2024 REGIONAL COMMUNITY HEALTH IMPACT: AT-A-GLANCE

SCOPE

The Presbyterian Regional Community Health team serves Taos, San Miguel, Santa Fe, Rio Arriba, Socorro, Quay, Doña Ana, Otero and Lincoln counties. These counties represent 260,000 Presbyterian customers. All of the counties served are considered rural or frontier counties except for Santa Fe and Doña Ana counties.

KEY HIGHLIGHTS FROM 2024

Growth and Financials

- $2,094,939 in awarded grants in 2024, a 69% increase from 2023
- Current funders include the Centers for Disease Control (CDC), Presbyterian Health Plan (PHP), Brindle Foundation and Presbyterian Healthcare Foundation (PHF).
- Six new funders were added in 2024 including the American Diabetes Association, Con Alma Foundation, Nusenda Credit Union, Santa Fe County, the U.S. Department of Agriculture (USDA) Farmers Market and Local Food Promotion program, and a private funder.
- $764,000 invested in community-based organizations including $180,000 to expand social care networks through the PHP partnership, $184,000 in local food systems and $400,000 allocated to partners on the CDC Diabetes award.
- Staff has increased by 22% from 2023, with a total of 11 team members.
- Geographic reach has expanded to include Quay and Curry counties.

Community Engagement and Voice

- 478 community engagements, including regular engagement and participation in three Health Councils.
- Conducted eight focus groups including three on virtual maternal care, two on food access, three with Community Health Workers (CHWs) engaged in diabetes care, and 16 key informant interviews.

DIRECT SERVICES AND PROGRAM REACH

1,085 patients served by CHWs, 39.9% were PHP members

385 enrolled in Northern Roots and over half are PHP Medicaid members

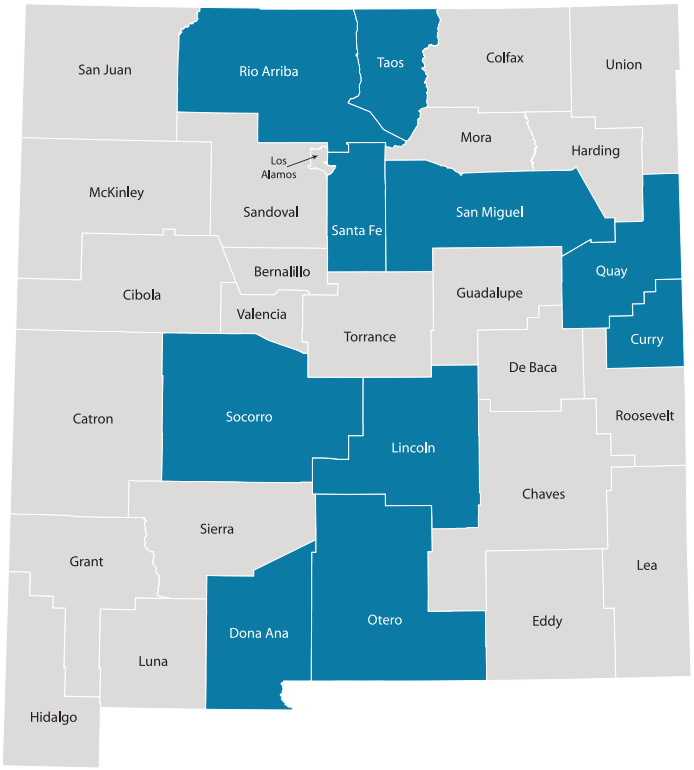
88 enrolled in Diabetes ReCHARGE through CHWs navigation

125 individuals enrolled in Kitchen Creations program

PRESBYTERIAN COMMUNITY HEALTH AND PHP REGIONAL PARTNERSHIP: AN INTEGRATED APPROACH IN EXPANDING ACCESS IN REGIONAL AND RURAL COMMUNITIES

BACKGROUND

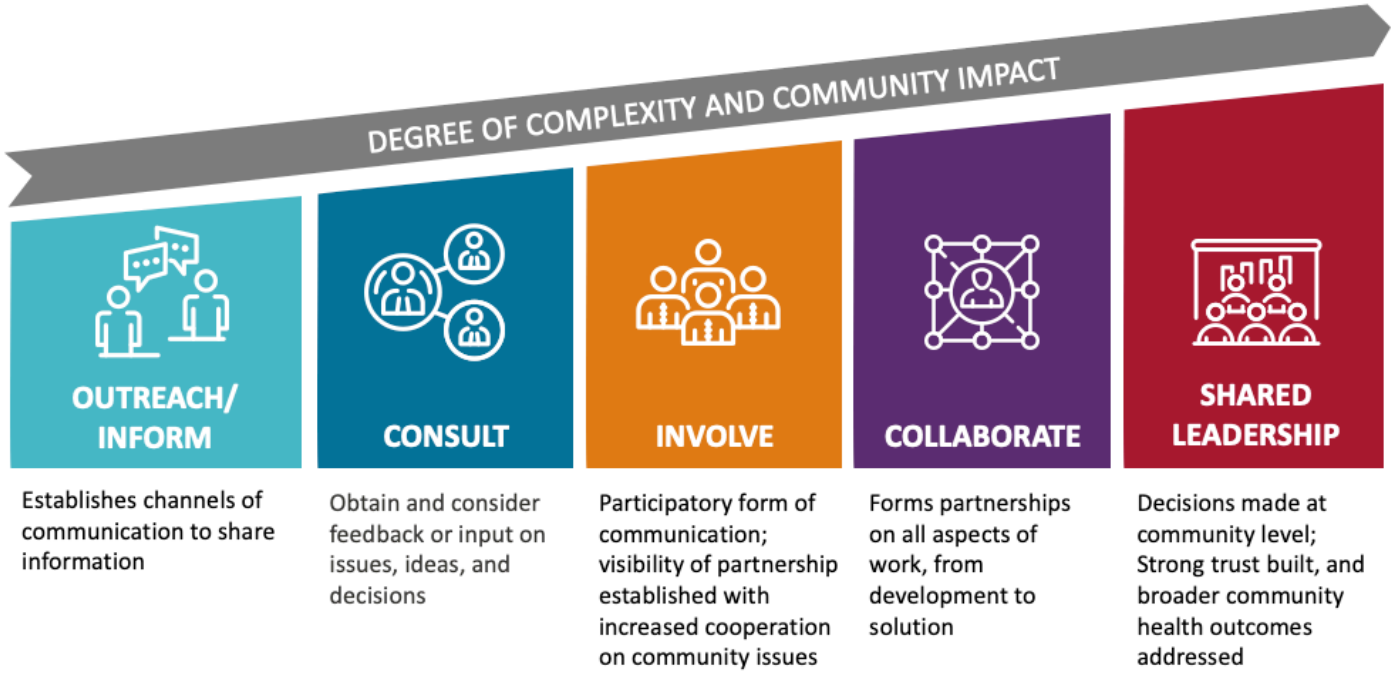
Starting in 2023, Presbyterian Community Health (CH) and PHP Population Health and Quality developed a formal partnership integrated into PHP's Population Health Framework for Turquoise Care. The goal of the **CH and PHP Regional Partnership** (Regional Partnership) is to leverage our collective strengths, collaborate to conduct meaningful community engagement to inform initiatives, and develop population-based strategies and programs in rural and regional areas of New Mexico to improve the health of members, patients and communities. The partnership was championed by PDS and PHP leadership, with intention to deploy an integrated approach in areas of the state that experience the biggest challenges to care.



The goals of the Regional Partnership are to build community trust and engagement, understand members' lived experiences, build community and community-based organization (CBO) capacity, and develop programs that bridge health and social care. The first phase of the Regional Partnership is focused on counties in northern and southern New Mexico, where there are significant health disparities and community readiness for engagement. Our model employs locally-based staff who serve as liaisons with community-based organizations, developing relationships with local leadership and community members and ensuring we have "on the ground" understanding of local needs.

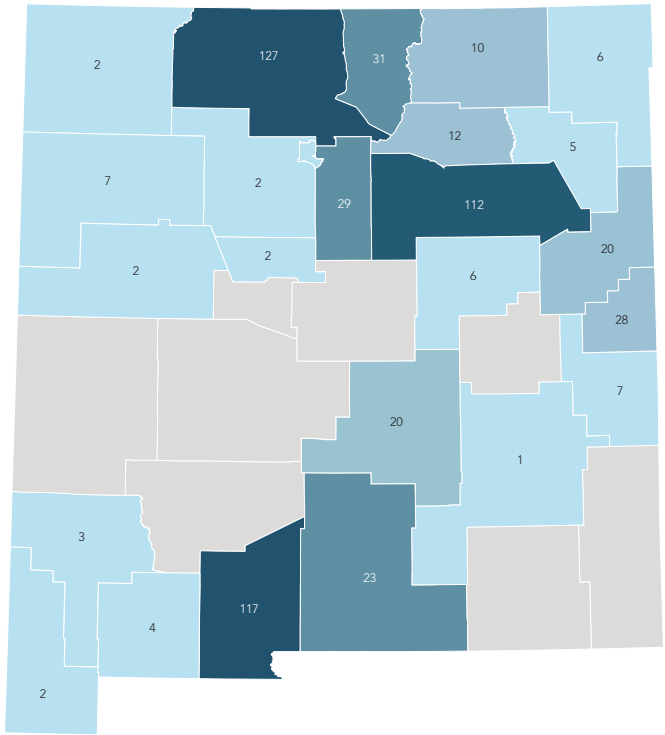
The CH and PHP Regional Partnership Model has four key areas of focus: Community Engagement, Priority Population Action Plans, the Voices for Equity (VFE) Community Ambassador Program and Formalized Partnerships and Interventions.

COMMUNITY ENGAGEMENT: INCORPORATING COMMUNITY VOICE TO IMPROVE EFFECTIVENESS OF SERVICES



Successes and Impact

- Expanding and deepening community engagement efforts:
  - The regional team completed **478** community engagements in 2024. Engagement includes participation in health councils, early childhood coalitions, and 100% action committees. # of engagements broken down by region served
  - The number of engagements by region served: northern **229**, southern **165**, eastern **29**, statewide **55**.
  - The team developed and launched a CBO Tracking Salesforce platform in 2024 with the goal of coordinating and tracking community engagement efforts across the Presbyterian enterprise.



**Breakdown of encounters by county: each engagement can serve multiple counties so the total number in the visual will exceed the total count of encounters (478).*

PARTNER SPOTLIGHT: SAN MIGUEL COUNTY EARLY CHILDHOOD COALITION

In 2023, our regional team began attending the San Miguel County Early Childhood Coalition (SMCECC), who quickly emerged as a key organizer and trusted messenger in a maternal and care health desert. Small but mighty, and deeply connected, SMCECC was the first partner to join the Voices for Equity Ambassador program, facilitating a focus group with seven participants in attendance. After a successful partnership, SMCECC became a clear fit for the expansion of the Northern Roots Food Is Medicine Intervention into Las Vegas. SMCECC has engaged a wide range of community organizations in program referrals, including the Court's behavioral health navigator, Women, Infant and Children (WIC), First Born Home Visiting, Children Youth and Families Department (CYFD), and more. Partnering with SMCECC has played a critical role in expanding services tailored to the needs of San Miguel County.

VOICES FOR EQUITY (VFE) COMMUNITY AMBASSADOR PROGRAM: ELEVATING MEMBER EXPERIENCE

VFE is designed to engage with and collect meaningful Turquoise Care member feedback that results in responsive and strategic actions that improve health outcomes and access to care. By partnering with trusted CBOs, VFE uses a collaborative and community led approach to give community members a more direct say in the design and delivery of their care and services. CBOs provide a structured conduit for Community Health to gain first-hand knowledge of the values, beliefs, perceptions, and cultural experiences of members in targeted populations. These insights inform specific Population Health Management strategies. PHP and PHS can utilize this feedback to fill gaps in communications, programs, and policies to ensure community needs are centered and prioritized.

Successes and Impact

- Three ambassadors joined the program: the Food Depot, SMCECC and Southern Area Health Education Center (SoAHEC).
- Co-designed focus group with PHP leadership on maternal virtual care to support the perinatal population. Completed **three in-person focus groups** and **one interview** conducted virtually by the Presbyterian team **(N =20)**.
- Identified **40 actionable recommendations**, more than 80% of which are already in process across various perinatal initiatives.

Community Testimonials:

PARTNER SPOTLIGHT:

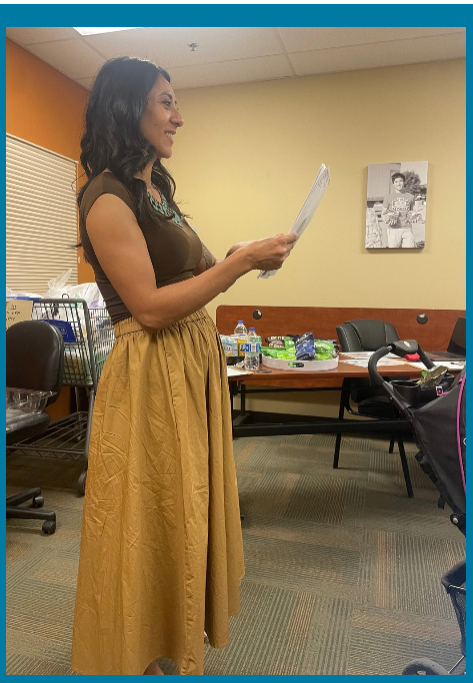
"Several participants from the focus group have started coming to Coalition events who weren't attending before. There's more of a bond around that shared experience" **- SMCECC Ambassador**

When asked why they decided to participate in the focus group, one person said, *"because of my experiences and I think so many people on Medicaid fall through the cracks."*

Measuring Success in 2025

VFE will expand to additional counties with a focus on New Mexico Health Care Authority (NMHCA) targeted populations in specific high disparity geographies. Our work will:

- Measure the impact of collaboration and alignment with PHP and PHS teams.
- Evaluate and track recommendations from focus groups.
- Implement a feedback loop with ambassadors and community partners.
- Continue to align focus group topics with PHS and PHP measures.



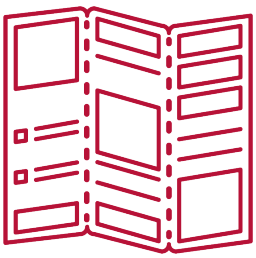
Val, Food Depot Ambassador, facilitating a VFE focus group.

Center for Health Innovation Public Health Institute

The San Miguel County Early Childhood Coalition

THE FOOD DEPOT
NORTHERN NEW MEXICO'S FOOD BANK

PRIORITY POPULATION ACTION PLANS: TAKING A DATA- AND COMMUNITY-INFORMED APPROACH TO ADVANCE COLLECTIVE GOALS



Strong community partnerships fostered through the Regional Partnership ensure our priorities, strategies, and plans for implementation are aligned with HCA and community needs. The Regional Partnership staff synthesized PHP and PHS data, existing Community Health Needs Assessments and Community Health Improvement Plans, qualitative data from community engagement activities, and other relevant inputs to identify priority population needs, assets, and opportunities. The team coordinates with key PHP departments (e.g., Performance Improvement) to develop joint strategies that provide a roadmap to **advance Turquoise Care measures, programs and requirements**.

Successes and Impact

- Built an action planning framework for the perinatal population in each priority county that will expand in 2025 to demonstrate tangible, integrated actions for each HCA priority population, including formalized partnerships, investments and evidence-based programs that tie to Turquoise Care measures and PHP and PHS shared goals.

- PHP and Regional CH executed a data sharing agreement that builds data capacity and expands our collective population health approach.

Measuring Success in 2025

Q1

Implement systems to collect, synthesize, and use various data sets to identify ongoing priority population needs, assets, and actions.

Q2

Implement a perinatal action plan and perform ongoing evaluation of impact.

Q3

Implement a children action plan and perform ongoing evaluation of impact.

Q4

Implement a Native American and Indigenous action plan and perform ongoing evaluation of impact.

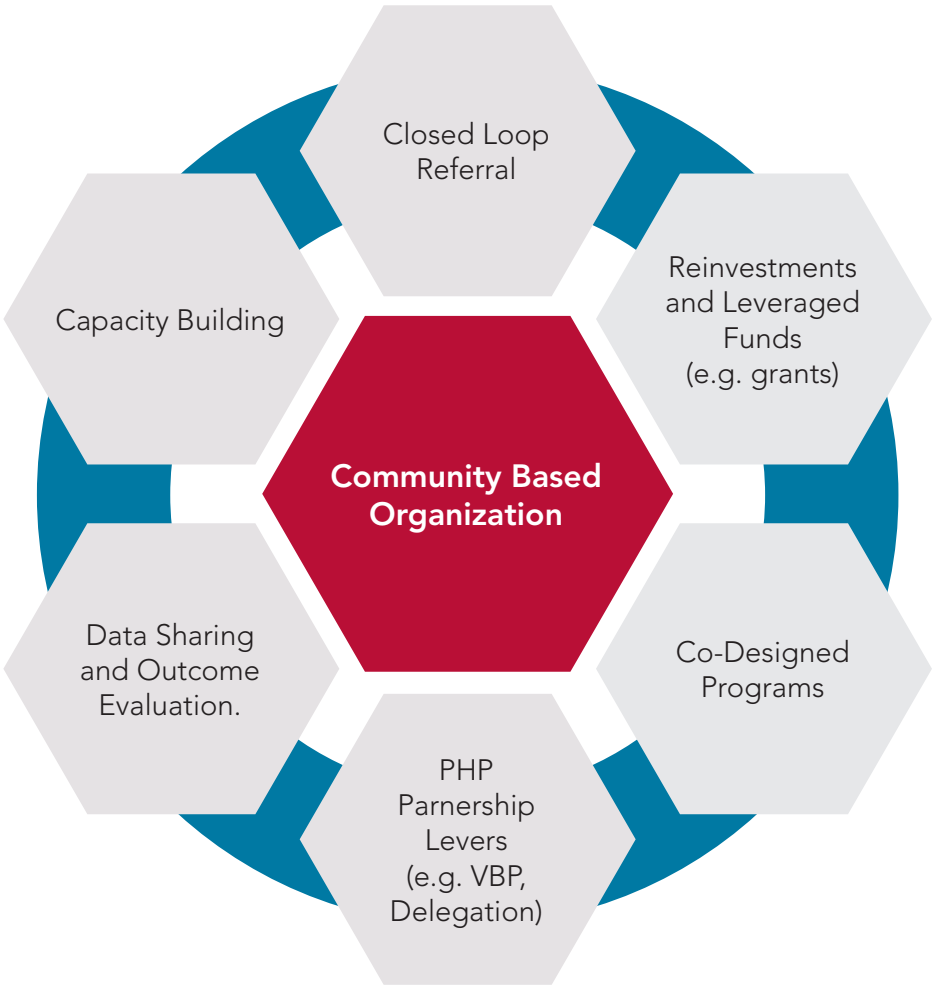
CO-DESIGNED PARTNERSHIPS AND INTERVENTIONS TO ADDRESS WHOLE PERSON CARE

In collaboration with PHP and building off priority population action plans, the CH team implements data-informed formalized partnerships, investments and/or evidence-based programs that tie to Turquoise Care measures and regional partnership goals.

Successes and Impact

Food Is Medicine Strategy and Summit

PHS continues to be a statewide leader for advancing Food Is Medicine (FIM) strategies. PHS played a lead role in planning and sponsoring the first ever FIM Summit held in November 2025. Meg Moore, Vice President of Population Health and Quality Strategy, and Carrie Thielen, Director of Regional Community Health, participated in two expert panels highlighting the longstanding impact of FIM programs at PHS, and the future of using Medicaid to sustain and scale programs.



Community Investments:

The Regional Partnership invested a total of **$180,000** in community organizations to implement and support programs, strengthen capacity building, and expand services.

Strengthening the social care network in rural New Mexico

- **Las Cumbres Community Services** was awarded **$25,000** to the Que Cute Healthy Baby program to improve access to and support of maternal and obstetrics care in rural communities in Rio Arriba and San Miguel counties. Through this funding, 51 new clients were served. All of the pregnant people in the Que Cute program received a prenatal and post-partum visit, and initiated breastfeeding, during the investment period. All clients' Social Determinants of Health (SDOH) needs were identified and resolved; they received a warm handoff to the home visiting program for ongoing support.
- **Mentioned in the Press**
  - *Santa Fe New Mexican Article Spotlight*

- *PresNet Article Spotlight: Las Cumbres & Community Foundation of SNM Investments*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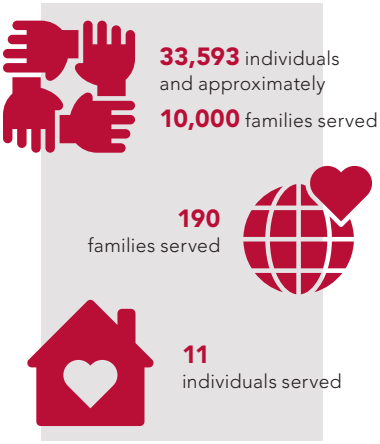
May 20, 2024

Supporting maternal care opportunities in northern New Mexico

As part of its commitment to improving perinatal care in New Mexico, Presbyterian Health Plan (PHP) is partnering with Las Cumbres Community Services, a community-based organization in northern New Mexico.

PHP made a $25,000 community investment to strengthen Las Cumbres ¡Que Cute! Healthy Baby program, which reduces stressors on moms and babies by connecting them to care navigators, resources and support systems.

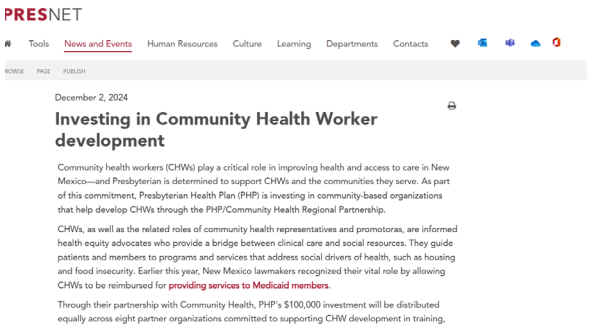
Access to prenatal care is an important indicator of maternal and child health. But health-related social needs, like inadequate housing, food and transportation, can impact how and when people receive care.



- In partnership with the Community **Foundation of Southern New Mexico** (CFSNM), **$25,000** was awarded to:
  - **Casa de Peregrinos (awarded $10,000):** Investment expands food distribution to rural areas of Doña Ana County.
  - **The Women's Intercultural Center (awarded $10,000)**: Investment builds and strengthens CHW network.
  - **Grajeda-Huckaby Low Barrier Housing (awarded $5,000):** Investment supports individuals in need of immediate housing assistance in a time of need associated with crisis prevention, substance abuse issues and rehabilitation mental health.

Expanding Healthcare Access through Investing in the Community Health Worker Workforce:

- A one-time community investment of **$12,500** each was awarded to **eight CBOs ($100,000 total)** across northern and southern New Mexico to build CBO capacity to integrate and support the Community Health Worker/Representative (CHW/R) role and work towards billing and sustainable funding sources to cover the services they provide. In 2024, CH developed a comprehensive needs assessment to understand the current approach to employing CHWs within community organizations, understanding their existing infrastructure and training, and providing toolkits and resources to facilitate provider registration, credentialing, contracting and billing. The partnership will continue to support organizations through various trainings and Community of Practice convenings into 2025.
  - Partners Selected: Picuris Pueblo, Las Cumbres Community Services, La Semilla Food Center, Community of Hope, Rio Grande ATP, Rural OB Access & Maternal Service, Empowerment Congress, and the Non-Metro New Mexico Area Agency on Aging.
- *PresNet Article Spotlight: CHW Investment project*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December 2, 2024

Investing in Community Health Worker development

Community health workers (CHWs) play a critical role in improving health and access to care in New Mexico—and Presbyterian is determined to support CHWs and the communities they serve. As part of this commitment, Presbyterian Health Plan (PHP) is investing in community-based organizations that help develop CHWs through the PHP/Community Health Regional Partnership.

CHWs, as well as the related roles of community health representatives and promotoras, are informed health equity advocates who provide a bridge between clinical care and social resources. They guide patients and members to programs and services that address social drivers of health, such as housing and food insecurity. Earlier this year, New Mexico lawmakers recognized their vital role by allowing CHWs to be reimbursed for providing services to Medicaid members.

Through their partnership with Community Health, PHP's $100,000 investment will be distributed equally across eight partner organizations committed to supporting CHW development in training,

Measuring Success in 2025

The regional team will continue to collaborate with PHP to bring new and expanded strategic partnerships to fruition, grow the FIM strategy, scale or increase effectiveness of programs to priority geographies, make modifications based on learning and changes to the healthcare and community landscape, and evaluate impact.

BUILDING A REGIONAL FOOD IS MEDICINE APPROACH TAILORED TO EACH COMMUNITY

OVERVIEW AND GOALS

Food Is Medicine (FIM) is defined as food-based nutrition interventions integrated in health care systems to advance health outcomes, nutrition security and health equity through a multi-sector approach. Regional CH implements a wide variety of evidence-based and community-driven FIM programs.

"Working with the Community Health program at Presbyterian Santa Fe Medical Center has been rewarding not just for me as a physician and person because of my commitment to health, wellness and sustainability, but has benefited my patients in so many ways. I recommend the Diabetes ReCHARGE program and our new hypertension management class to all my patients with these chronic conditions. Not only are there documented improvements in their diabetes control, but my patients feel like they finally understand their condition and have agency in managing it. They have learned about nutrition, participated in the Food as Medicine Farmer's Market program and have built a community with other class participants. I love collaborating with the regional team and appreciate the Community Health programs enthusiasm for new ideas and finding creative new ways to improve the health of the people of our community. "

-Dr. Mara Saulitis – Medical Director at PMG St. Michael's

NORTHERN ROOTS: WHERE FAMILIES EAT, LEARN, AND GROW: INCREASING FOOD ACCESS AND WRAP AROUND

Support for Families in Northern New Mexico

The Northern Roots Produce Rx program is a comprehensive FIM intervention in Santa Fe, Rio Arriba and San Miguel counties, that provides families with 16 weeks of local fruits and vegetables at weekly food sites, CHW navigation to community resources, nutrition education and access to healthcare supports (e.g. well-child appointment support).

Participants are referred into the program through a provider or external partner referral to a clinic-based CHW for enrollment and support. The unique relationship between the provider and CHW has proven to be a key factor in overall engagement and retention in the program, and CHWs facilitate ongoing connection and trust among participants. The program eligibility recommendations include perinatal patients, children up to 18 years of age and their caregivers, and a diagnosis of food insecurity, diet-related conditions, and/or at the providers' discretion. Northern Roots also receives external partner referrals to increase priority population reach and build a community FIM network, including PHP Medicaid, El Centro Family Health in Española, SMCECC, Gerard's House, WIC, and Las Cumbres Community Services. Participation continues to double year-over-year since it began in 2021. The Northern Roots program supports increasing access to well-child checks and childhood immunizations in alignment with Turquoise Care goals.

- In 2024, 459 participants were referred to Northern Roots and 385 of those participants were enrolled
- 2,111 food bags were distributed, representing a local food investment of $87,102
- 69% were Medicaid recipients (over half are PHP Medicaid members)
- 83% identified as Latino/Hispanic and 4% identified as American Indian
- 66% of referrals were for children, 17% for pregnant or adult caregivers, 17% for grandparents or older kin raising grandchildren
- Post-survey data shows improvements in:
  - Access to Fresh Produce ⬆️45%-80%
  - Confidence in Nutritious Meal Prep ⬆️50%-85%
  - Knowledge of Healthy Eating ⬆️55%-90%
  - Household Food Security ⬆️40%-75%
  - 100% of post-survey respondents reporting a positive or very positive experience
    - "So wonderful. The kids loved unpacking the groceries and developed a bond with Alice."
    - "It was great! Allowed extra time with my daughter cooking and experiencing new foods."
    - "Really helped me to realize importance of diet and consistency."

American Diabetes Association FIM Research Study: Contributing to Body of Research on Impact of Produce Rx on Diabetes Outcomes

In 2024, regional CH partnered with the American Diabetes Association, New Mexico Farmers' Marketing Association, and Gretchen Swanson Center for Nutrition to study the impact of the Fresh Rx farmers market voucher program on the health and lives of patients diagnosed with type 2 diabetes. As one of four states selected for this first-of-its-kind FIM study, Pathway for Produce Prescriptions in Diabetes Management (PPT2D) employed a robust, mixed methods approach, including an intervention group (N= 40) and a control group (N= 27), measuring changes in A1C (Primary), the D6 Bundle, Food Insecurity, and Dietary Intake and Behaviors vs. Standard of Care. Study results will be available in 2025.

"I look forward to picking up my produce bag every week because I get to talk to CH staff at the clinic who are always helpful and informative."
- PPT2D study participant

Patients enrolled in the intervention group received a 16 week Community Supported Agriculture and shared overall positive feedback about the program, including connection to ongoing support for social drivers of health, and physical and mental health outcomes.

Santa Fe Farmers Market - Del Sur: Increasing Access to Healthy Food on the Southside of Santa Fe

Regional CH partnered with the Santa Fe Farmers' Market and Santa Fe Farmers' Market Institute for the seventh season to host the Del Sur Market at Presbyterian Santa Fe Medical Center (SFMC), providing a total investment of **$17,700**. Del Sur Market supports equitable access to nutritious, local food in the 87507 zip code of Santa Fe, with higher-than-average utilization of SNAP, WIC, and other food benefits. Regional CH partners with Cooking with Kids for nutritious snack demos at the market. We partnered with SFMC providers to give patients produce vouchers to use at Del Sur as part of comprehensive FIM programming. A highlight of the market for both farmers and SFMC staff is employee wellness days, during which $10 vouchers are provided to staff to purchase produce with. In 2024 Del Sur Market hosted over 26 community-based organizations, Presbyterian Home Health, and Medicare outreach, to provide wrap-around resources, education, and entertainment for market goers.

Santa Fe Medical Center Teaching Kitchen:
A Hands-on Approach to Healthy Eating and Nutrition

Regional CH partners with registered dietitians and New Mexico State University's extension office to provide classes that support health lifestyle skills, knowledge, and habits. Healthy eating classes provide opportunities to learn basic cooking methods, knife handling skills, food safety, family cooking, and recipe modifications. Classes also provide guidance and nutrition support for management of chronic health conditions such as hypertension, diabetes, and weight management. Active living classes aim to decrease stress while providing support to improve strength, flexibility, and promote overall wellness, no matter the fitness level.

In 2024 we provided:

- Four Cooking Matters for Adults classes, totaling 63 participants
- Four Sprouting Kitchen nutritious cooking workshops
- Two Kitchen Creations, one Stress and Resilience, and one Walk with Ease class

Tuesdays
3pm - 6pm

July 2 -
Sept. 24

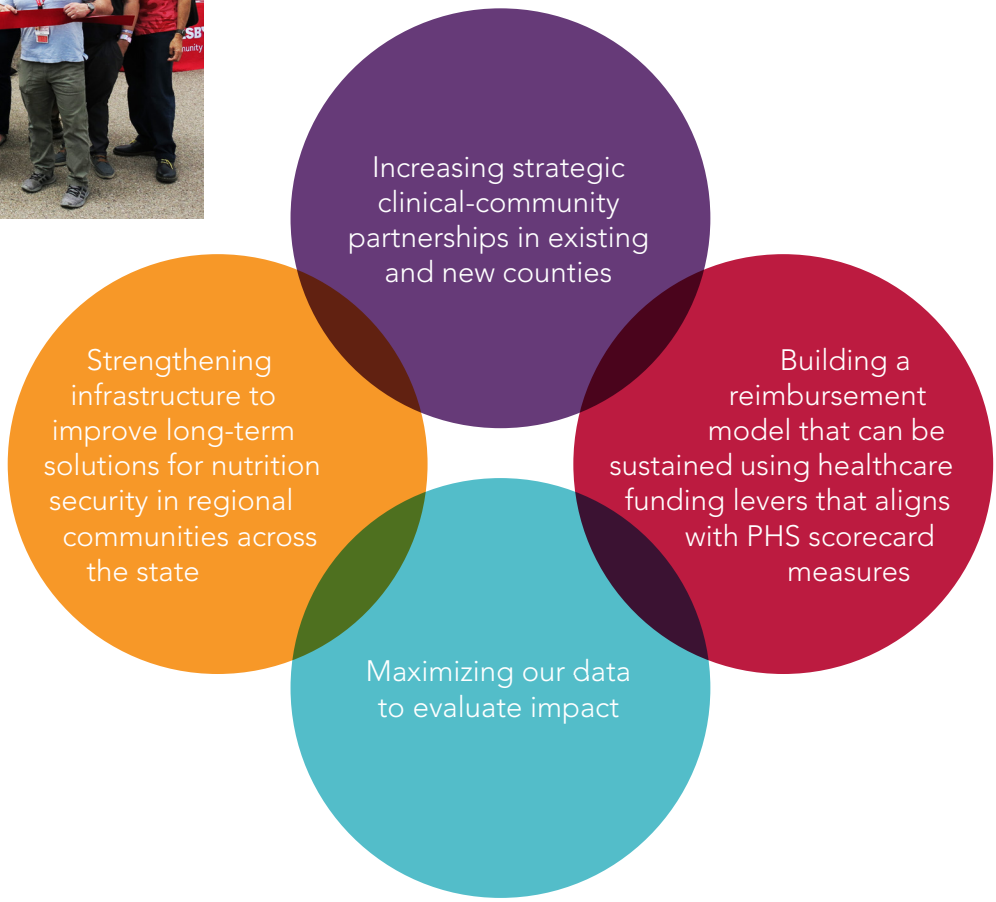
SANTA FE FARMERS' MARKET
LOCALLY GROWN
EST. 1968

Located in the Main Parking Lot at Presbyterian Santa Fe Medical Center 4801 Beckner Rd.

Santa Fe Farmers' Market partners

SANTA FE FARMERS' MARKET INSTITUTE

PRESBYTERIAN Community Health



REGIONAL COMMUNITY HEALTH WORKER MODEL: INCREASING ACCESS TO SOCIAL CARE AND HEALTH EDUCATION

OVERVIEW OF PROGRAM

The Regional CHWs serve as key members of the care team for many of our patients and members. The Regional CHW team includes a CHW supervisor and three full-time CHWs embedded in our healthcare delivery system at Santa Fe Medical Center, St. Michael's PMG clinic and Presbyterian Española Hospital (PEH). CHWs receive referrals directly from Santa Fe Medical Center providers and community organizations and navigate patients to Northern Roots or formal diabetes and hypertension education programs, provide patient education within their scope of work and address patients' social needs using the UniteUs closed loop referral system.

COMMUNITY HEALTH WORKER CLINIC INTEGRATION AND PARTNERING WITH COMMUNITY ORGANIZATIONS

The Regional CHWs received a total of 1,085 referrals in 2024 including 459 for Northern Roots (42% of total referrals), 235 for Diabetes Education (22%), 173 for basic social needs (16%), 73 for hypertension or high cholesterol education (7%) and 145 (13%) for other reasons. A total of 55 providers across 21 departments submitted referrals in Epic. Additionally, a total of eight referrals were received externally. External referrals have grown exponentially since 2025 as the process for referral was socialized with community partners and more organizations were trained to refer their clients to our programs.

Program Referred	Total	% Referred
Northern Roots	459	42%
Diabetes Education	235	22%
Basic Social Needs	173	16%
Other	145	13%
Hypertension Education	56	5%
High Cholesterol	17	2%
Total	**1,085**	**100%**

Age Group	Referral Count	Percentage
Minors (0-17)	314	36%
Adults (18-64)	373	43%
Seniors (65+)	188	21%
Total	**875**	

In 2024, 47% of the referrals were for patients over the age of 45 and 11% were for patients between the ages of three and 11. An estimated 44% of patients who had a CHW encounter had Medicaid, 28% had Medicare and 20% Commercial coverage. Of the 1,085 referrals through Epic, 39.9% were for PHP covered members (n=433). Of those PHP members who were referred to Regional CHWs, 64% (n=276) had PHP Turquoise Care coverage, 16% had PHP Medicare (n=72) and 20% (n=85) had PHP Commercial coverage with the vast majority from PHP Administrative Services Only (ASO) contracts.

Age Band	Referral Count	Percentage
0 - 2	72	8%
3 - 11	96	11%
12 - 17	77	9%
18 - 34	149	17%
35 - 44	69	8%
45+	412	47%
Total	**875**	**100%**

Payor Mix Category	Subcategory (if applicable)	Referral Count	% of Total
Commercial		**173**	**20%**
	PHP Commercial	85	49%
	Other Commercial	89	51%
Medicaid		**383**	**44%**
	PHP Medicaid	276	72%
	Other Medicaid	107	28%
Medicare		**245**	**28%**
	PHP Medicare	72	29%
	Other Medicare	173	71%
Other/Unknown		**73**	**8%**
	(blank)	54	74%
	Other	19	26%
Grand Total		**875**	**100%**

COMMUNITY HEALTH WORKER SUPPORTED HEALTH EDUCATION PROGRAMS

Payor Mix Categories	Referral Count	Percentage
Medicaid	383	44%
Medicare	245	28%
Commercial	174	20%
(blank)	54	6%
Other	19	2%
Grand Total	**875**	**100%**

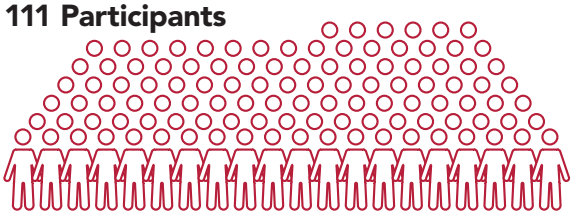
Expanding Access to Diabetes & Heart Health Education

The Regional CHWs have played an integral role in expanding access to diabetes education through Diabetes ReCHARGE and Kitchen Creations classes. Diabetes ReCHARGE is an ADCES-accredited class that was developed by Community Health in 2020 and delivered virtually beginning in 2021. Since inception, there have been a total of 251 participants who learned about diabetes and nutrition, reading labels and understanding blood sugars, meal planning, physical activity, medication management and relieving stress. Kitchen Creations is a four-week hands-on cooking and nutrition series for adults with diabetes that covers meal planning, balancing carbohydrates, vegetables and grains, and heart healthy cooking. Participants receive incentives, including a cookbook, and build community through shared meals.

Impact

- Between 2023 and 2024, a total of **111** individuals in northern New Mexico were enrolled in Diabetes ReCHARGE, including 23 in 2023 and 88 in 2024 across **nine, four-week cohorts**.
- In 2024, individuals participating in Diabetes ReCHARGE across all sites dropped their A1c values by 0.51 (7.83 pre to 7.32 post).
- Since the start of Diabetes ReCHARGE in 2021, there has been an average drop in A1c by 0.83 points, exceeding the ADA's definition of a meaningful drop in A1C of 0.51%.

111 Participants



Diabetes ReCHARGE Sessions in 2024:

- 28 classes
- Eight post-program Connections Sessions
- Seven cohorts
- Three in-person sites
- Virtual options available

Kitchen Creations Classes in 2023-2024:

- Expanded access to diabetes education with hands-on cooking in Rio Arriba, Quay, Curry and Doña Ana counties
- A total of six, four class series were offered in 2024 including three series in Spanish
- 125 individuals participated in the six cohorts of the four-class series in 2024
- A total of three cohorts of the blood pressure self-monitoring program were delivered by CHWs at Presbyterian Española Hospital (PEH).

Additionally, CH partnered with the New Mexico Farmers' Marketing Association to establish a market ambassador program that will launch in 2025. The New Mexico Farmers' Marketing Association will have seven ambassadors at each of the farmers markets in Abiquiu, Clovis, Dixon, Española, Santa Fe, Las Vegas and Tucumcari throughout the 2025 market season to help provide information to participants about upcoming diabetes classes. Through this partnership, we were able to provide a $20 voucher to all who participated in classes, with up to $80 for participating in the four-class series. A total of 84 individuals living in Rio Arriba, San Miguel, Quay, Curry and Santa Fe Counties received vouchers and $4,940 in vouchers were distributed for the purchase of fresh fruits and vegetables.

Expanding the Network of Those We Support

In addition to expanding support for clinic referrals, the CH team also worked to build formal partnerships with Quay and Curry Health Councils, El Centro Family Health, Bridge to Health in Rio Arriba County and the Food Depot to market and disseminate information about upcoming diabetes offerings through their networks. El Centro Family Health, Bridge to Health and the Food Depot have also been trained to refer any of their clients to our CHWs for navigation to diabetes education opportunities. Finally, a series of three diabetes podcasts were recorded with the Quay County Health Council on diabetes education including the role of insulin and glucose, portion control and carb counting and how to balance food choices. These podcasts are hosted on a public YouTube channel that can be shared widely with patients, members and community members.

Professional Development

In addition to supporting our patients, CH has also developed new professional development trainings for CHW/CHRs, Promotoras and other healthcare professionals around the state to understand food insecurity and the important role of food and nutrition in health. This 90-minute training was offered twice in 2024 and 75 individuals participated in the training. Additionally, our team collaborates with the Health Equity team to provide support for health equity training. In 2024, a total of 51 training sessions were hosted and there were more than 1,300 individual attendances. A total of 157 community members participated in the training along with 237 non-PHS clinicians and 183 members of the PHS workforce. The CH team is also working with an external consultant to conduct focus groups and key informant interviews to understand what resources are available to CHWs working in diabetes, where there are gaps and how to work closely with the Office of CHWs to continue building out trainings to support the engagement of CHWs in diabetes prevention and education across the state.

Building the Closed Loop Referral Network

Our CH team continues to support statewide closed-loop referral efforts and participates in the statewide Social Drivers of Health Collaborative meetings. Our CHW training and models of care emphasize the use of UniteUs to connect patients to social services to address their social services and support needs/ social drivers of health. Additionally, we are continuing to socialize the role of a closed loop referral with community partners and continuing to build out a network of social service organizations to whom our CHWs can refer. We actively worked with Santa Fe Connect and community leaders in Rio Arriba, Taos, San Miguel, and Doña Ana counties to identify and support capacity for closed loop referral networks. In 2024 we also developed a contractual partnership with Santa Fe Connect to receive referrals into the Northern Roots program, and for the first time are fully participating in the closed loop network.

"I am a single mother with an 8-year-old daughter. I could not find adequate housing for me and my child and when I did, I could not afford the rent. Then one day I went to see my doctor at Presbyterian Española Hospital who referred me to a CHW who was able to help me find a place with help from the Flex Fund program. The CH team helped me pay for my new place, which was a lifesaver. I don't think you realize the difference the CH team can make to someone like me who was at rock bottom. I cannot thank you all enough for your kind assistance and for giving me a chance to rebuild my life and hope for the future."

– Patient in Española