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			