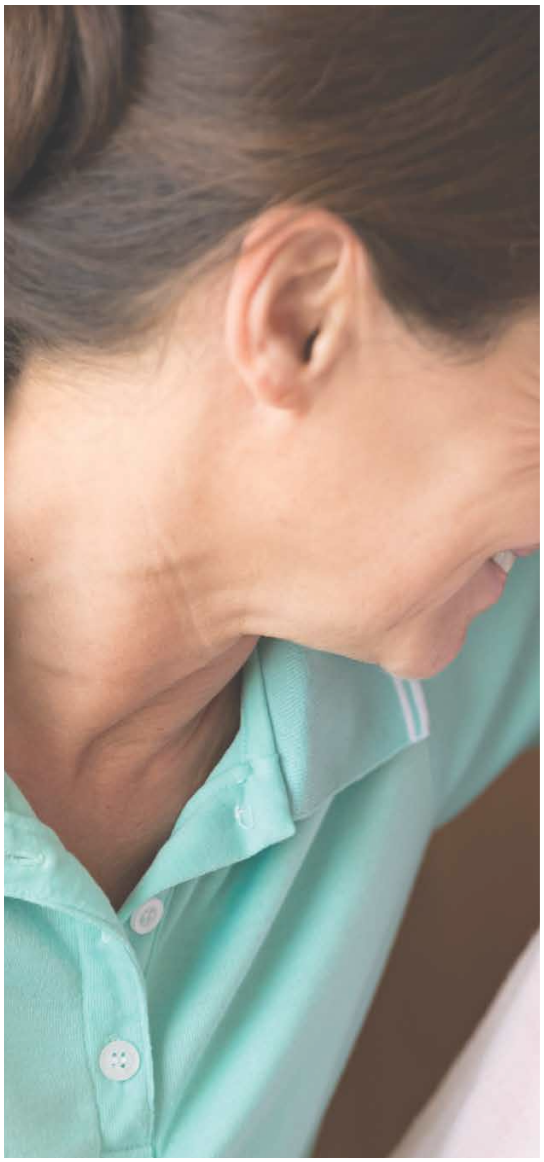

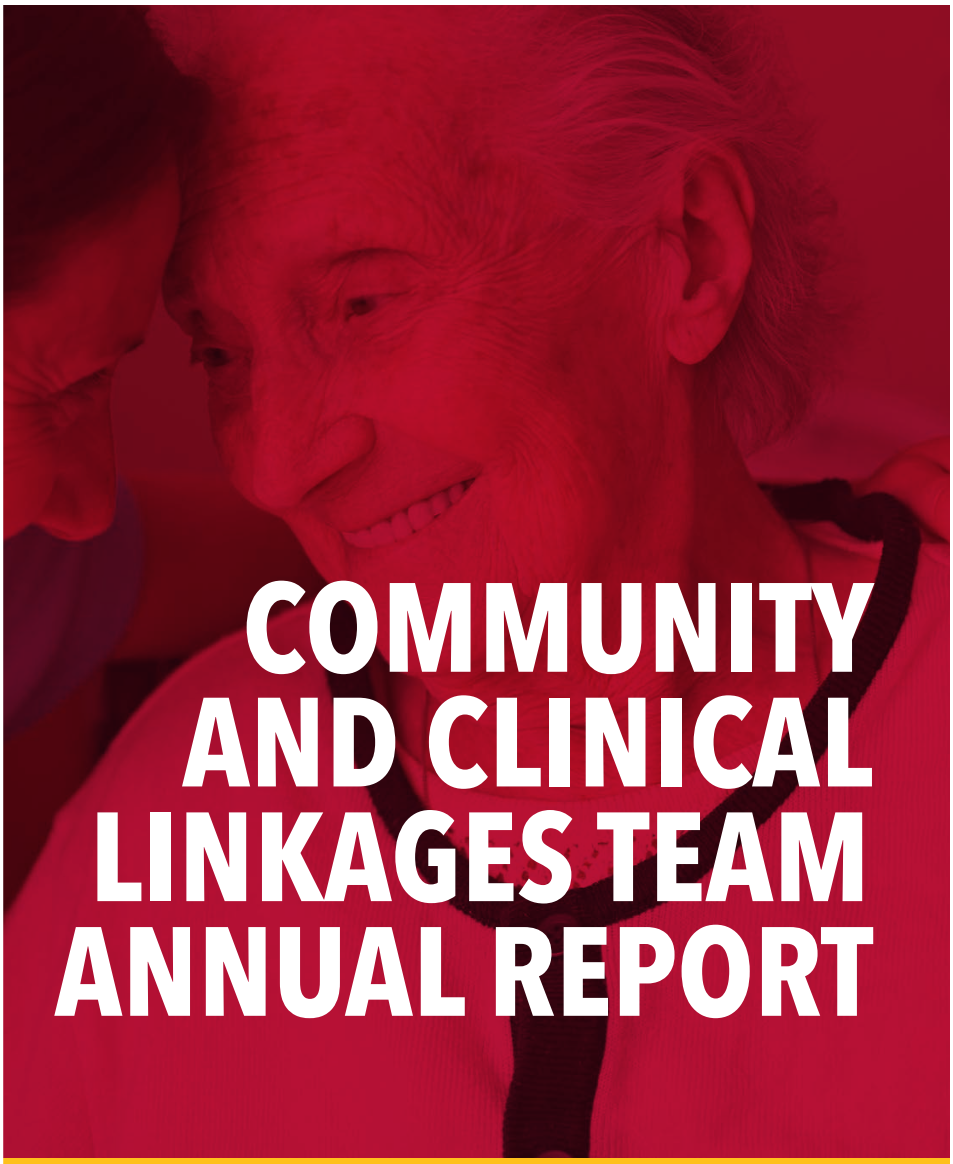

COMMUNITY AND CLINICAL LINKAGES TEAM ANNUAL REPORT

PRESBYTERIAN
Community Health

Calendar Year (CY) 2024

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Executive Summary

The purpose of this report is to provide an annual update of the programs and activities of the Community & Clinical Linkages (CCL) Division for Calendar Year 2024. The work of this division is informed by and directly extended from Presbyterian's 2023-2025 Community Health Assessment and Implementation Plans. During this reporting period, the portfolio of work as well as the organizational structure for the CCL division significantly broadened to now include:

- **Health-Related Social Needs** - Implementation and Evaluation of enterprise-wide Health Related Social Needs (HRSN) Screenings.
- **Closed-Loop Referral Technology** - Facilitation of Integration of closed-loop referral technology via the Unite Us platform.
- **Integration of Community Health Workers** - Integration of Community Health Workers (CHWs) within primary care and specialty care within the Central Delivery System (CDS).
- **Integration of Peer Support Specialists** - Integration of Peer Support Specialists (Peers) with emergency department and specialty care settings in both the Central and Regional Delivery Systems.

Relevant status updates as well as programmatic successes and achievements for this reporting period include, but are not necessarily limited to:

- **655,932** patients responded to HRSN screening questions
- **229,000** personalized resource lists were generated for Presbyterian Healthcare Services (PHS) patients through Unite Us last year
- **1,128** referrals received across all CDS CHWs programs
- **4,790** unique patients were engaged by Peers in PHS emergency departments and in Perinatal and NICU specialty care settings

The continued patient and provider demand for CHWs and Peers services remains noteworthy. During this reporting period there was an approximate 75 percent increase in referrals received across all CDS CHWs programs. Demand for Peer services within PHS emergency departments also remained steady with a marginal decrease of engagements with unique patients compared to CY 2023. Variations in demand for peer services and patient engagement are expected as successful peer engagement strategies that promote timely linkage to care will reduce patient emergency department (ED) utilization related to substance use concerns.

As the CCL Division continues to expand its mission-critical body of work on behalf of the PHS system, it has also sought to enhance its partnerships with relevant PHS stakeholders through synching with enterprise priorities, optimizing EPIC referral workflows and functionality, and through actively engaging in quality improvement efforts. In this report, we will provide updates on enterprise-wide efforts and site-specific and clinic-specific programmatic updates as well as relevant programmatic success stories. The invaluable and tireless work across the CCL division continues to fundamentally align with our overarching vision and commitment to community health.

The Community & Clinical Linkages Division

The CCL division includes CHWs, Peer Support Specialists (Peers), supervisors, operations managers, and staff focused on systems design, implementation, and data insights. CHWs and Peers are frontline staff who work directly with patients to address social and behavioral health needs. They bring lived experience, cultural knowledge, and strong connections to the communities they serve. Program managers and infrastructure staff support the design, implementation, and continuous improvement of the programs and systems that make this work possible. Together, the team blends direct service with systems transformation to advance equity-driven strategies across Presbyterian.

Organizational Structure & Approach

Our work is guided by Presbyterian's Community Health Assessment (CHA) and Community Health Implementation Plan (CHIP), which are developed every three years through a community-driven process. These plans identify the top health priorities across the communities we serve and establish strategic goals in the areas of social health, behavioral health, and physical health. See Appendix 2 for more detail regarding the CHA and CHIP. All our work is rooted in a commitment to health equity, cross-sector collaboration, and creating systems that are both scalable and responsive to the communities we serve. Our strategies are designed to advance this shared vision through **Systems Transformation and Direct Patient Support**.

Systems Transformation

CCL builds key infrastructure, policies, and partnerships to integrate social care into healthcare. Through universal screening for health-related social needs (HRSNs), referral coordination, and CHW and Peer program development, we create scalable, sustainable solutions that ensure HRSNs are systematically identified and addressed as part of routine clinical encounters. Healthcare systems are evolving, driven by regulatory and accreditation requirements, as well as a growing commitment to health equity as a fundamental pillar of high-quality care. There is increasing recognition that achieving equitable health outcomes requires a holistic approach—one that goes beyond clinical care to address the broader factors that influence health.

Direct Patient Support

CCL bridges healthcare, behavioral health, and social care—helping providers, care teams, and community partners work together to connect patients to the support they need beyond the clinical setting and driving change at the individual and community levels. CHWs and Peers are essential connectors between healthcare, patients, and community-based services. They enhance whole-person care by addressing patients' social, behavioral and physical health needs while improving patient experience and engagement. CHW and Peer models strengthen care teams and provider capacity by reducing workload and improving care coordination, while also contributing to high levels of satisfaction among care team members, who recognize CHWs and Peers as invaluable partners in delivering equitable, patient-centered care. Through CHW and Peer models, we intentionally invest in a direct service strategy that strengthens connections between patients and systems designed to support them.

Key Strategies

By seeking impact at multiple levels, CCL ensures that our healthcare system is both effective at scale and deeply responsive to the communities we serve. Our work strengthens the link between healthcare providers, community-based organizations, and patients—championing health equity as a guiding principle as well as a reality embedded in how care is delivered. CCL's work is guided by five key strategies which support strategic goals in the 2023-2025 Community Health Implementation Plan:

- **Embed social care into healthcare**
- **Integrate CHW and Peer roles into clinical settings**
- **Support patients through CHW and Peer-led services**
- **Use data to drive system improvements**
- **Ensure long-term sustainability and scalability of our work**

Embed Social Care into Healthcare

Continuously improving our universal screening for HRSNs and referral pathways ensures patients are consistently screened for HRSNs and provided recommendations for community-based organizations to better address unmet needs. Our work in this area is focused on integrating social care into clinical practice so that it is a routine part of care delivery and aligns with enterprise priorities for health equity, value-based care, and quality improvement. Focus areas include:

- Position social care and peer support as essential to delivering safe, compassionate, and equitable care, not as standalone or ancillary programs.
- Refine and scale universal HRSN screening workflows to ensure patients are assessed at least twice a year for food, housing, transportation, utilities, and interpersonal safety needs — helping to identify barriers to health and support timely intervention.
- Enhance the EMR-integrated resource directory so care teams can provide patients with timely, tailored recommendations that improve access to services and reduce avoidable health risks.
- Advance the use of technology-enabled referral networks as a core infrastructure for care coordination, improving patient outcomes and easing care team burden by reducing manual tracking and follow-up.

Integrate CHW & Peer Support Roles into Clinical Settings

Establish clear roles, workflows, and collaboration models that position CHWs and Peers as essential members of care teams. Expand the CHW and Peer workforce to increase availability and ensure more patients can access their support. **Focus areas include:**

- Grow CHW and Peer workforce in alignment with clinical needs to expand patient access to their compassionate, personalized support services.
- Align CHW and Peer roles with clinical priorities to ensure their work directly supports safe, high-quality, patient-centered care.
- Utilize a technology-enabled referral network (Unite Us) to streamline coordination with community resources, improve tracking of patient follow-through, and reduce care team workload.
- Continuously refine CHW and Peer workflows to support strong collaboration with care teams, reinforce team member engagement, and strengthen overall effectiveness of whole-person care.

Support Patients through CHW & Peer-Led Services

Expand and strengthen our CHW and Peer-led services to improve patient navigation, advocacy, and access to resources. Utilize a technology-enabled referral network to coordinate referrals across healthcare, social services, and community resources. **Focus areas include:**

- Deliver personalized support to patients facing barriers to care, including help with appointment management, transportation, and navigation – reducing missed care and supporting better health outcomes.
- Provide coaching, mentoring, education, and peer support to empower patients in recovery and behavioral health journeys, reinforcing compassionate, whole-person care.
- Build trust through culturally responsive, relationship-based services, ensuring patients from historically excluded populations feel safe, respected, and supported.
- Advocate for patients as they navigate complex healthcare and social systems, helping them overcome systemic barriers and access the resources needed to stay healthy.

Use Data to Drive System Improvements

Leverage HRSNs screening and referral data to identify trends, disparities, and opportunities for improvement. Evaluate referral effectiveness, identify process inefficiencies, and strengthen care coordination. Generate and share actionable insights from social care data to inform strategies and drive system-wide improvements. **Focus areas include:**

- Use patient referral data (Unite Us) to evaluate referral effectives, identify process breakdowns, and strengthen coordination between healthcare and community-based organizations
- Use data from HRSNs screenings (Tableau), resource referrals (Unite Us) and patient interventions (Epic) to identify needs, track disparities, and guide improvements that keep patients healthy.
- Generate and share actionable insights to inform equity-focused quality improvement, helping teams make data-informed decisions that enhance care delivery and align with enterprise goals.

Ensure Long-Term Sustainability and Scalability

Align strategies, activities and intervention with sustainable funding opportunities, reimbursement frameworks, and evolving healthcare models. Strengthen infrastructure and workforce support by ensuring CHWs and Peers have the tools, training, and resources needed to be effective in their roles**. Focus areas include:**

- Strengthen infrastructure and support for CHWs and Peers by ensuring they have the tools, training, supervision, and career pathways needs for long-term success.
- Align strategies, activities, and initiatives with enterprise to reinforce social care and behavioral health care as core elements of equitable, value-based, and high quality healthcare delivery.
- Establish sustainable internal funding structures that embed social care and behavioral health care into routine healthcare operations and ensure their long-term viability.
- Pursue external funding, policy alignment, and strategic partnerships to expand capacity, increase system impact, and support patients and communities over time.

Operational Highlights and Insights

During this reporting period, the portfolio of work as well as the organizational structure for the CCL division significantly broadened to now include:

- **Health-Related Social Needs** - Implementation and Evaluation of enterprise-wide HRSNs.
- **Closed-Loop Referral Technology** - Facilitation of Integration of closed-loop referral technology via the Unite Us platform.
- **Integration of Community Health Workers** - Integration of CHWs within primary care and specialty care within the CDS.
- **Integration of Peer Support Specialists** - Integration of Peers with emergency department and specialty care settings in both the Central and Regional Delivery Systems

The strategies outlined in the previous section reflect CCL's twofold approach to advancing health equity: systems transformation and direct patient support. Our efforts cut across multiple strategies and levels of impact—building infrastructure, policies, and partnerships while also delivering hands-on support to patients and communities. The following sections highlight key areas of our work and show how our team brings our strategies to life.

Health-Related Social Needs Screening

Supports strategies: Embed Social Care into Healthcare; Use Data to Drive System Improvements; Ensure Long-Term Sustainability & Scalability

A foundational element of our systems transformation work is the universal screening process for HRSNs, which our team oversees on behalf of the entire Presbyterian system. This enterprise-wide process ensures that all patients can be screened at least twice a year for key needs — including food insecurity, housing instability, transportation access, utilities support, and experiences of violence or abuse—and that those with identified needs automatically receive information about relevant community resources. By integrating a resource directory (Unite Us) directly into our electronic health record (Epic), we ensure that every patient is offered meaningful support at the point of care, without adding extra burden to providers.

This standardized approach enables us to identify HRSNs consistently and at scale, reduce variability and bias in how patients access social care, normalize conversations about HRSNs within clinical workflows, align medical and community-based interventions, and generate data that can inform equity-focused quality improvement across the system.

Highlights

HRSNs Screening Is System-Wide

- 56% of all Presbyterian patients have been screened since implementation
- Screening is now a routine part of care in all clinical settings
- Each screening represents an opportunity to connect patients with needed support

HRSN Screening is Embedded into Routine Workflows

- HRSNs screening has been embedded into clinical workflows across all PHS care settings—including primary, specialty, inpatient, emergency, and urgent care
- 2024 screening rates remained stable, demonstrating sustained integration across the system

Improved Coordination Through Interoperability

- Screening results are displayed as a color-coded wheel in the patient's chart.
- All care team members can view and act on the most recent screening responses.
- Shared visibility reduces duplication of screening efforts.
- Supports more efficient, coordinated, and patient-centered care.

Insights

While universal screening is a systems intervention, it also helps us better understand our patients. These data provide a foundation for understanding the broader HRSNs affecting our population. As we improve our data infrastructure, future analysis will help leaders across PHS identify patterns by location and population group—turning screening data into actionable insights for care coordination, resource investment, and strategic planning. During this reporting period:

- 655,932 patients responded to HRSN screening questions (2024)
- 11% of patients screened reported at least one HRSN
- The following were the top reported needs of patients screened:
    - Food insecurity (43%)
    - Transportation (28%)
    - Housing instability (20%)
    - Violence/abuse (8%)
    - Utilities (1%)*

**Note: screening for utilities began in December 2024*

Unite Us: Technology for Resource Recommendations and Closed-Loop Referrals

Supports Strategies: Embed Social Care into Healthcare; Support Patients through CHW and Peer-Led Services; Use Data to Drive System Improvements; Ensure Long-Term Sustainability & Scalability

Unite Us is the technology platform that powers our approach to addressing health-related social needs (HRSNs) at scale. Embedded directly into our electronic health record system, it enables both automated resource recommendations and coordinated referrals across healthcare and social service sectors.

Highlights

Unite Us Generates Automated Resource Recommendations at Scale

Each year, tens of thousands of patients who screen positive for HRSNs receive a personalized list of community resources, generated through Unite Us and delivered with their after-visit paperwork.

- Lists are generated automatically for patients who screen positive for HRSNs.
- Over 229,000 personalized resource lists were created for Presbyterian patients in 2024 alone.

Unite Us Coordinates Referrals Between Healthcare and Community-Based Organizations

Unite Us enables care teams to make direct, trackable referrals to community organizations. The platform serves as the backbone of a statewide closed loop referral network and allows teams to document patient consent, monitor referral outcomes, and coordinate follow up support. This strengthens connections between healthcare and community-based services.

- 1,384 community-based organizations across New Mexico are connected through the Unite Us referral network.
- The referral network is currently used by care teams across the PHS delivery system and health plan, including CHWs, Peers, Case Managers, RNs, MDs, APCs, Care Coordinators, EMTs and Call Center representatives.
- Case outcome tracking is built into every referral, enabling visibility into whether services were delivered, declined, or unavailable.

Insights

Unite Us data provides a powerful tool for continuous improvement. Because the platform tracks referral outcomes, we can identify where referrals are succeeding, where they are breaking down, and what systemic barriers may be preventing patients from connecting to services. These insights inform quality improvement efforts, resource planning, and partnership development, helping us strengthen the referral process and improve coordination between healthcare and community-based organizations.

As closed-loop referral adoption expands, Unite Us is emerging as a valuable source of data to guide system improvement. The platform's ability to track referral outcomes, identify follow-through gaps, and highlight high-performing partners positions it as a key tool for continuous quality improvement and equity-driven planning. For an overview of current referral metrics and the types of insights the system can generate, see Appendix 4.

Supporting Patients through CHW and Peer Services

Supports strategies: Embed Social Care into Healthcare, Integrate CHW & Peer Support Roles into Clinical Settings, Ensure Long-Term Sustainability & Scalability

At Presbyterian, CHWs and Peers form a social care team that brings lived experience, cultural insight, and trusted relationships into the care setting. Often members of the communities they serve, Presbyterian's CHWs and Peers work across healthcare settings to support patients in-person, by phone, or virtually. They offer patients accessible, relationship-centered care with a focus on connecting individuals to the community-based resources and support needed to improve their health and well-being.

While CHWs focus on addressing health-related social needs (HRSNs) such as food, housing, transportation, and utilities—Peers provide mentorship, recovery support, and guidance for those navigating behavioral health and substance use challenges. Together, they reduce barriers to care, improve engagement, and strengthen the link between healthcare, social services, and community life. Their work supports patients directly while also equipping care teams with the insight and tools to provide more holistic, person-centered care.

Summary of Key Results from CHW and Peers (2024)

In 2024, CHWs and Peer Support Specialists combined received nearly 1,600 referrals from providers across multiple care settings and provided support to more than 7,700 unique patients. Their work extended well beyond initial referrals, with over 16,800 documented patient interactions, reflecting the ongoing, relationship-based nature of their support. The table below provides a detailed breakdown of referrals, patient reach, and total interactions by role.

	CHWs	Peers	Total
Referrals from Providers	751	840	1591
Unique Patients Served	2633	5112	7745
Documented Patient Interactions	6476	10339	16815

While this report specifically focuses on CHWs and Peer efforts led by the CCL Division, we would also like to acknowledge the extensive body of similar work that is being done by the Regional Community Health Team which primarily serves rural communities across New Mexico.

Primary Care

PMG Las Estancias, PMG Constitution (Kaseman), PMG Atrisco and PMG San Mateo

CHWs play a key role in primary care clinics by helping patients navigate non-medical barriers to health. In these settings, CHWs build trusted, long-term relationships with patients, and help patients stay connected to preventive care. They often work with patients who have frequent emergency room visits or gaps in primary care, addressing challenges like housing, transportation, and access to food or medications.

Key Results from CHWs in Primary Care Settings (2024):

- 507 referrals to CHWs
- 1,388 patients received support from CHWs
- 3,813 total patient interactions recorded – reflecting ongoing, multi-touch nature of CHW support
- 304 patients participated in the Las Estancias Food Farmacy

The CHW program continues to extend its reach and presence across the PHS enterprise. In CY 2025, we anticipate extending CHW services to the following site and location:

- PMG Montgomery

Emergency Department: Peer-led SBIRT Initiatives

Espanola Hospital, Presbyterian Hospital, Kaseman Hospital

According to the New Mexico Substance Use Epidemiology Profile published by the New Mexico Department of Health (2024), all ten of the leading causes of death in New Mexico are at least partially attributable to the use of alcohol, tobacco, or other drugs. Additionally overdose death from opioids has remains of enormous concern the patients and communities that we serve.

To address these growing community-based concerns, we have stood up and implemented a peer-led Screening, Brief Intervention, and Referral to Treatment (SBIRT) program in multiple emergency departments across our PHS enterprise. Through this evidence-based public health approach, our Peer team can identify and engage with patients that may be struggling with substance use and abuse concerns.

Through leveraging their lived experience with their own recovery process, Peers work with patients to provide compassionate support to enhance patient motivation to seek the appropriate level and type of recovery-based care and treatment.

Our program has continued to expand its service offerings to include in-person as well as virtual peer support as needed to promote access to rural access and other regionally based hospitals. Additionally, our peer program continues to provide ongoing education and technical assistance within PHS, which will enable the continued launch of our program to new emergency department sites. Below is a summary of the ED locations where our SBIRT program is currently live.

In-person Peer Support Locations	Virtual Peer Support Locations
• Presbyterian Española Hospital • Presbyterian Hospital • Presbyterian Kaseman Hospital	• Plains Regional Medical Center • Dr. Dan C. Trigg Memorial Hospital • Lincoln County Medical Center • Presbyterian Santa Fe Medical Center • Socorro General Hospital • Presbyterian Rust Medical Center

Key Results from Peer-led SBIRT Initiatives in Emergency Departments (2024):

- 822 Referrals to Peers
- 4,596 patients received support from Peers
- 9,513 total patient interactions recorded – reflecting ongoing, multi-touch nature of Peer support

The Peer program continues to extend its reach and presence across the PHS enterprise. In CY 2025, we anticipate extending Peer and SBIRT services to the following sites and locations:

- All Central Delivery system emergency departments
- All PRES*Now* Locations

OB/GYN & Perinatal Care

PMG Pan American (Northside), PMG Las Estancias, Cedar Clinic, Presbyterian Hospital

CHWs support patients through pregnancy and post-delivery by helping them navigate care, understand key health conditions, and access critical services. At PMG Pan American and Cedar OB/GYN clinics, CHWs provide education on topics like hypertension, diabetes, and preterm labor, while also helping patients attend appointments and connect to family planning and pediatric care.

Peer Support Specialists complement this work by offering emotional support, advocacy, and guidance grounded in their own lived experience. In OB/GYN and NICU settings, Peers help patients manage stress, process their experiences, and build confidence during vulnerable moments. They play a unique role in supporting patients facing behavioral health challenges, substance use recovery, or complex social circumstances, particularly during the postpartum period and NICU stays. Together, CHWs and Peers form a collaborative support model focused on strengthening maternal and child health.

Key Results from OB/GYN & NICU Settings (2024):

- 262 referrals to CHWs
- 1,245 patients received support from CHWs
- 516 patients received support from Peers
- 2,663 total patient interactions recorded by CHWs
- 826 total patient interactions recorded by Peers

Pharmacy Specialty Care

PMG Las Estancias

At PMG Las Estancias, CHWs work directly with Pharmacist Clinicians to improve patient engagement and medication adherence for patients with chronic conditions like diabetes and hypertension. Their support includes glucometer troubleshooting, prior authorization support, and individual appointment reminders.

Key Results from Pharmacy-Integrated Support (2024):

- 1,117 engagements with pharmacy patients
- 1,129 interactions recorded (e.g., bilingual services, glucometer assistance, reminder calls)

Complex Case Management Collaboration

Population Health

In 2019, Presbyterian Community Health developed a partnership with the Population Health team in which CHWs work closely with complex case managers (CCMs) and transition of care (TOC) nurses to assist with complex patient needs and high-volume caseloads. CHWs have an in-depth understanding of the health-related social needs of the communities they serve and work closely with patients in the community and in their homes. During this reporting period the assigned CHW had:

- 340 referrals
- 204 open navigations
- 1361 contact attempts

Emergency Flex Fund

With Presbyterian Healthcare Foundation's generous financial support, the Emergency Flex Fund is now in its fifth year of offering one-time financial support toward resolving complex and emergency health-related social needs (HRSNs) for our patients. Emergency Flex Funds have been provided for HRSNs, including housing needs like rental, mortgage or deposit assistance. In 2024, we received a generous anonymous donation of $105,000 to add to this fund. During this reporting period, we had a total of 20 Flex Fund requests totaling $21,899.92 that were authorized to assist our patients with HRSNs including housing needs like rental, mortgage or security deposit assistance. Of the total amount allocated:

- 64% assisted with housing needs
- 21% assisted with utilities needs
- 15% assisted with transportation needs

We routinely receive gratitude and appreciation from our patients and their support systems who receive critical and timely financial assistance through our Emergency Flex Fund.

"Thank you for all your help, we found a house to rent and were able to keep all our pets with us."

Data Tools

Supports Strategies: Embed Social Care into Healthcare, Use Data to Drive Systems Improvements and Decision-Making, Ensure Long-Term Sustainability and Scalability.

To improve visibility into health-related social needs HRSNs screening, closed-loop referrals, and patient support activities, we have developed and adopted a suite of data tools that reduce manual reporting, support strategic planning, and enable quality improvement:

Health-Related Social Needs Screening Dashboard: A Tableau-based dashboard displaying key performance indicators for HRSNs screening. It includes screening completion rates and screen-positive rates for each need domain (e.g., housing, food, transportation) across care settings and geographic locations. This dashboard supports regulatory compliance, highlights gaps in screening coverage, and helps identify areas with high levels of unmet need.

Epic Workbench Reports and Slicer Dicer: These self-service reporting tools allow teams to pull customized data from Epic to monitor screening, referrals, and CHWs services. The use of Slicer Dicer represents a shift away from manual tracking in spreadsheets and ad hoc reporting. It enables quicker insights, supports data validation, and allows teams to explore trends by location, provider, or patient population.

Unite Us Insights Dashboard: This customized dashboard tracks referral volume, patterns, and outcomes across the Unite Us closed-loop referral network. It provides visibility into how often referrals are made, whether they are accepted and resolved, and which organizations are involved in fulfilling patient needs. This tool is accessible to users without Epic access and allows teams to assess referral effectiveness, identify barriers, and inform cross-sector collaboration.

These tools support data-informed decision-making, enhance our ability to monitor progress, and reduce reporting burden across teams. They also lay the foundation for stronger alignment with equity, quality, and regulatory priorities. See appendix 6 for more information.

Key Informant Interview Process

As part of our effort to understand and demonstrate the impact of CHWs services, we used data-informed methods to gather insights from both CHWs and clinical team members. We conducted a series of key informant interviews with CHWs to learn directly from their experiences supporting patients and working within clinical teams. These interviews surfaced rich, qualitative insights into how CHWs help patients navigate systems, build trust, and address barriers to care.

To complement this perspective, we also surveyed clinical team members who work with CHWs, including physicians, nurses, care coordinators, and managers. The survey captured care team observations about how CHWs contribute to improved care coordination, patient engagement, and provider capacity. While this survey focused specifically on CHWs, it provides a strong foundation for understanding the value of integrating social care roles into healthcare delivery.

This dual approach helps us build an evidence base that reflects both frontline experience and care team perspective. The findings support system-level planning, guide improvements, and help generate buy-in by showing how CHW services advance equity, quality, and patient-centered care. A summary of key themes from the interviews and surveys is available in the Appendix 7.

Program Growth & Sustainability Efforts

Program sustainability remains a priority for the CCL division, and it is anticipated that sustainability efforts will continue to include a combination of. 1) alignment with organizational priorities like health equity and quality improvement initiatives; 2) internal funding mechanisms fee for service and value-based care payment models; 3) external funding mechanisms like continued procurement of grant funding; and 4) through enhancement of programmatic infrastructure.

Alignment with Organizational Priorities

Given Presbyterian's enduring commitment to high-quality healthcare with health equity as a throughline, we anticipate these to be guiding frameworks for our work ahead. The continued industry-wide shift toward value-based will create new opportunities for us to create and position CHW and Peer roles to affect key outcome domains like patient experience, perinatal outcomes, linkage to and retention in care, readmission reductions, and improvement in social and behavioral health.

During this reporting period, we initiated a key informant interview project with our CHWs program stakeholders – which was inclusive of providers, clinic managers, and other key participants in this program. This project was initiated to solicit direct input from our stakeholders to assess both satisfaction and impact of the CHWs program. An early review of these findings demonstrated both high levels of satisfaction with our program as well confirmation that our CHWs were having a direct and positive impact on patient clinical and social outcomes and on the experience of providers rendering care. In the case of the latter, early findings also suggest that CHWs are critical in expanding provider capacity within PCP settings and provide viable solutions to complex patient challenges that would otherwise cause moral distress.

Additionally, state-based policies and emerging quality-based opportunities like the Healthcare Delivery and Access Act (HDAA)[1] has become a value-based care vehicle to further enable sustainability of the peer and SBIRT programs. The HDAA Hospitals can earn Hospital Quality Performance and Residual Funds payments based on their Medicaid inpatient and outpatient utilization and quality scores. SBIRT is included as one of the core performance measures for acute care hospital systems, which in turn has continued to promote the uptake of Peer and SBIRT services across the PHS enterprise. The CCL division continues to work in direct collaboration with the Quality and Compliance teams to support these emerging value-based, revenue generating opportunities.

Internal Funding Mechanisms

The CCL division has already had early success in leveraging internal funding mechanisms through partnering with clinic practices as well as through Population Health to fund and sustain multiple CHW positions. We anticipate forthcoming funding for perinatal CHW positions as part of Presbyterian's enterprise-wide perinatal strategy. The continued system level as well as state-based focus (i.e., Comprehensive Addiction and Recovery Act) on perinatal outcomes, parental mortality and wellbeing will create new funding opportunities for CHWs to directly engage with these patient populations to enhance their overall health and social outcomes.

Additionally, our division continues to actively partner with internal teams to enable CHWs and Peers to bill for services. The state of New Mexico has taken significant steps to recognize CHWs and Peers as billable service providers. This past year, we have initiated a billing pilot in one of our OB/GYN clinics to trial the CHW billing process. To our knowledge we are one of the few and possibly only programs in the state to implement this process within a healthcare setting. We intend to continue to iterate and expand this pilot to create new opportunities to financially sustain our programs.

External Funding Opportunities

Procurement of grant funding will continue to be a priority for the CCL division, as grant funding enables us to trial new interventions, develop new programmatic capabilities, and enables us to diversify our mechanisms of sustainability. At the time of preparing this report, we are in active negotiations to finalize a multi-year contract with the New Mexico Department of Health to expand our system's capacity to provide our patients and communities with increased access to overdose prevention services, harm reduction resources, training and educational services, as well as furthering the implementation of SBIRT within our emergency departments and throughout our larger healthcare delivery system. We also intend to explore and pursue grant funding that will further support our CHWs body of work – especially in perinatal and post-partum care as this is a key priority area for Presbyterian.

Enhancement of Programmatic Infrastructure

The CCL division also recognizes that enhancing programmatic infrastructure is key to enabling sustainability, to providing much-needed predictability for our team members, and to reducing process variability through promotion of standardization. This past year, we did extensive work in areas like creation of a CCL program manual, safety planning, and standardization of documentation. We intend to continue to develop additional supervisory tools to aid quality improvement efforts for both our CHW and Peer teams.

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[1] *In Calendar Year 2020 (CY20), HCA/MAD established the Hospital Access Program (HAP) Directed Payment with the pool of dollars previously allocated to the Safety Net Care Pool (SNCP) Hospital Uncompensated Care (UC) which CMS required HCA to sunset December 31, 2019. In CY22, HCA began working with provider advocacy groups and MCOs in the development and transition into the Hospital Value Based Program (HVBP). The HVBP sunset on June 30, 2024. As of July 1, 2024, the HVBP program has transitioned to the Healthcare Delivery and Access Act.*

To date, we have only had 1 peer supervisor, but with the continued program expansion we will be adding another peer supervisor role to increase capacity for our northern and regional work. These quality improvement efforts will also be inclusive of the key informant interview project which is intended to solicit critical information from our program partners and stakeholders to formulate key performance indicators that will further refine our CHWs program. Our team has and will continue to engage in ongoing process-improvement efforts which includes the creation of essential tools, training, standard operating procedures, policy development, and effective supervision for our CHWs and Peers.

Conclusion

The CCL Division remains incredibly proud of the impactful work done by our teams, and we remain grateful for the support that we continue to receive from our program partners and stakeholders across the delivery system. Every day our teams live out PHS' promise of delivering safe, compassionate, and equitable care to our patients and our communities. We know that the facilitation of trust is central to creating meaningful relationships with our patients and providers alike. Moreover, and in keeping with our programmatic strategy, we know that enhancing patient care also necessitates system transformation. That kind of transformation is also only possible, because we collectively exemplify the willingness to go the distance to ensure that our patients receive the high quality and compassionate care that they have always deserved.

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Appendix 1: Terms & Definitions

- **Closed-Loop Referral:** A referral made through Unite Us where the receiving organization updates the outcome, allowing Presbyterian care teams to see if the patient was contacted and received services. This supports follow-up, care coordination, and tracking of health-related social needs resolution.
- **Community Health Assessment (CHA):** A systematic process used by Presbyterian Healthcare Services to identify the key health issues facing the communities we serve. The CHA combines quantitative data and community input to understand health trends, social and behavioral health needs, and barriers to care.
- **Community Health Implementation Plan (CHIP):** A three-year action plan developed in response to the CHA findings. The CHIP outlines specific goals, strategies, and initiatives Presbyterian will pursue—often in partnership with community organizations—to improve health outcomes and advance health equity.
- **Community Health Workers (CHWs):** Community Health Workers are members of the community they serve and typically share the same language, culture, socioeconomic status, and life experiences with the community members that they serve.
- **Contact Attempts:** The number of times a CHW attempted to reach a patient. Attempts can be successful or unsuccessful (e.g., patient answered the phone vs. CHW left a message) and includes subsequent follow-up attempts.
- **Health-Related Social Needs (HRSNs):** Social and economic needs that people experience that affect their ability to maintain their health and well-being. HRSNs include needs such as employment, affordable and stable housing, healthy food, personal safety, transportation and affordable utilities.
- **Individual Encounters:** One-on-one interaction with a community member at an event.
- **Member:** Any person who shares a common interest and set of values with others.
- **Open Navigations:** The number of cases in which the CHW is actively navigating the patient and addressing their needs. This number is indirectly correlated to the number of referrals received during that time period.
- **Organization Encounters:** An event specific to members of an organization (i.e., not open to the community at large) or outreach done at a specific organization.
- **Outreach Attempts:** Contact attempts made to a person or organization in-person, via email or via phone.
- **Pathways Used:** The intervention or activity the CHW used to assist patients seen by the pharmacist clinician.
- **Pharmacy Patients Contact:** The patients contacted are based on the number of scheduled appointments on the pharmacist clinician's panel.
- **Peer Support Specialist:** Peer support specialists act as a recovery and empowerment catalyst: guiding the recovery process and supporting individual recovery choices, goals, and decisions.

- **Referrals:** The number of provider referrals received in our referral work queue. (Exception: Complex Care referrals are received via email.)
- **Referral Network:** A technology-enabled, coordinated system of healthcare, social service, and community-based organizations that work together to connect individuals to services that address their health-related social needs utilizing closed-loop referral functionality.
- **Screening Brief Intervention and Referral to Treatment (SBIRT):** Is an evidence-based public health approach that can be used for assessing and intervening with alcohol and substance misuse before serious complications develop
- **Unite Us:** A secure platform used by Presbyterian to refer patients to community services, track outcomes, and coordinate care. It supports closed-loop referrals to help ensure patients experiencing health-related social needs are connected to community-based resources.

Appendix 2: Community Health Assessment & Community Health Implementation Plans

As part of our purpose to improve the health of the patients, members, and communities we serve, and in alignment with the Patient Protection and Affordable Care Act, Presbyterian Healthcare Services (PHS) conducts a community health assessment (CHA) every three years to identify the priority health issues facing each of our communities. This process is deeply rooted in community engagement, as PHS partners with local health councils, conducts forums, and gathers input to better understand the key drivers behind some of the health issues our communities face.

Using CHA findings, PHS collaborates with the community to develop its Community Health Implementation Plan (CHIP), which outlines specific goals, strategies, and actions designed to improve health outcomes in a meaningful and measurable way. In the most recent CHA cycle (2022–2025), the community identified social health, behavioral health, and physical health as the top priority areas. In response, the following strategic goals were developed:

Priority Area: Social Health	
Strategic Goal 1	Increase patient and member connections to PHS, community, and government resources and services that address health-related social needs
Strategic Goal 2	Increase access to affordable, healthy food for households experiencing highest rates of food insecurity
Priority Area: Behavioral Health	
Strategic Goal 1	Improve prevention and treatment of unhealthy substance use including tobacco, alcohol, and illicit drugs for youth and adults
Strategic Goal 2	Increase access to behavioral health services and reduce stigma associated with accessing those services for youth and adults
Priority Area: Physical Health	
Strategic Goal 1	Improve prevention and self-management of chronic disease
Strategic Goal 2	Improve COVID-19 and Flu vaccination status among high-priority populations

Appendix 3: Metrics Available Through Unite Us Insights Dashboard

While Presbyterian's use of closed-loop referrals through Unite Us is still growing, the data infrastructure is now in place to generate meaningful insights as adoption expands. Early data are limited in volume, but they have already demonstrated the platform's potential to support equity-driven transformation. Over time, Unite Us data can help surface disparities in referral success across populations and service domains, enabling more focused and effective interventions.

Metrics Available Through Unite Us:

- Referral Status Tracking. Referrals include real-time status updates such as Sent, Accepted, Rejected, and In Review, providing visibility into referral success and failure points.
- Completion Rate by Referral Type. Allows analysis of which types of referrals are most likely to be resolved successfully—early statewide data shows over 75% of referrals in the top five service categories resulted in successful resolution of patients' health-related social needs.
- Completion Rate by Organization. Tracks referral outcomes by receiving organization, enabling identification of high-performing partners with strong follow-through.
- Breakdown of Referral Statuses. Offers insights into why referrals don't result in services (e.g., due to capacity, declined consent, or communication gaps.
- Referral Volume by Service Type. Identifies the most common types of services patients are referred to (e.g., food, housing, transportation), helping prioritize resource development and community partnerships.
- Turnaround Time. Measures how quickly referrals are accepted or acted upon by community organizations to assess network responsiveness and patient experience.
- Stratification by Demographic Factors. Referral data can be stratified by race, ethnicity, age, language, geographic region, and other demographic variables to identify disparities in referral access, completion, and engagement.

Appendix 4: SBIRT Intervention Overview

Enduring stigma and lack of access to timely and preventative treatment and recovery services for substance and alcohol use disorders remain complex social issues. Moreover, research has found that individuals with SUDs and AUDs are more likely to have a history of trauma (NIDA, 2024), to seek care in emergency departments than other patient populations, and may also be more likely to (Zhang et al, 2021):

- Present with complicating psychiatric symptoms
- Receive disparate care to include diagnosis and treatment based on their gender, race, and ethnicity
- Have a revisit to the emergency department within 72 hours

To address the growing concerns with the use of substances in the general population, Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based public health approach that can be used for assessing and intervening with alcohol and substance misuse before serious complications develop (Ting et al, 2023). Research done by Ting et al (2023) on SBIRT programs have improved interdisciplinary team members':

- **Knowledge** of SUDs and AUDs
- **Attitudes** and beliefs about people with SUDs and AUDs
- **Skills** in discussing concerns related to SUDs and AUDs with patients seeking care
- **Abilities** to assess and respond risk and severity of patient presenting concerns

The SBIRT program effectively addresses substance use by integrating three core components:

- **Screening** quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- **Brief intervention** focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **Referral to treatment** provides those identified as needing more extensive treatment with access to specialty care.

Appendix 5: Patient Success Stories

Community Health Worker Success Stories

Cedar OBGYN: A 20-year-old female was referred to the CHW for support after a difficult diagnosis. The patient expressed thoughts of self-harm and presented a drafted suicide letter. The support of various care team members was called upon including the medical provider, medical assistant, integrated behaviorist, peer support specialist (PSS), and CHW. The CHW used active listening and Mental Health First Aid (MHFA) techniques to assure the patient that they are doing the right thing by seeking help. After further consideration, it was determined that a higher level of care was required and a plan to have the patient seen at the nearest psychiatric emergency room was created. The CHW worked with the behavioralist to ensure that the transportation method chosen provided the most sensitivity and dignity toward the situation. After exploring their options, a family member agreed to provide transportation for the patient. During this time, virtual support of a PSS was initiated, and the patient was able to complete an initial intake. The CHW assured the patient was comfortable while waiting for their family member to pick them up by offering snacks, drinks, and a blanket. Once the family member arrived, the CHW discreetly communicated that a higher level of care was needed from a different facility. It was confirmed that the patient arrived safely and received the care they needed by behavioral health professionals. A lesson learned was that these types of referrals are out of scope for a CHW and therefore had to reach out to different members of the care team, including their supervisor, for guidance. However, the CHW was instrumental in building trust with patient and advocate on their behalf. The patient had a positive experience stating, "thank you for caring about me, would it be okay to give you a hug?"

Kaseman Family Practice: A patient was referred to the CHW for assistance with housing after being unhoused for 2 years and living in her car. The patient was experiencing an increase in mental and physical health issues due to being unable to lie down to sleep. After several attempts at various local agencies, the patient began to feel discouraged as she was given a housing voucher by two different agencies only to be told they were given to families due to priority over a single woman. Initially, the patient was uninterested in CHW services and unreachable. However, after some persistence by the CHW, she took it upon herself to meet the client in person at her next appointment. The patient appreciated this and moved her to trust the efforts of the CHW and her continued persistence. This also moved the patient to write an apology letter for how she initially treated the CHW. Once the mutual trust was established, the CHW and patient worked to find additional resources for housing and were able to garnish a housing voucher from ABQ Healthcare for Homeless. A lesson learned, we do not know what experiences people have gone through and therefore being persistent and treating people with compassion goes a long way. The patient expressed this by saying, "thank you for being with me every step of the way with an encouraging word and always being there even when I wasn't being kind to you."

Peer Support Specialist Success Stories

Plains Regional Medical Center: A 44-year-old female scored positive for meth use misuse. Patient was on the 72-hour lookback report and Peer made a follow-up call after patient was discharged. Patient was hesitant at the beginning of the phone call and as she heard more of what a Peer support worker is, she engaged in the conversation and shared her story and why she went to the emergency department. Patient stated she was married and after divorce she began [consuming] large amounts of alcohol for several years. She eventually stopped drinking alcohol and [started using] up meth. Patient came into the ED for support for meth use and wants to stop using meth as it is interfering with her relationship with family. Patient no longer had medical insurance and does not qualify for Medicaid. Peer support listened and offered emotional support and suggested applying with New Mexico Be Well, NA 12-step support groups, and was also connected with a local group 12 step member for guidance. Patient stated she was grateful for the connection as she has not talked to anyone about her meth use and it felt good to share what is going on with her. Patient was not ready for referrals for IOP, but accepted resources. Patient agreed to a follow-up call for Peer Support Services. Patient was able to carry a conversation in her language which she was happy for, "I don't get to speak Navajo much out here, my children don't speak much Navajo, too, so this was nice that we could talk in Navajo. This meant a lot to me. Thank you."

Presbyterian Hospital: I connected with a patient about recovery and what did that look like for [the patient] and what struggles [the patient] was having that were preventing or hindering his ability to move forward with his recovery – one being his living situation, so that when he [finishes] with treatment [he] can have a plan to where he is going to [maintain his sobriety]. We got into deep conversations about what he wanted for his life and the changes that had to be made to move forward. I also shared stories about my own recovery and what that looked like and what I did to make sure [nothing got in the way of my recovery goals]. We shared laughs, cries and excitement. He expressed how he was interested in Santa Fe Recovery and wanted to start there and move on to a long-term treatment facility or program. I called and got him a bed that was originally scheduled for [date redacted] but he missed that appointment due to transportation issues. I rescheduled his admit date for [date redacted] and he called and texted me today to share what emotions he was feeling and how this fear came over him. I let him know that he would experience a lot of different emotions, especially now that he won't be [using any substances] that [may impact his thinking] and that it is important to feel those feelings and work through them. We spoke until they called him back to start the admission process and he was calm and had a "ready" mind set. I encouraged him to reach out to me so we can get started on getting him ready for his next chapter and what facility he was interested in so when he is discharged, he will go straight to the other facility. I will wait to hear from him and wish him good luck.

Appendix 6: Data Tools Summary

This appendix provides an overview of the key data tools currently in use or under development to support Community & Clinical Linkages (CCL) work.

Tool	Primary Use Case	Insights	Limitations
Tableau Dashboard: Health-Related Social Needs (HRSN) Screening Results	Custom built to meet CMS reporting requirements; includes groupers that are not currently available in Slicer Dicer tool. Provides access to screening data for teams across PHS, including those without access to Epic.	• Screening rates can be compared over time to monitor consistency and scale • High-need domains can be identified by setting or location • Surfaces gaps in screening coverage across care settings or departments	• Reflects a 30-day lookback period; data not available in real time • Changes or updates require support from analysts outside the department • New questions or data needs require custom development; not self-service
Unite Us Insights Dashboard: Referral Outcomes	Includes info on the number of referrals sent through the Unite Us, whether they were accepted or resolved, and how long it took for partners to respond. Data can be filtered by patient demographics, referring or receiving organization, service domain, and time. Includes data from all referral network partners across New Mexico for comparison.	• Patterns in referral volume show where workflows are established or underutilized • High rates of unresolved referrals identify service gaps or process breakdowns • Long partner response times highlight operational delays or capacity issues • Variation in resolution rates across domains or locations can inform partnership strategies and resource planning	• Only includes referrals made through Unite Us; does not capture other types of referrals (e.g., warm handoffs, printed lists, EMR notes) • Relies on network partners to close the loop and document outcomes • License-based access to dashboard; current contract includes only three licenses

Tool	Primary Use Case	Insights	Limitations
Workbench Reports and Slicer Dicer: **EMR-Based Custom Reporting**	Self-service reporting within Epic for exploration of hunches using live clinical and demographic data. Provides flexible, on-demand analysis of HRSNs, referrals, and patient demographics. The tool is especially useful for operational, quality improvement, and strategic planning questions and does not require support from data analysts.	• Identify trends and patterns in screening, referral, or service use across different patient populations • Explore variation by site, department, or provider group to support operational planning • Examine relationships between HRSNs and clinical factors such as diagnoses or utilization • Generate data to support hypothesis testing, quality improvement, or program evaluation	• Access limited to users with Epic permissions and some familiarity with data navigation • Information incomplete when social care workflows are primarily documented in Epic Smartforms • Data models, filters and groupers are standardized • Certain filters (such as department versus location) are not clearly defined

Appendix 7: Key Informant Interviews Summary

This one-page summary highlights key themes from interviews with CHWs and surveys of clinical team members who work with them. The full report is available by request.

Enhancing Clinical Partnerships with Community Health Workers

Insights from Clinical Team Interviews and Surveys

Prepared by the Community & Clinical Linkages Team | March 2025

Summary

Community Heath Workers (CHWs) have emerged as a key partner in advancing safe, compassionate and equitable care. Their role in addressing health-related social needs (HRSNs) helps patients overcome barriers to care, strengthens provider capacity and supports the well-being of both patients and care teams. In late 2024 the Community Clinical Linkages (CCL) team surveyed CHWs and care team members – including providers clinic managers, and administrative staff. The overall intent of this effort was to evaluate the CHW program and identify performance metrics to guide future planning.

We heard a consistent message: CHWs are essential teammates who help patients get the care they need – both inside and outside the clinic. They improve care continuity. enhance patient experience, and extend provider capacity in meaningful ways.

Key Findings

CHWs Bridge the Gap Between Medical and Social Care. CHWs are experts in connecting patients to food, housing, and transportation services. They'll critical gaps that influence health outcomes.

"CHWs are integral to connect patients to community resources so they can achieve their best health."

CHWs Improve Patient Experience and Engagement. CHWs build trust, follow up consistently, and help patients stay on track with care plans.

"Patients value having a consistent and reliable relationship with CHWs. This helps build trust & comfort "

CHWs Expand Provider Capacity and Improve Team Function. CHWs relieve burden on providers by addressing social needs and surfacing hard-to-detect barriers.

"CHWs really help when we identify patients with needs, and I don't have the time or resources to help."

Care Teams Strongly Support CHW Services. Staff across roles view CHWs as knowledgeable and trusted colleagues who improve workflows and team culture.

"The services that CHWs provide are invaluable. They are trusted and valuable members of our team."

Opportunities for Growth

Respondents shared clear ideas for growth:

- Expand CHW access and scope
- Improve communication about CHW services
- Address operational barriers (office space work-flow)
- Enhance CHW outcome and impact reporting

CHWs don't just support patients – they support providers and care systems. As we continue to invest in CHWs these findings provide a clear roadmap for improvement and measurable impact.