2024 IMPACT REPORT
NORTHERN NEW MEXICO

PRESBYTERIAN
Community Health

Health Equity means all patients, members, and communities we serve can achieve their best health.

Community Health is the bridge between healthcare and community to better understand health, support the conditions to thrive, and reduce inequities. Together with Santa Fe Medical Center, Presbyterian Española Hospital, The Presbyterian Foundation, and Presbyterian Health Plan, we worked with our community partners to complete a Community Health Assessment (CHA) and a Community Health Implementation Plan (CHIP) for 2023-2025. This report summarizes the progress to date on the community-informed priorities below.

Priority Area 1: **BEHAVIORAL HEALTH**

Long Term Goal: All New Mexicans have access to behavioral health services to improve overall well-being.

Presbyterian's behavioral health initiatives work to improve the prevention and treatment of unhealthy substance use and increase access to behavioral health services by reducing the stigma associated with accessing services.

In 2024, Presbyterian's **Peer Support program** assisted individuals and families struggling with substance use. Certified Peers offer in-person and virtual support to patients who have experienced an overdose and those experiencing substance related episodes in the Emergency Departments (ED). The peer support program offers non-clinical activities based on shared lived experiences that engage, educate, and support an individual to successfully recover from substance use disorders. Peers helped implement a new evidence-based **Screening Brief Intervention and Referral Treatment** (SBIRT) process at Presbyterian Española Hospital and Santa Fe Medical Center where peers connect with patients in-person or virtually. 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.

1,041 patients screened through SBIRT in Northern NM

15 patients living in San Miguel
65 patients living in Taos
303 patients living in Santa Fe
534 patients living in Rio Arriba

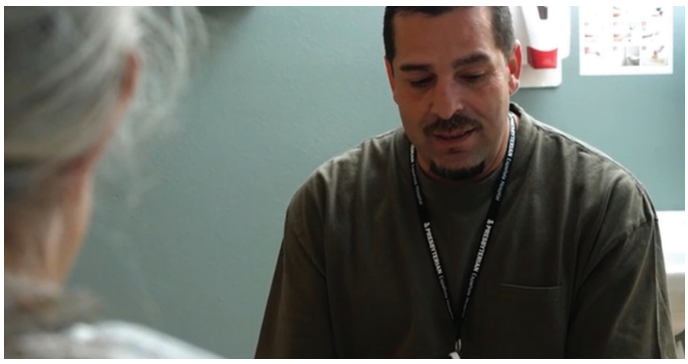


Image of Ronnie Flores, Peer Support Specialist

A peer met with a patient who screened positive through the SBIRT process. They were admitted to Presbyterian Española Hospital, experiencing health complications resulting from heavy alcohol consumption. The patient stated he is moving out of state for work and will live in a shelter until they are financially stable. The patient stated they would like to go to Alcoholics Anonymous (AA) to remain abstinent from the drinking and learn to maintain a life in recovery.

"As a Peer, I shared that I am personally a member of AA and with the patient's consent I reached out to another member within their location. The patient and the member were able to connect and have a much-needed conversation about recovery and the 12 Step program. The patient and the AA member planned on meeting when the patient arrives in town. The AA member also agreed to serve as a sponsor for the patient, and to help work the 12 steps with them and support them through their journey to recovery."

– Peer Support Worker (Northern Region)

Revised January, 2026

Community Investment
Behavioral Health

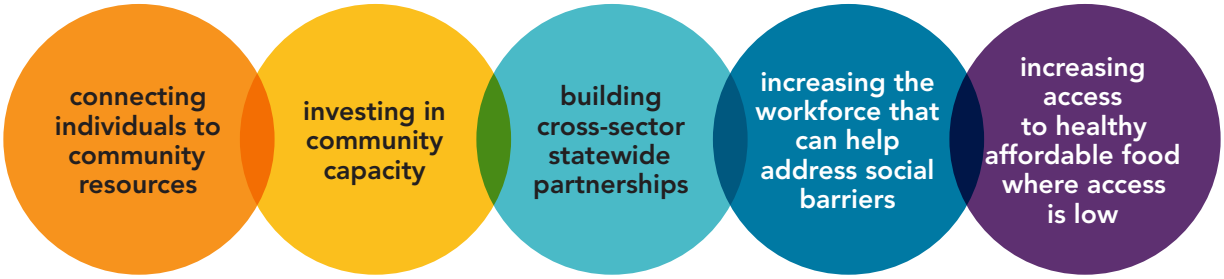
Presbyterian provided **over $8,000** to the New Mexico Suicide Prevention Coalition in Taos, The New Mexico Reentry Center, and Girls Inc. of Santa Fe.

Priority Area 2: **SOCIAL HEALTH**

Long Term Goal: All New Mexicans live in social conditions that promote attaining the full potential of health and well-being

When people are hungry, unhoused, or don't have reliable transportation, they may struggle to attain the full potential of their health and well-being. When social needs are addressed as part of healthcare delivery, health outcomes improve and healthcare costs are reduced. Presbyterian has developed and implemented tools, methods, and processes that have been adopted system-wide to identify and address unmet social needs.

Our initiatives aim to identify and address unmet social needs by:



Presbyterian invests in building partnerships through statewide networks to build everyone's capacity to address social needs, strengthen collective impact through data, and collaboratively inform inter-operability and adoption of closed-loop referral technology.

NEW MEXICO
Social Drivers of Health Collaborative

The New Mexico Social Drivers of Health Collaborative consists of community-based groups, health care agencies, governments, businesses, and organizations working together to share data and resources to promote health equity for all New Mexicans. Since 2023, Presbyterian has served as the administrative backbone thanks to seed funding from a $328,000 grant and continues to fund the collaborative. In 2024, the Collaborative launched their website, published their charter, adopted principles and values, hosted a learning circle and peer-led learning series focused on the closed loop referral system, and continued to strengthen their partnerships through membership pledges. Membership includes 105 voting members; 15 steering committee members; 5 workgroups, and newsletter reach of 345 individuals.

12 Community-Based Organizations
10 Healthcare Organizations
7 State Agencies
4 County Departments
4 University Departments
4 Technology Providers
4 Community Members
3 MCOs/Medicaid
2 Tribal Health Departments
2 Coordinated Care Networks
2 Consultants
1 City Department
&
NM Health Information Exchange

Community Investment
Social Health

Presbyterian provided **$5,000 in support** of the Communities in Schools Family Emergency Fund which is used to help prevent eviction or utility shut offs keeping families in safe, stable homes.

Identifying and Addressing Social Needs in Clinical Spaces

Health related social need screening is routinely done twice a year in all settings, including primary care, specialty care, when a patient is admitted, the emergency department, and urgent care. **Fifty-six percent (56%)** of all patients have been asked if they need help with food, housing, utilities or other social needs that help keep them and their families healthy since screenings started in 2021. **Over 229,000 personalized resource lists** were automatically created in response to Presbyterian patients' identified needs in 2024 alone. Presbyterian Community Health has a Community Health Resiliency Fund that is used on a case by case basis when all available resources are exhausted. In 2024, Community Health Resiliency Funds were used to assist with housing (60%), utilities (21%) and transportation (15%). Thank you to The Presbyterian Healthcare Foundation and its generous donors.

Top needs identified through screenings:

- Food Insecurity (43%)
- Transportation (28%)
- Housing Instability (20%)
- Violence/abuse (8%)
- Utilities (1%)*

*screening began 12/2024

At Presbyterian, **Community Health Workers** are a vital member of the social care team and bring lived experience, cultural insight, and trusted relationships into the care setting. Often members of the communities they serve, Presbyterian's CHWs work across healthcare settings and services 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.

Type	#	%
Northern Roots	459	42%
Diabetes Education	253	22%
Basic Social Needs	173	16%
Hypertension/ High Colesterol Education	73	7%
Other	145	13%

The Regional CHWs received a total of **1,085 referrals** in 2024. A total of **55 providers across 21 departments** submitted referrals in Epic. 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 Presbyterian Community Health programs.

Expanding Healthcare Access by Investing in the Community Health Worker Workforce

A one-time community investment of **$12,500 each** was awarded to **8 Community Based Organizations** (CBOs) 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. Early findings indicate major success in strengthening the regional CHW workforce. Mesilla Valley Community of Hope alone trained and certified **16 CHWs**, while all partner organizations advanced billing readiness, implemented sustainable community-based health navigation and education models, and received ongoing support from the New Mexico Health Care Authority (HCA) to sustain this progress.

Partners Selected: Picuris Pueblo, Las Cumbres Community Services, La Semilla Food Center, Mesilla Valley Community of Hope, Rio Grande ATP, Rural OB Access & Maternal Service, Empowerment Congress of Doña Ana County, and the Non-Metro New Mexico Area Agency on Aging.

Community Investment

Social Health

The Regional Partnership, comprised of Community Health and Presbyterian Healthcare Plan (PHP) has invested money to support CBOs to implement and support programs, strengthen capacity, and expand services.

Las Cumbres Community Services was awarded **$25,000** to support the ¡Que Cute! Healthy Baby Program to improve access and support with maternal and obstetrics care in rural communities in Rio Arriba and San Miguel counties.

Prescription food programs are food access programs initiated by a referral from a Physician or other member of a patient or members' care team that support individuals who are identified as food insecure and helps them use food as medicine to prevent and address chronic disease such as hypertension, diabetes, and cancer.

Northern Roots: Where Families Eat, Learn and Grow

The Northern Roots Produce Rx program is a comprehensive Food Is Medicine (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 to the program through a provider or external partner to a clinic bases CHW for enrollment and support. The CHW is a key factor in engagement and retention in the program, as they create a trusted relationship with families. The program is recommended for perinatal patients, children up to 18 years of age and their caregivers, with a diagnosis of food insecurity, diet-related conditions, or at their providers' discretion. The program receives external referrals from partners to increase priority population reach and build a FIM network – partners include PHP Medicaid, El Centro Family Health in Espanola, SMCECC, Gerard's House, WIC, and Las Cumbres Community Services.

459 patients were referred to Northern Roots

385 patients enrolled

2,111 food bags were distributed

Post-survey data shows improvement in:

Knowledge of Healthy Eating
55% to **90%**↑

Access to Fresh Produce
45% to **80%**↑

Confidence in Nutritious Meal Prep
50% to **85%**↑

Household Food Security
40% to **75%**↑

> **"It was great! Allowed extra time with my daughter cooking and experiencing new foods."**
>
> – Northern Roots Participant

> **"Really helped me to realize importance of diet and consistency."**
>
> – Northern Roots Participant

Community Investment

Local Food

$87,102 to purchase locally grown food distributed by Northern Roots

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. Patients enrolled in the intervention group received a 16-week Community Supported Agriculture and share 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). 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. SFMC providers gave 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

The Regional CH team 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.

63 participants

4 Cooking Matters for Adults Classes

4 Sprouting Kitchen Cooking Workshops

2 Kitchen Creation Classes

2 Active Living Classes

Community Investment

Local Food

Presbyterian Regional team invested **$17,00** to host the Santa Fe Farmers' Market – Del Sur with Santa Fe Farmers' Market and Santa Fe Farmers' Market Institute.

Priority Area 3: **PHYSICAL HEALTH**

Long Term Goal: All New Mexicans have access to health care and healthy environments that promote improved physical health

COMMUNITY HEALTH WORKERS SUPPORTED HEALTH EDUCATION PROGRAMS

The regional CHWs have played an integral role in expanding access to diabetes education through Diabetes ReCHARGE and Kitchen Creations classes.

Kitchen Creations Classes 2023-2024

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, a cookbook, and build community through shared meals.

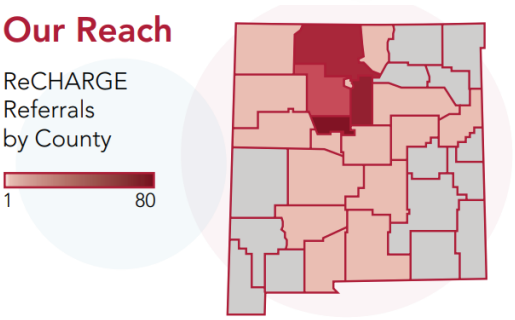
6 four-class series were offered with **3** in Spanish

125 individuals participated

Expanded access to diabetes education with hands-on cooking in **Rio Arriba** and **Quay county**, among others.

Diabetes ReCHARGE is our accredited Diabetes Self-Management Education and Support (DSMES) program. The program is designed to help newly diagnosed New Mexicans with diabetes learn more about diabetes and how to manage it. During 2024, participants represented 11 New Mexico counties including Rio Arriba, San Miguel, Sandoval, and Bernalillo, among others. Participants saw a clinically meaningful **reduction in average A1c**. From an initial team of two dietitians, Diabetes ReCHARGE has grown to a team of three registered dietitians, three CHWs, and three support staff in 2024.

Our Reach



88 individuals participated from Northern NM

28 classes

7 cohorts

"Thank you for these classes. I was able to lower my A1C and come off insulin."

– Patient

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 Presbyterian 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.

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.

75 individuals participated

This 90-minute training was offered **twice**

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.

HEALTHY EQUITY & ACCESS

Health Equity and Access are lenses in which we implement programs and services

According to the Robert Wood Johnson Foundation, health equity exists when every individual has a fair and just opportunity to be healthier. This requires removing obstacles to health, such as poverty and discrimination and their consequences, including powerlessness and lack of access to gainful employment with fair pay; quality education and housing; safe environments and healthcare. **Access** to healthcare and community-based resources and **Equity** – ensuring that everyone has a fair and just opportunity to be as healthy as possible – will serve as lenses through which we implement programs and service.

Health equity is essential to Presbyterian's purpose to improve the health of the patients, members, and communities we serve. In 2019, Presbyterian embarked on a formalized journey to address health equity in our communities and for our patients and members. We adopted a framework developed by the Institute for Healthcare Improvement for healthcare organizations to achieve health equity, which identifies five practices:

PHS LGBTQIA+ Cares Program was established in January of 2023 through funding from a private grant of $250,000 with the overall goal of improving access to quality, affirming, patient-centered, best-practice care and reducing overall health inequities faced by LGBTQIA+ New Mexicans through direct patient and member support as well as programmatic development and systems change. With 2023 mostly a planning and capacity building year, 2023 and 2024 accomplishments include:

30+ LGBTQIA+ patients and members received 1:1 navigation support

20 LGBTQIA+ individuals navigated through colleague consultation

1,700 healthcare workers and community members participated in cultural and clinical education

Each Presbyterian Hospital was awarded Healthcare Equality Index (HEI) "High Performer" status. The HEI evaluates healthcare facilities on policies and practices dedicated to the equitable treatment and inclusion of LGBTQ+ patients, visitors and employees.

Presbyterian collaboratively organized and hosted the **2024 New Mexico Gender-Affirming Care Symposium** – a free, 2-day medical gender-affirming care symposium.

The conference objectives encouraged learners to be able to:

1. Develop & perform evidence-based in-scope practices to support patients' access to and/or provide the gender-affirming care services that they need.
2. Use trauma-informed and patient-centered practices to offer an affirming and supportive clinical environment for transgender and nonbinary patients, as well as those still figuring out aspects of their gender.

"My husband and I have been together for 26 years. We were married in Santa Fe in 2014. We have never had an issue living our authentic selves with our PCP or anyone on the Presbyterian staff. This has not been the same in other states unfortunately. BRAVO to Presbyterian."

– LGBTQIA+ survey respondent

"I generally felt safe and heard, which I haven't felt in a long time with my previous doctor. Overall, I would recommend both Presbyterian and my doctor to others."

– LGBTQIA+ patient

"I really appreciate all the legwork you've put in and I really feel like you've gone above and beyond… I was feeling hopeless about this situation before I talked to you, but having your support has made an impact. Thank you."

– Patient and Health Plan Member

Community Investment

LGBTQIA+

Presbyterian contributed over **$35,000** to support community partners.

Presbyterian Community Health offers free **health equity** training sessions, hosted by community organizations, open to Presbyterian clinical & administrative staff as well as the public. We seek to learn from all perspectives as we provide affordable, accessible, and culturally appropriate healthcare and champion health equity for our New Mexico communities.

Some of the trainings offered include:

- Addressing Trauma, Racism and Bias in Care Pathways
- Anti-Ableism in Healthcare Settings
- Equitable Lactation Care
- Harm Reduction 101 and 201
- Introduction to Gender-Affirming Care
- Mental Health First Aid
- Native American Cultural Awareness and Healthcare Systems
- Polysubstance Use 101 and 201
- Transgender Cultural Fluency 101 and 201
- Unconscious Bias
- Youth Mental Health First Aid

835 participants attended free health equity training sessions

Health Equity Highlight

Presbyterian Health Plan successfully achieved National Committee for Quality Assurance (NCQA)'s Health Equity Accreditation

"Thank you for helping me understand your community and acknowledge them properly. Before the training I was a little overwhelmed when a coworker kept reminding me of pronouns. I was not aware of the psychological distress it might cause this non-binary person. I would do my best to refer to my coworker as "They." Thank you!"

– Transgender Cultural Fluency 201 open session taught by TGRCNM

Building the Closed Loop Referral Network

The regional team collaborated 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 Indigenous Evaluators Network (IEN) was founded in 2022 by Indigenous community members from 4 organizations – the network has since increased to 10+ organizations. Since 2022, Presbyterian Community Health has provided funding that went to local gatherings focused on promoting knowledge exchange, establishing partnerships and networks, and strengthening capacity amongst members. IEN supports the development and adaptation of Indigenous methodologies and measures that capture language resiliency, cultural strengths, and wellness from a holistic perspective as part of tribal evaluation and for research purposes. The network serves as a resource to help strengthen the evaluation capacity within Tribal communities, as well as a space for collective thinking, organizing, and advocacy for Indigenous matters using appropriate data.

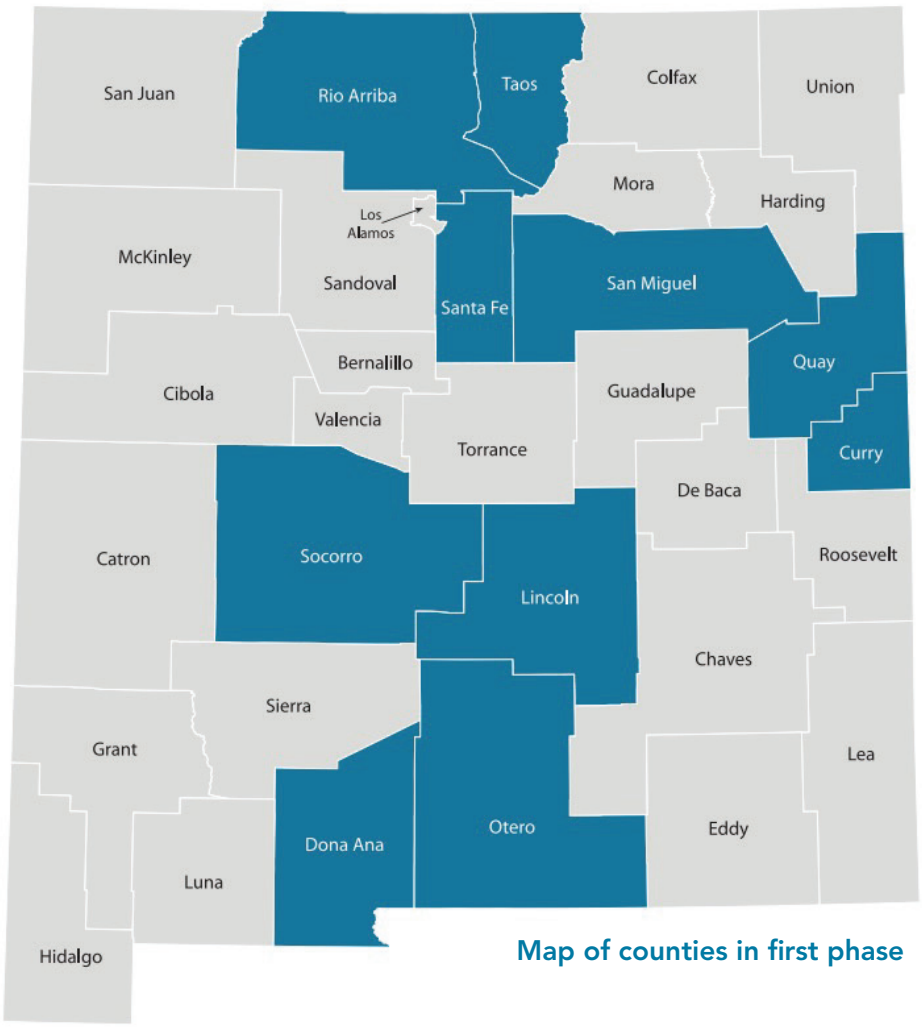
REGIONAL PARTNERSHIP

Presbyterian Community Health and PHP Population Health and Quality developed a partnership in 2023 to better integrate PHP framework for Turquoise Care. The goal is to leverage collective strength, collaborate meaningful community engagements to inform initiatives, and develop population-based strategies and programs in rural and regional areas of New Mexico. The partnership has four key areas of focus:

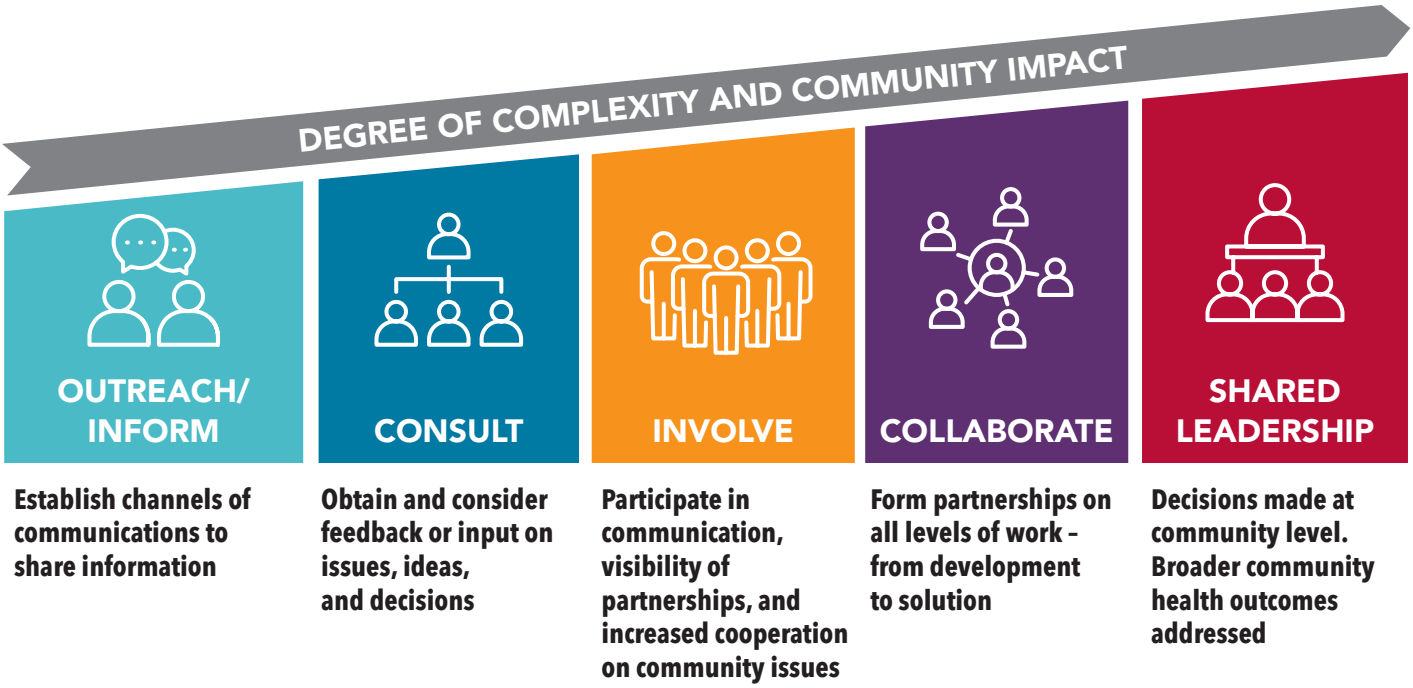
The regional partnership aims to build community trust, engagement and understand lived experiences of the community. While building and strengthening community engagement, the partnership will work with community-based organizations (CBO) to help build up their capacity and develop programs that will bridge health and social care. Northern and Southern New Mexico communities will be part of the first phase of this partnership as there is a significant health disparities and the community readiness for engagement. The partnership model employs local staff who serve as liaisons with CBOs, ensures that staff are developing relationships with local leadership and community members to ensure that we have an "on the ground" understanding of local needs.

Community Engagement

The regional partnerships will incorporate community voices to improve the effectiveness of services within the community. There are 5 steps of the community engagement.



Map of counties in first phase



Voices for Equity Community Ambassador Program: Elevating Member Experience

Voices for Equity (VFE) is designed to engage 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 firsthand 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.

VOICES FOR EQUITY
A COMMUNITY AMBASSADOR PROGRAM

3 ambassadors joined VFE

3 in-person focus groups

1 virtual interview

40 actionable recommendations, more than **80%** is already in process

"I'm thrilled to see the upcoming developments. I'm incredibly proud of the participants and deeply appreciative of all the work this team is doing to bring these changes to life. It's inspiring to see that we're not just collecting data but actively using it to drive meaningful action. This is exactly the kind of impact we hoped for, and I'm grateful to be part of it."

– VFE Ambassador

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