simultaneously through internal Food is Medicine programs and other evidence-based approaches.

### Program/Tactic 1: Produce Prescriptions and Nutrition Education and Counseling

Presbyterian will work to increase fresh fruit and vegetable consumption and increase access to and use of varied, local produce through two key approaches: produce prescription programs and nutrition education and counseling.

Key Performance Measures:

- Number of unique people participating in Food is Medicine interventions, demographics
- Improvement in blood pressure
- Improvement in A1c
- Self-reported health behaviors - improvement
- Improved food security
- Number of referrals and referring providers to Food is Medicine programs

## Strategy 3: Vaccines

Presbyterian will provide free and accessible vaccination opportunities in the community and for the Presbyterian workforce.

### Program/Tactic 1: Community Vaccination Clinics

Key Performance Measures:

- Number of vaccinations administered to community members

### Program/Tactic 2: Workforce immunization

Key Performance Measures:

- Number of vaccines administered to the workforce

Presbyterian will not directly implement the following interventions and strategies identified by the community, though many of the coalitions and partnerships Presbyterian participates in address these or may partially address these:

- Farmers' markets programs (like DoubleUp Food Bucks)
- Senior centers food sites
- Mobile wellness units
- Expanding walking paths/developing new walking paths
- Increase in community gardens as a healthy lifestyle intervention
- Establish new farmers' markets in Valencia County
- Increase affordability of fitness programs

The above interventions are part of a larger strategy of improving physical health in Central New Mexico. While we may not directly add these activities to our implementation plan, we recognize that

our work on community coalitions and in partnership with specific organizations overlaps with many of these activities including expanding access to community gardens, increasing walking trails, mobile health, and establishing new farmers' markets. We will continue to support the organizations who lead this important work but will not lead the work ourselves.

### Region Specific Programming, Interventions and Partnerships

The Healthy Here coalition, through the CDC REACH grant, includes working with Senior Center and congregate meal sites to improve their nutrition standards and guidelines. Previously, this coalition has also focused on walking paths and trails and continues to assess walkability, pedestrian and bike safety issues, and transit related built environment interventions. The Presbyterian Community Health Resource Center located at the Kaseman Campus has a community garden. Presbyterian with the help of partners and volunteers including partners from Bernalillo County will continue to develop the garden soil, grow vegetables and flowers, and enhance the community garden maintained on its property. Presbyterian Health Plan, the Presbyterian Healthplex, and various community and employee wellness programs include some programs and services focused on mobile health clinics, gym and pool access, and complementary therapies and health improvement programs for a healthier lifestyle.

### The Evidence

There is some evidence that nutrition prescription programs can increase fruit and vegetable consumption and food security, which may lead to improved health-related knowledge, improved dietary habits, and improved nutrition and health outcomes.<sup>5</sup> Additionally, diabetes self-management education (DSME) programs can help people who struggle with glycemic control improve their A1c.<sup>6</sup>

There is currently conflicting evidence on the effectiveness of food is medicine interventions where some studies show an improvement in key health metrics while others do not. This difference is largely due to variations in program design and study design. More evidence is needed to further understand how food is medicine interventions can impact health, which Presbyterian Community Health will incorporate into program evaluation efforts in 2026-2028. Because Food as Medicine is a suite of interventions with varying methods of implementation, which is reflected in the current literature, there is a need to study these interventions for effectiveness in a variety of settings and implementation

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<sup>5</sup> County Health Rankings and roadmaps. (2026). Nutrition Prescriptions. Retrieved from

<https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/nutrition-prescriptions>

<sup>6</sup> Chrvla, C. A., Sherr, D., & Lipman, R. D. (2016). Diabetes self-management education for adults with type 2 diabetes mellitus: a systematic review of the effect on glycemic control. *Patient education and counseling*, 99(6), 926-943.

approaches.<sup>7</sup> Some studies have found FAM program participation improved blood pressure<sup>8,9</sup> while others found no significant change in blood pressure<sup>10,11</sup> possibly due to these variations.

## Priority Area: Healthy Communities

We are determined to do our part to keep our patients and members healthy across New Mexico.

Our population-level goal is to identify meaningful ways healthcare institutions can positively impact the conditions in which people live, work, or play to improve their long-term health. At the population level, we measure progress in this area through understanding changes in unemployment rates, poverty rates, severe housing cost burden (percent of people who spend 50% or more of their income on housing), adverse weather events, and drinking water violations. All of these indicators tie back to the needs our communities have expressed and illustrate the overall composition of systemic and environmental issues that impact everyday health.

At the system level, we aim to contribute to increasing economic opportunities, community investments, meaningful engagements, and explore opportunities to impact the communities we serve. Key PHS system measures include the average days to fill nursing positions and community brand preference.

## Community Assets and Gaps

Through collaborative conversations, in partnership with NM Department of Health, community-based organizations, Health Councils, and community members, we identified the following assets and gaps related to the Healthy Communities priority area.

Our Central New Mexico community identified a plethora of services related to access to supporting community health and well-being, including build environment factors including sidewalks and walking trails, clean air and water regulations, and warming and cooling facilities.

These assets are key in framing our implementation plan both from understanding what others are doing and how we can support what is already happening. There are, however, still gaps our

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<sup>7</sup> Seligman, H. K., Angell, S. Y., Berkowitz, S. A., Elkind, M. S. V., Hager, K., Moise, N., Posner, H., Muse, J., Odoms-Young, A., Ridberg, R., Troxel, A. B., Yaroch, A. L., & Volpp, K. G. (2025). A Systematic Review of “Food Is Medicine” Randomized Controlled Trials for Noncommunicable Disease in the United States: A Scientific Statement From the American Heart Association. *Circulation*, 152(4). <https://doi.org/10.1161/CIR.0000000000001343>

<sup>8</sup> Berkowitz, S. A., Ammerman, A. S., Knoepp, P., Anderson, R. E., Taylor, L. H., Jedelee, J. M., Archibald, J., Xue, K., Wertman, E., Dellva, B., Pignone, K., Qaqish, B., Dolor, R. J., Turner, S., Lumpkin, J. R., & DeWalt, D. A. (2025). Food Insecurity Interventions to Improve Blood Pressure: The Healthy Food First Factorial Randomized Clinical Trial. *JAMA Internal Medicine*. <https://doi.org/10.1001/jamainternmed.2025.5287>

<sup>9</sup> Cook, M. A., Taylor, K., Reasoner, T., Moore, S., Mooney, K., Tran, C., Barbo, C., Schmidt, S., Stein, A. D., & Webb Girard, A. (2023). Participation in the Georgia Food for Health programme and CVD risk factors: A longitudinal observational study. *Public Health Nutrition*, 26(11), 2470-2479. <https://doi.org/10.1017/S1368980023001611>

<sup>10</sup> Clark, J. M., Maw, M. T. T., Pettway, K., Chander, G., Elias, S., Zisow-McClean, S., Maruthur, N. M., & Greer, R. C. (2025). Impact of Medically Tailored Meals on Clinical Outcomes Among Low-Income Adults with Type 2 Diabetes: A Pilot Randomized Trial. *Journal of General Internal Medicine*, 40(8), 1711-1719. <https://doi.org/10.1007/s11606-024-09248-x>

<sup>11</sup> Hager, K., Shi, P., Li, Z., Chui, K., Berkowitz, S. A., Mozaffarian, D., Chhabra, J., Wilken, J., Vergara, C., Becker, E., Small, S., Ling, B., Cash, S. B., Folta, S. C., & Zhang, F. F. (2023). Evaluation of a Produce Prescription Program for Patients With Diabetes: A Longitudinal Analysis of Glycemic Control. *Diabetes Care*, 46(6), 1169-1176. <https://doi.org/10.2337/dc22-1645>

communities identified. These include larger issues with clean air and water including pollution, the need for more walkable communities, safe community spaces, expanded access to broadband and general digital literacy, more cooling and warming centers, places to join community in ways that encourage social systems and interpersonal emotional and social support, key workforce development opportunities including investments, living wages, job security, promoting entrepreneurship, and expanding education.

## Key Strategies

Our community identified areas organizations engaging in community health improvement should focus on. These include creating and expanding walkable communities, addressing built environment issues, economic development, and weather-related interventions.

Our community identified the following approaches/interventions that may work in the community or that they would like to see to address Healthy Communities:

- Training for communities to develop capacity to advocate for greener environments
- Establish heating and cooling centers
- Develop spaces for community to gather including multigenerational and multicultural centers for inter-generational programs - i.e. adopt a grandparent and community belonging circles.

A vast array of organizations currently support work in this area including Presbyterian Healthcare Services, University of New Mexico Health Sciences Center, public libraries, city and county governments, and community-based organizations. Presbyterian will continue to develop its relationships with these organizations for alignment of interventions and programs for this implementation cycle.

## Presbyterian will implement the following interventions and strategies:

### Strategy 1: Proactive Financial Assistance Practices & Policies

Presbyterian will offer transparent, user-friendly, patient-centered and accessible financial assistance by better utilizing technology and presumptive eligibility, proactive communication, and no-wrong door approaches. Through community partnerships, we will ensure patients can afford the care they need without sacrificing other basic needs.

Key Performance Measures:

- Total dollars provided in financial assistance
- Community benefit ratios

### Strategy 2: Workforce Development

#### Program/Tactic 1: Internships, Scholarships for Youth

Presbyterian will work to increase incentives and opportunities to give youth interest and opportunities to pursue careers in healthcare.

Key Performance Measure:

- Number and type of opportunities provided to youth to interface with healthcare professionals, by hospital and region

#### Program/Tactic 2: Nursing Career Pathways

Presbyterian will support current employees with tuition assistance, onsite experience, and job placement to earn a BSN or LPN online.

Key Performance Measures:

- Number of program graduates

### Program/Tactic 3: Healthcare Advanced Learning Lab

Presbyterian will provide an innovative, supporting learning environment where healthcare professionals and students receive hands-on simulation education and training using advanced technology. We will work to enhance current skills and teach new ones to improve the quality of care, experiences, and outcomes for the communities we serve.

Key Performance Measures:

- Number and types of requests for use

## Strategy 3: Health System Anchor Institution Strategy for Community Wealth Building

### Program/Tactic 1: Healthy Neighborhoods ABQ

Presbyterian will increase local purchasing, spending, and procurement.

Key Performance Measures:

- Percent of food budget used for local food procurement
- Pounds of local food procured for Presbyterian Community Health programs

### Program/Tactic 2: Rural Anchor Initiatives

Presbyterian will uplift community conditions through partnerships and economic investments including creation of workforce training and living-wage jobs; influence affordable housing, local safety and access to infrastructure; and local spending.

Key Performance Measures:

- Rank largest employers in Communities
- Number of employees

## Strategy 4: Community Engagement & Support

### Program/Tactic 1: Community Investments and Benefit

Presbyterian will award one-time sponsorships and community grants with priority for community organizations whose missions relate directly to 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.

Key Performance Measures:

- Dollars invested by priority area and geography

### Program/Tactic 2: Voices for Equity: Community Ambassador Program

Presbyterian will deepen the complexity of engagement with the community including through outreach and information, community consultation, participatory involvement, shared leadership, and collaboration, especially on solving issues.

Using a Community Engagement Framework, Presbyterian will coordinate relationships and engagement with community coalitions and key stakeholders to build trust between Presbyterian and

community partners, better understand community needs, advance regional strategies, ensure activities are community-informed, and identify opportunities for formalized partnerships.

Community stakeholders include but are not limited to schools, local and state government, Tribal entities, PHP network providers, higher education institutions, community-based organizations, community coalitions, health councils, and business sectors

Key Performance Measures:

- Number of engagements by county and region

### [Program/Tactic 3: Community Partnership](#)

Presbyterian will partner extensively with community-based organizations and coalitions as vendors, subcontractors, and to provide in-kind support for community and coalition-based efforts.

[Presbyterian Community Engagement](#) provides funding to support local organizations that are focused on the well-being of our communities. These community-based nonprofits have structures in place to support needs specific to New Mexicans while reinforcing the care we provide at Presbyterian.

### [Submit an Application Now](#)

Key Performance Measures:

- Number of class instructors
- Number and types of organizations engaged

## Strategy 5: Volunteerism & Community Service

### [Program/Tactic 1: Volunteer Program](#)

Presbyterian will 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.

Community connections are built and strengthened in many ways. One of them is through volunteerism and community service. Presbyterian's Volunteer Program is one of such programs that directly builds stronger communities by fostering empathy, providing essential services, and connecting individuals to a shared sense of purpose and belonging. Both individuals and the community at large benefit from the mutual support, shared experiences, awareness of needs and assets, and collaborative efforts that volunteerism creates.

How Volunteering Builds Community Connection

- Provides a Shared Purpose
- Fosters Empathy and Understanding
- Strengthens Social Networks
- Addresses Community Needs
- Creates a Sense of Belonging
- Provides capacity and sustainability for organizations with necessary services and missions
- By contributing time and effort to local causes, individuals feel more connected to their community and experience a greater sense of purpose and fulfillment.

Other benefits of volunteering with Presbyterian include:

- Free flu shots
- Gift Shop discounts

- Free membership at the Presbyterian Healthplex (minimum hours required)
- Annual Appreciation & Awards Luncheon
- Employee Assistance Program (available to the volunteer only, minimum hours required)

Adult volunteers are at least 18 years old and Youth volunteers are 16 - 17 years old. Volunteers serve in nearly every department of the hospital and provide a weekly commitment of 4 hours per week and an overall minimum commitment of nine months.

To learn more about this program, opportunities, the impact of volunteerism, go to <https://www.phs.org/community/volunteer>.

Key Performance Measures:

- Number of volunteers by hospital, by region

## Strategy 6: Learning & Exploratory Assessment for New Environmental Strategies

Community conversations revealed the growing community concern around environmental health and sustainability. Specifically, as stated in our 2026-2028 CHA, air quality, heat and cold-related exposure illness, and extreme adverse weather events are contributing to poor health both through direct impact of wildfires, flooding, and drought, but indirectly through impacting wellness and future orientation. Presbyterian recognizes the potential for these topics to be out of scope for a health system, but we are committed to remaining accountable to our communities and will investigate in good faith what opportunities exist for our system's involvement in addressing these concerns.

Key learning measures for this area include heat and cold-related ED utilization and pediatric asthma screenings (PQIP).

### Program/Tactic 1: Learning, Planning, & Capacity Building

Presbyterian will identify 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 related to this topic area, potential funding/investment opportunities, and community partnership opportunities. Finally, Presbyterian will work to build internal awareness and attention to the issues our communities have raised in this area.

In lieu of key performance measures, we will instead focus on compiling information and reporting out with our community partners.

Presbyterian will not implement the following interventions and strategies identified by the community:

- Training for communities to develop capacity to advocate for greener environments
- Establish heating and cooling centers
- Develop spaces for community to gather including multigenerational and multicultural centers for inter-generational programs - i.e. adopt a grandparent and community belonging circles.

While we recognize the importance of these topics, Presbyterian is currently exploring how we fit in as a health care organization. Over the three years of this implementation cycle, we will explore what role our hospitals can play in providing safe spaces for heat and cold relief and how we can expand community health programming to include more social/emotional support programming and community gathering. We recognize that other organizations may be working in these areas and will explore potential for support and partnership over the next three years.

### Region Specific Programming, Interventions and Partnerships

Presbyterian continues to support the local economy through continued employment opportunities and local investments. In Central New Mexico, Presbyterian's food access programs will continue to maintain strong partnerships with local growers and suppliers to distribute locally grown and harvested foods to patients, members, and community through food access programs. Presbyterian's Food Farmacy, Presbyterian's Northern Roots program, and the emergency food pantry at the Presbyterian Healthplex all contract with MoGro to source healthy and fresh foods from local farms.

Presbyterian continues to serve as an anchor institution for Healthy Neighborhoods Albuquerque, a collaborative effort to align anchor institutions to leverage intellectual capabilities and buying power to increase local investments on a project-by-project basis with the goal of improving the long-term health and economic wellbeing of the community.

Additionally, Presbyterian will continue to support the efforts of Healthy Climate New Mexico, which will include summits on addressing and preparing for climate-related health in New Mexico. This includes the convening of the Extreme Heat Summit slated for Spring 2026, which will include heat resiliency education for health professionals.

Presbyterian's Health Equity training courses include a pilot educational session that teaches CHWs and frontline workers about resources in the community and how to educate patients and community members about what they can do to be prepared for extreme heat or to respond to extreme weather events. This pilot will inform whether and how to scale and improve this training as an implementation strategy.

### Needs Not Addressed in the Presbyterian Healthcare Services 2026-2028 CHIP

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 health needs in each city, town, county, tribal area, and region including varying factors that contribute to whether or not health worsens or improves over time. Healthcare and especially one organization alone is insufficient to address all the needs one community has, much less statewide. However, it is necessary that healthcare take an active and leadership role in addressing more than what is found within the four walls in order to keep people healthy and preserve quality of life. Presbyterian has prioritized areas within our scope of control or influence and has committed to contribute in-kind capacity, staffing, and coordination to long term partnerships and collaborations with public health, government, healthcare, philanthropic, and community-based entities to work together to achieve bold visions for better health. Through these partnerships and ongoing assessment, planning, and community accountability actions, Presbyterian will help spread awareness of which entities are working to address which needs and priorities with specific programs, interventions, and resources. Presbyterian will participate in collaboratives and partnerships that aim to help match best fit partnerships across sectors and align and leverage resources where they will have the most impact. Presbyterian will continue to commit to help navigating patients, members, and community members to services and resources that can support their needs and to help steward, support, and cultivate an environment where those services can flourish. It is essential and central to our success to make sure our activities are informed by community voice and are responsive to the health needs of our communities.

### We want to hear from you!

Please contact us at [CommunityHealthTeam@phs.org](mailto:CommunityHealthTeam@phs.org) with comments, questions, and input on our 2026-2028 community health priorities and plans. We welcome and encourage you to share your thoughts and ideas with us! Thank you for your partnership in this important work.