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PRESBYTERIAN HEALTHCARE SERVICES COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP)

Plains Regional Medical Center | 2020 – 2022

PRESBYTERIAN

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Overview

Presbyterian Healthcare Services (Presbyterian) exists to improve the health of the patients, members, and communities we serve. Aligned with our purpose and in compliance with Internal Revenue Services (IRS) regulations, Plains Regional Medical Center (PRMC) completes a Community Health Assessment (CHA) and a Community Health Implementation Plan (CHIP) every three years. The CHA describes 1) the community served: Curry County, 2) the process for conducting the assessment, and 3) a description of assets and resources that already exist in the community. Many of these assets include programs, services, and physical assets that will aid Presbyterian and partners in addressing the identified community health priorities.

Plains Regional Medical Center partnered with the Curry County Health Council to complete a community health assessment and identify significant community health needs.

The top seven community health priorities identified for Curry County by the health council for 2020-2022, listed in **no order of priority** are:

1. Healthy Eating
2. Physical Activity
3. Prevention of Unhealthy Substance Use
4. Mental Health
5. Access to Care
6. Homelessness
7. Social Determinants of Health

For 2020-2022, the Plains Regional Medical Center community health priorities for Curry County listed **in order of priority** are:

1. **Behavioral Health**
2. **Social Determinants of Health**
3. **Access to Care**
4. **Healthy Eating and Active Living**

The full Community Health Assessment can be found on www.phs.org.

This community health implementation plan describes goals and strategies that Presbyterian developed with community partners to impact all of the needs prioritized by the community in the Community Health Assessment. Presbyterian combined all of the significant health priorities into four categories and each is addressed by goals and strategies within the plan. There are no prioritized health needs not addressed in this plan, though there are many additional assets, ongoing programs, and services in Curry County included and not included

specifically in this plan to address prioritized health needs including the United Way Youth Initiative, the "3-7 Project", Celebrating Recovery: "The Landing" teens, the Prescription Monitoring Program, the Quit Now Hotline, DWI Prevention Programming, Teen Court, MATT25, Goodwill, Habitat for Humanity & Restore, community gardens, farmer's markets SNAP Double Up Food Bucks, the Produce for the People Food Bank, The DOH Healthy Kids program, and many others.

The goals and strategies detailed in this plan are bold and comprehensive. Through yearly action planning with partners and stakeholders, yearly monitoring of progress, strategic investment, leveraging resources, capacity building, strong partnerships, and quality improvement efforts, Presbyterian Community Health will assist each hospital, community health council and other partners, and our healthcare system to implement and evaluate these strategies.

Plan Development

Presbyterian and community partners have been and will continue to use a modified Collective Impact approach for community health improvement planning and implementation. This approach focuses on capacity building and partnership with local health infrastructure to leverage resources and implement broad evidence and practice–based community health activities in order to address significant health needs in the County. Additionally, in the formation of these goals and strategies, Presbyterian has drawn from the following frameworks and national coalitions: RWJF Culture of Health[1], Pathways to Population Health[2] – an initiative of 100 Million Healthier Lives[3], the Centers for Disease Control and Prevention "three buckets of prevention"[4] (figure 1), the Anchor Institution Framework, and The Root Cause Coalition.

[1] https://www.rwjf.org/en/cultureofhealth.html
[2] http://www.pathways2pophealth.org/
[3] https://www.100mlives.org/
[4] https://stacks.cdc.gov/view/cdc/47598

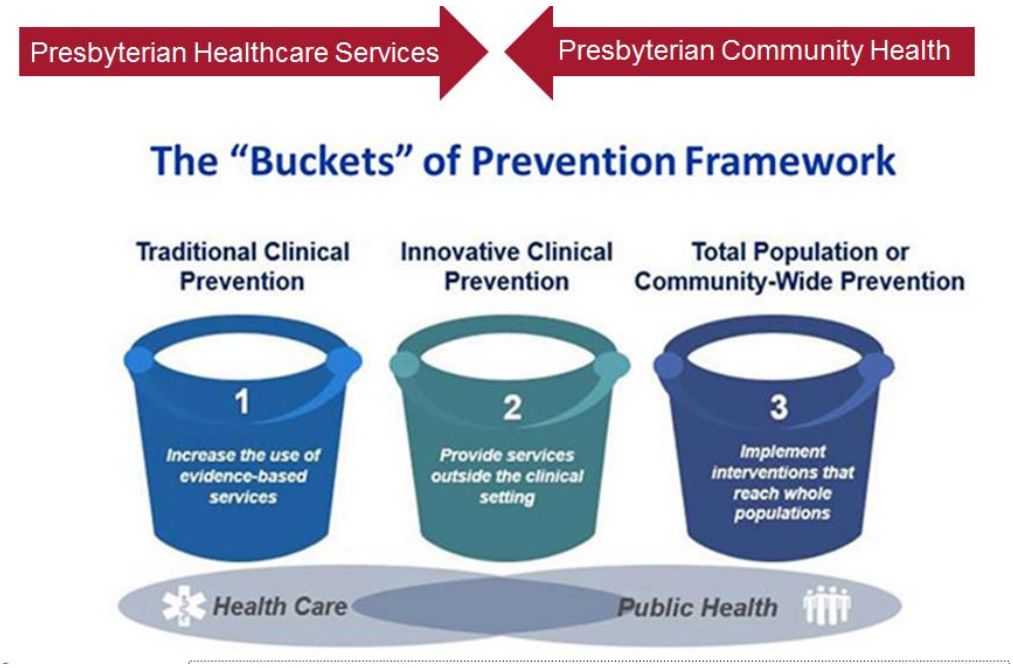


Figure 1 Use of the CDC Three Buckets of Prevention Framework

Evidence supporting strategies and interventions was drawn from The County Health Rankings – What Works for Health[5], The Substance Abuse and Mental Health Services Administration (SAMHSA) and its National Registry of Evidence-based Programs and Practices (NREPP), CDC recommended community strategies, and the US Preventive Services Task Force.

Presbyterian not only plans to continue its significant partnership with local health councils, state public health agencies, anchor institutions, and other community partners, but will continue to build alignment and integration among departments within Presbyterian including Population Health, Quality and Patient Experience, Telemedicine, and Behavioral Health, among many others.

Lessons learned from six years of implementation, feasibility, the desire to maintain progress, and scale of impact factored into this third iteration of implementation plans. Stated goals and strategies address the unique needs of the community, simplify and scale successful interventions with demonstrated impact, and incorporate new and innovative models for health systems to drive population health improvement (figure 2).

[5] http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

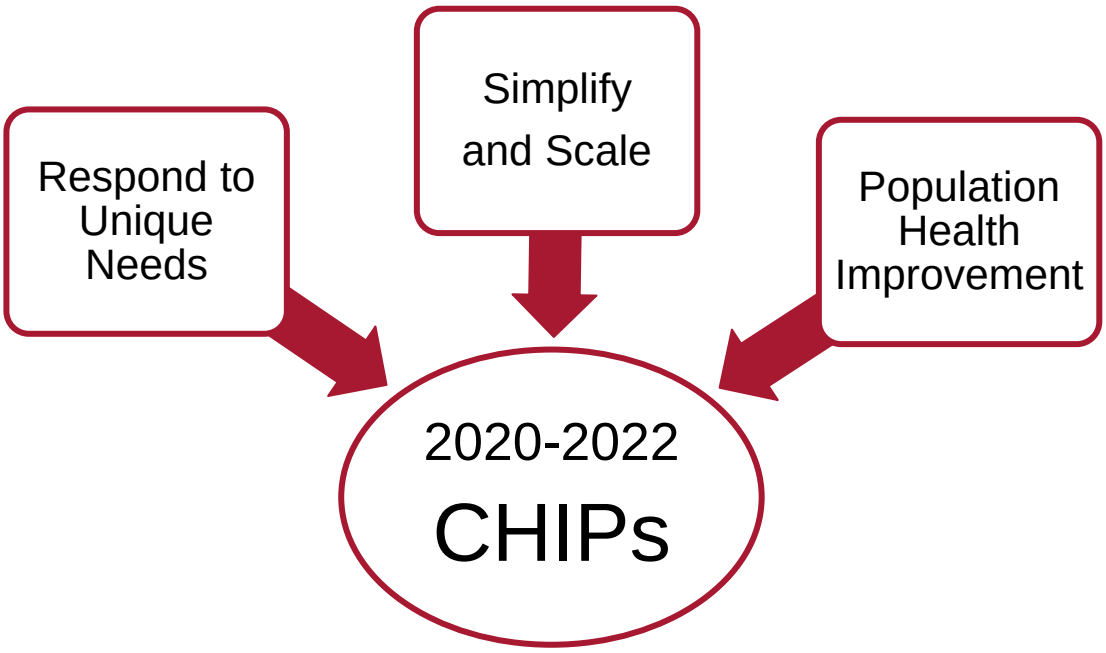


Figure 2 CHIP Strategies Development Model

The following principles were also used to guide the development of the interventions incorporated in the Implementation Plans:

- Data will be used to drive identification of interventions
- Interventions will be based on professional theories and will be consistent with professional and/or best known evidence or practices
- The purpose of the interventions will be clearly stated and easy to understand
- Interventions will be simple and will support and enhance existing interventions
- Interventions will be practical and realistic
- Interventions will be sustainable
- Interventions will be engaging to the priority population
- Interventions will be age-appropriate and culturally relevant
- Interventions will promote equity and will not reinforce inequities in health outcomes
- The plan will be integrated with existing hospital and Presbyterian plans
- Presbyterian will collaborate with existing agencies to strengthen adopted strategies
- Interventions will be evaluated and monitored

Additionally, Presbyterian used the guidelines from 2018 IRS Schedule H instructions[6] (p. 16), which specify that a community health improvement service and community benefit operations must:

- Be carried out or supported for the purpose of improving community health or safety
- Be subsidized by the organization
- Not generate an inpatient or outpatient bill
- Not be provided primarily for marketing services
- Not be more beneficial to the organization than to the community (e.g. not designed primarily to increase referrals of patients with third-party coverage)
- Not be required for licensure or accreditation
- Not be restricted to individuals affiliated with the organization (employees and physicians)
- Meet at least one community benefit objective, including improving access to health services, enhancing public health, advancing generalizable

[6] https://www.irs.gov/pub/irs-pdf/i990sh.pdf

knowledge, and relieving government burden

- Respond to demonstrated community need

Where applicable and not included with the above, Presbyterian used the guidelines for Community Building Activities (p. 4-5) for activities in the following categories:

- Physical improvements and housing - including but not limited to, the provision or rehabilitation of housing for vulnerable populations
- Economic development – can include, but is not limited to, assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness
- Community support – can include, but is not limited to, childcare and mentoring programs for vulnerable populations, and violence prevention programs
- Environmental improvements – including but not limited to, activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards
- Leadership development and training for community members - includes, but isn't limited to, training in conflict resolution and civic or cultural skills
- Coalition building – including but not limited to, participation in community coalitions and other collaborative efforts with the community to address health and safety issues
- Community health improvement advocacy – including but not limited to, efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation
- Workforce development – including but not limited to, recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved, and collaboration with educational institutions to train and recruit health professionals needed in the community
- Other – refers to community-building activities that protect or improve the community's health or safety that are not described in the categories listed above

Presbyterian has dedicated approximately two million dollars for community health operations and community health implementation for the ten counties its nine hospitals serve. Presbyterian Community Health also works closely with internal and external partners to leverage federal and local grant funds to support implementation of these plans. Many internal and external partners also contribute significant in-kind and financial resources toward the implementation of these plans. Additionally, in 2018, Presbyterian formed a Community Benefit Committee

who monitors community benefit investment and whose aim is to make strategic, proactive recommendations about resources dedicated to community benefit.

Strategies to Address Prioritized Significant Health Needs

Plains Regional Medical Center, Community Health, and their partners will be implementing activities specific to Curry County and related to the identified health needs of Behavioral Health, Social Determinants of Health (SDOH), Access to Care, and Healthy Eating and Active Living over the three year time period of calendar year 2020 – through calendar year 2022.

Listed below are the general aims and strategies identified for each priority area. Call out boxes highlight some specific examples and programs. System-wide strategies will be deployed across the eight counties where Presbyterian has hospitals, prioritized according to capacity, resources, and other strategic considerations. Strategies unique to each county, their local health council, hospital, and other stakeholders are also identified.

Improve Behavioral Health

Presbyterian aims to build conditions to thrive through:

- Preventing unhealthy substance use including tobacco, alcohol, prescription and illicit drugs by youth and adults living in our community, receiving care or insurance benefits from Presbyterian, and/or Presbyterian's workforce by increasing resiliency, promoting primary prevention, providing education about behaviors and treatment resources.

- Improving well-being for youth, families, and individuals, by: reducing stigma associated with behavioral health conditions and stigma associated with receiving mental health and substance use treatment; by increasing opportunities to find and receive the appropriate level of intervention and care; and by increasing access to and completion of substance use and other behavioral health treatments

The figure below illustrates the connection between the community health assessment, three year (or annual) measurable outcomes, and specific strategies.

Goal: Decrease drug overdose deaths in Curry County over the next three years by 5%*

CHA Community Indicator (annual trend): Age Adjusted Drug Overdose Deaths per 100,000 population

Objective: Increase number of Providers prescribing/providing Medication Assisted Treatment in Curry County over the next three years

Outcome Measure : Percent change in number of providers prescribing Suboxone with Naloxone in 2019 compared with 2020 by county (source: Prescription Monitoring Program)

Strategy (#12): Increase substance use disorder treatment and fill gaps in care by training and certifying providers in Medication-Assisted Treatment (MAT)

Process Measure 1: Number of PHS providers trained to provide MAT to date	Process Measure 2: Number of non-PHS providers attending PHS trainings to provide MAT to date

* consistent with New Mexico Department of Health Strategic Plan

System Wide Strategies

1. Support coordinated strategies to inform communities about available community and healthcare resources for prevention programming, substance use treatment, and mental and emotional health resources
    a. Increase awareness of available resources
    b. Ease transition and navigation to services and treatment

2. Partner with county and tribal Health Councils to support behavioral health (i.e., prevention of unhealthy substance use and promotion of good mental health) and other related health council priorities identified in the CHA and unaddressed directly by this plan
    a. Where applicable: Support health council efforts to build relationships and increase activities outside of the major cities and improve health in rural and other areas of the county
    b. Support regional collaboration

Increase awareness of available resources by promoting the use, maintenance, and refinement of one statewide resource directory, SHARE NM www.sharenm.org

3. Advance local community health leadership development and support community capacity building efforts in each county, includes building provider and health service capacity

4. Support and advance policy and system change that advances Behavioral Health in institutions, communities, and the State
    a. Continue to build and support community partnerships and multi-sector collaborations to address behavioral health
    b. Promote hiring practices that support people in recovery or those with prior justice involvement to get jobs and to economically advance

5. Support positive youth and family development to build increased resiliency and reduce toxic stress

> Continue to invest in youth development and leadership and recreation programs

6. Promote equity and the elimination of health and healthcare inequities
    a. Investigate and promote cultural relevancy and language accessibility for community health improvement activities
    b. Broaden coalition of stakeholders and partners to better facilitate services and programs that address needs of medically underserved, low-income, or minority populations.

7. Encourage dissemination of SAMSHA's Youth Mental Health First Aid and Question, Persuade, Respond (QPR) trainings to help identify and support youth in crisis.

8. Increase clinical opportunities to identify substance use, and other behavioral and mental health needs and intervene for prevention or treatment
    a. Increase use of healthcare and community data to stratify and identify populations for the right level of treatment or prevention at the right place, time, and by the right provider.
    b. Establish and utilize Peer Support Worker model in hospitals to identify opioid overdoses in emergency departments and navigate patients to treatment as appropriate

9. Expand access to Clinical Education for Behavioral Health, Substance Use Disorders, and Child Mental Health
    a. ECHO model
    b. Tobacco Cessation
    c. Screening, Brief Intervention
    d. Motivational Interviewing
    e. Anti-Stigma

> *Develop a community of practice for Peer Support Workers through regular ECHO clinics*

10. Implement and deploy Opioid Stewardship across the Presbyterian enterprise to ensure appropriate utilization of opiates across the Presbyterian continuum.
    a. Standardize Clinical Best Practice
    b. Educate on Alternative Pain Control
    c. Increase safe storage & disposal
        a. Support take back programs
        b. Education on safe storage and disposal

11. Increase access to Behavioral Health services through:
    a. Primary care Collaborative Care Model and Patient Centered Medical Homes
    b. Identify and explore innovative partnerships to increase wrap-around services

12. Increase substance use disorder treatment and fill gaps in care
    a. Train and certify providers in Medication-Assisted Treatment (MAT)
    b. Implement emergency department Buprenorphine distribution and education
    c. Increase naloxone distribution and education
    d. identify and promote treatment modalities for methamphetamine use
    e. Facilitate continuum of and transitions to care with Integrated Addiction Medicine Team
    f. Round out the care team and create peer recovery coach positions

13. Identify and address social comorbidities for patients with behavioral health and substance use needs

Strategies Unique to Curry County

1. Support Health substance use and behavioral health strategies including:
    a. Support programs and interventions for positive youth development and positive family development
    b. Support take-back initiatives in the community
    c. DWI prevention
    d. Teen Court and other diversion programming

2. Participate and/or convene conversations about regional solutions for access to behavioral health care

3. Provide opportunities for clinical providers and patients to more easily utilize available tobacco cessation programs and products through education, clinical supports, and other available means.

Educate providers about how to easily connect patients to quit support by using Epic order sets and other functions

4. Explore expansion of Behavioral Health Consult Liaison Service to PRMC ED primarily through telemedicine

Address Social Determinants of Health (SDOH)

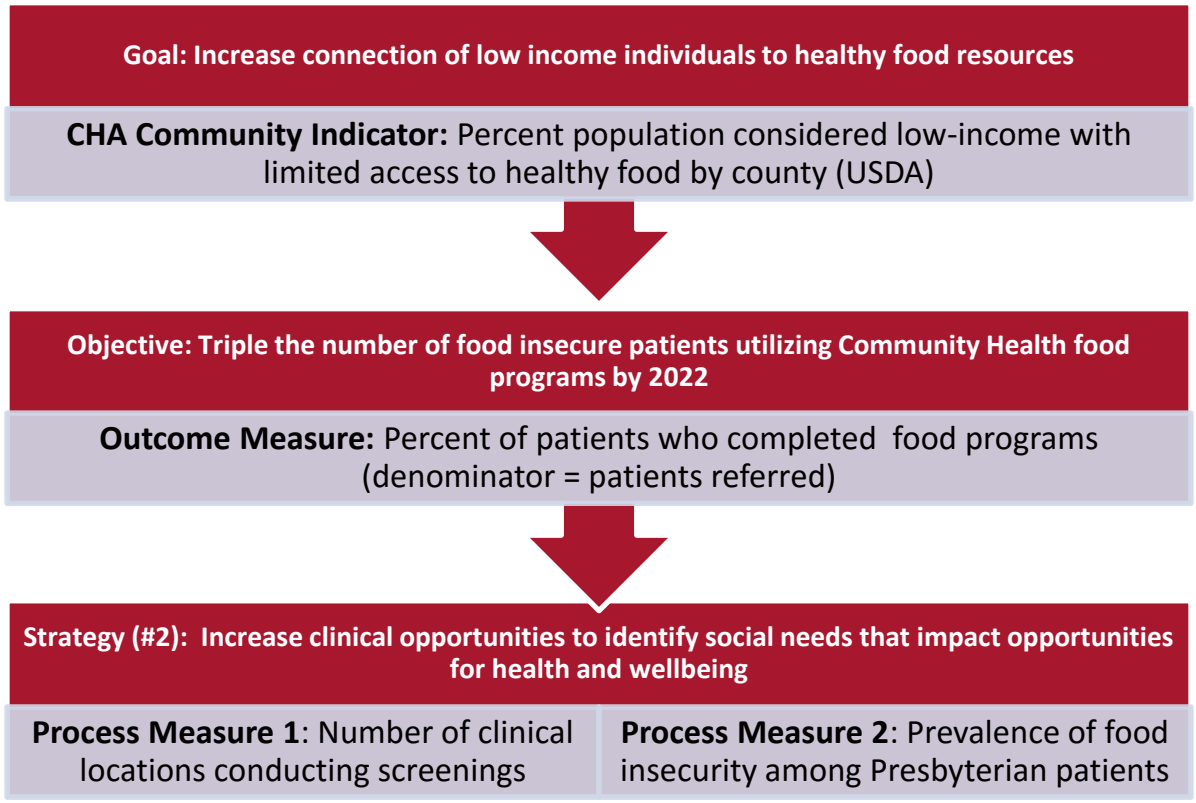
Presbyterian aims to build conditions to thrive through:

- Increasing identification of health-related social needs and connecting individuals to community resources.

- Increasing community resource gap identification and strategic investment by Presbyterian and others in the social service system to improve the health of patients, health insurance members, and communities.

- Increasing the number of partners, policies, investments, and programs that address the root causes of unmet social needs.

The figure below illustrates the connection between the community health assessment, three year (or annual) measurable outcomes, and specific strategies or programs.



System Wide Strategies

1. Lead Presbyterian through implementation of 5-year Social Determinants of Health strategic plan
    a. Ensure leadership engagement and accountability through development of vision and process model and through strategic alignment

2. Understand the needs of the population served
    a. Define preliminary goals for addressing needs including organizational readiness assessment and internal/external gap analysis
    b. Pilot screening and referral with select populations

c. Define populations for scale

Identify prevalence of food insecurity, housing instability, and interpersonal safety

3. Increase clinical opportunities to identify social needs that impact opportunities for health and wellbeing
    a. Build supportive infrastructure including job descriptions for new clinical team members, hierarchies, technology, and policies and procedures
        i. Integrate electronic health record (EHR) with community resource and referral platform
    b. Develop new screening and referral workflows and integrate into existing clinical workflows
    c. Develop and implement trainings
    d. Screen patients and provide resources for the social needs they identify
    e. Collect and study data
    f. Continuously improve quality

4. Support coordinated internal and community strategies to inform and connect individuals to social services and resources to address health-related social needs
    a. Maintain and increase strong community resource provider, health care provider, insurance provider, government, and other community partnerships
    b. Increase awareness of available resources
        i. Support SHARE NM to be the primary statewide resource service
        ii. Develop general resource for positive screens
        iii. Develop advanced and tailored resource and referral capabilities in partnership with SHARE NM and NowPow
        iv. Encourage any entity planning to build or disseminate a resource guide, list, or directory to partner with and engage in two-way information sharing with SHARE NM to ensure efficiency and the most up to date resources are available to all New Mexicans.
    c. Increase awareness and use of SHARE NM, tailored resource lists, and available resources
    d. Increase awareness and utilization of available health plan/insurance benefits that address health-related social needs
    e. Equip clinical personnel with data and tools they need to provide general and tailored health-related social needs resources to patients

"NowPow" stands for "Knowledge is Power" and is the name of the vendor who links identified needs to tailored resources within a custom resource directory, all without having to leave the Electronic Medical Record. Improvements to the directory are shared with SHARE NM for the benefit of the community. www.NowPow.com

f. Ease transition and navigation to services for patients with health-related social needs
g. Identify and analyze gaps in resources available to meet social needs
h. Assess results and continuously improve quality

Continue to offer trainings for state CHW certification, open community wide

5. Support and advance external policy and system change
    a. Share lessons learned and progress of Bernalillo County Accountable Health Communities and all other SDOH initiatives
    b. Partner with national organizations like the Institute for Healthcare Improvement, Robert Wood Johnson Foundation, the Commonwealth Fund, the American Hospital Association and others to learn and share knowledge to advance equity and innovate population health approaches to the Social Determinants of Health
    c. Evaluate select programs and disseminate results
    d. Identify opportunities to inform and collaborate with private and public entities as they plan housing developments
    e. Transportation and urban/rural planning partnerships
    f. Be aware of and support community informed justice strategies including community policing, diversion programs, and other initiatives
    g. Join or convene coalitions

6. Support and advance internal policy and infrastructure
    a. Improve processes and procedures related to identification of interpersonal violence within clinical settings
    b. Increase internal health system resources to address housing and homelessness
        i. Collaborate and coordinate with Presbyterian Health Plan Housing Coordinator
        ii. Investigate and increase staff who are trained as SOAR program advocates to increase SSI/SSDI outreach, access, and recovery for individuals eligible for Social Security disability benefits and who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or co-occurring substance use disorder.
    c. Investigate and implement a Medical-Legal Partnership
    d. Increase access to resources, referrals, and navigation for persons who have low income, are on Medicaid, and receive financial assistance to pay for health services.
    e. Increase number of Community Health Workers who are able to help address health-related social needs
    f. Continue to define and refine Community Health Worker (CHW) scope of practice, resources, training, continuing education, and role in clinical and community settings
        i. Increase sustainability for Community Health Workers

ii. Increase collaboration between Community Health Workers and Peer Support Specialists to address health-related social needs and other needs of persons seeking treatment for substance use disorders.

7. Provide continuing medical education, training, and other opportunities to increase providers' and staff knowledge about social determinants of health and health-related social needs, their impact on patient health, best practice, and available interventions

8. Partner with the county Health Councils to impact specific social determinants of health prioritized by each community
    a. Partner with local health councils as the conveners of public health, social, and health services in the community to help identify necessary investments and plans to impact social determinants of health

9. Advance local community health leadership development and support community capacity building efforts in each county, includes building provider and health service capacity
    a. Continue to support capacity for community service providers to participate in closed loop referral and data sharing partnerships

10. Promote equity and the elimination of health and healthcare inequities
    a. Broaden coalition of stakeholders and partners to better facilitate services and programs that address needs of medically underserved, low-income, or minority populations.

Strategies Unique to Curry County

1. Support health council strategies to address social determinants of health
    a. Support local and regional capacity to develop and implement coordinated strategy for addressing housing and homelessness
    b. Guide needed investments and identify and leverage funding to fill gaps and increase service capacity

2. Support Presbyterian employees and volunteers in opportunities or events to address food insecurity, poverty, or other social determinants of health through drives, donations, volunteerism, day of service, etc.

Increase Access to Care

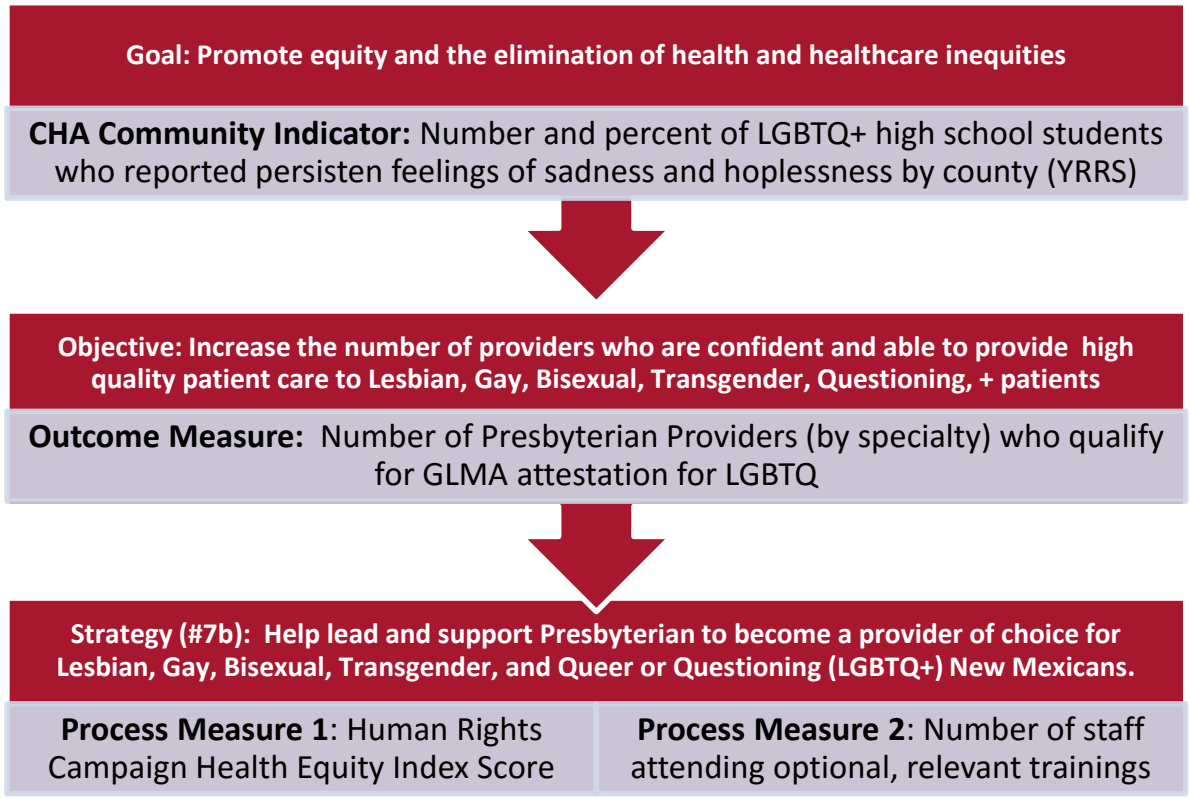
Presbyterian aims to build conditions to thrive through:

- Increasing individuals' ability to better manage their health and navigate health and social care.

- Adding members of the care team and supportive infrastructure to increase and enhance connection to appropriate assistance including behavioral health, chronic disease management, and social supports.

- Grow capacity to meet demand for healthcare services.

The figure below illustrates the connection between the community health assessment, three year (or annual) measurable outcomes, and specific strategies or programs.



System Wide Strategies

1. Support health council and other groups' Access to Care strategies and initiatives
    a. Coordinated strategy to inform, educate, and connect residents to available resources, services, and benefits
    b. Existing and new Health Literacy initiatives
2. Expand the Wellness Referral Center to help providers and clinical staff connect patients to resources for healthy eating, active living, and chronic disease management

Identify and prioritize communities for scale according to capacity and interest

3. Support evidence based or theory driven chronic disease and/or diabetes management and prevention initiatives
    a. Identify and implement sustainability measures to ensure long term success
    b. Increase number of and diversity of offerings
    c. Offer train the trainer for the Chronic Disease Self-Management Program (CDSMP) in English and Spanish
    d. Help identify and connect patients and community members to the best level of intervention for chronic disease self-management or prevention education and assistance (i.e., CDSMP, DPP, MNT, other)
    e. Increase linkages between available Presbyterian and community programming and referring entities (including self-referral)
        i. Reduce barriers for participants to enroll in and complete
        ii. Increase follow up and information to referring entity

Align Equity of Care Pledge with Presbyterian Strategic Initiatives for the next 3 years to increase adoption and sustainability

4. Advance local community health leadership development within both clinical and community spaces and support capacity building efforts in each county to maximize common goals and aligned community and clinical practice
    a. Every hospital and every Presbyterian Medical Group clinics has at least one representative on the health council
    b. Increase communication about clinical and community health initiatives to stakeholders

5. Expand population health workforce
    a. Increase incorporation of certified or "lay" health workers including Community Health Workers, Promotoras, Community Health Representatives, Peer Support Specialists, Home Visitors, and other front line workers into the care team to improve navigation of care, address social needs, and provide additional supports to patients and providers.

6. Create and support opportunities and "communities of practice" for providers and other professionals to share "Bright Spots" – or successful and replicable interventions, programs, or policies to increase access to care
    a. Support Frontline Workers' Conference and other health professional conferences, workshops, and continuing education opportunities
    b. Align and coordinate sharing of lessons learned, training, and education opportunities etc. across Presbyterian Delivery system (and health plan?) for Community Health Workers, Peer Support Workers, chronic disease self-management educators, and others

7. Promote equity and the elimination of health and healthcare inequities
    a. Help lead and support Equity of Care pledge activities
        i. Continue to improve collection and increase use of race, ethnicity, language preference and other socio-demographic data

ii. Maintain and increase quality of cultural competency training
iii. Identify and implement steps to increase diversity in leadership and governance
iv. Coordinate and align with Presbyterian Health Plan cultural sensitivity efforts

b. Help lead and support Presbyterian to become a provider of choice for Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning (LGBTQ+) New Mexicans.
   i. Convene an LGBTQ Equity of Care Steering Committee
   ii. Maintain and improve training and continuing education for clinical and all staff.
   iii. Improve collection and use of gender identity and sexual orientation information in the Electronic Health Record to improve patient care
   iv. Identify and implement improvements to help attract and retain LGBTQ+ employees; increase environmental supports enabling LGBTQ+ employees to Thrive at work.

c. Support and align with efforts that aim to increase patient and provider satisfaction by:
   i. Reducing provider burnout
   ii. Reducing stigma felt by patients accessing services, particularly those patients who have complex social or behavioral health needs, have experienced trauma, discrimination, and/or other toxic stress
   iii. Increasing trust between providers and patients
   iv. Providing supportive infrastructure for providers and clinical teams
   v. Increasing health literacy and agency for patients

d. Investigate and promote cultural relevancy and language accessibility for community health improvement activities

Prioritize emergency room staff and first responders for stigma reduction trainings and activities

e. Broaden coalition of stakeholders and partners to better facilitate services and programs that address needs of medically underserved, low-income, or minority populations.

8. Help connect New Mexicans with information on the latest and best benefits available from various insurance plan choices, provide information that will help them navigate and utilize benefits they already have

9. Support free community shot clinics

10. Investigate and implement telehealth solutions for rural and urban communities

11. Maintain and improve efforts to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving needed medical care.
    a. Provide emergency and other medically necessary care free or at a discount if an uninsured or underinsured patient is unable to pay.

b. Continue to investigate and implement improvements to the financial assistance policy, counseling, and other supportive services for patients seeking financial assistance.

Strategies Unique to Curry County

1. Reduce barriers for patients and providers to prevent and manage diabetes
    a. Identify and partner with clinical champions
    b. Increase learning and best practices around diabetes self-management

2. Increase regional collaboration to address access to care

Support and Promote Healthy Eating and Active Living

Presbyterian aims to build conditions to thrive through:

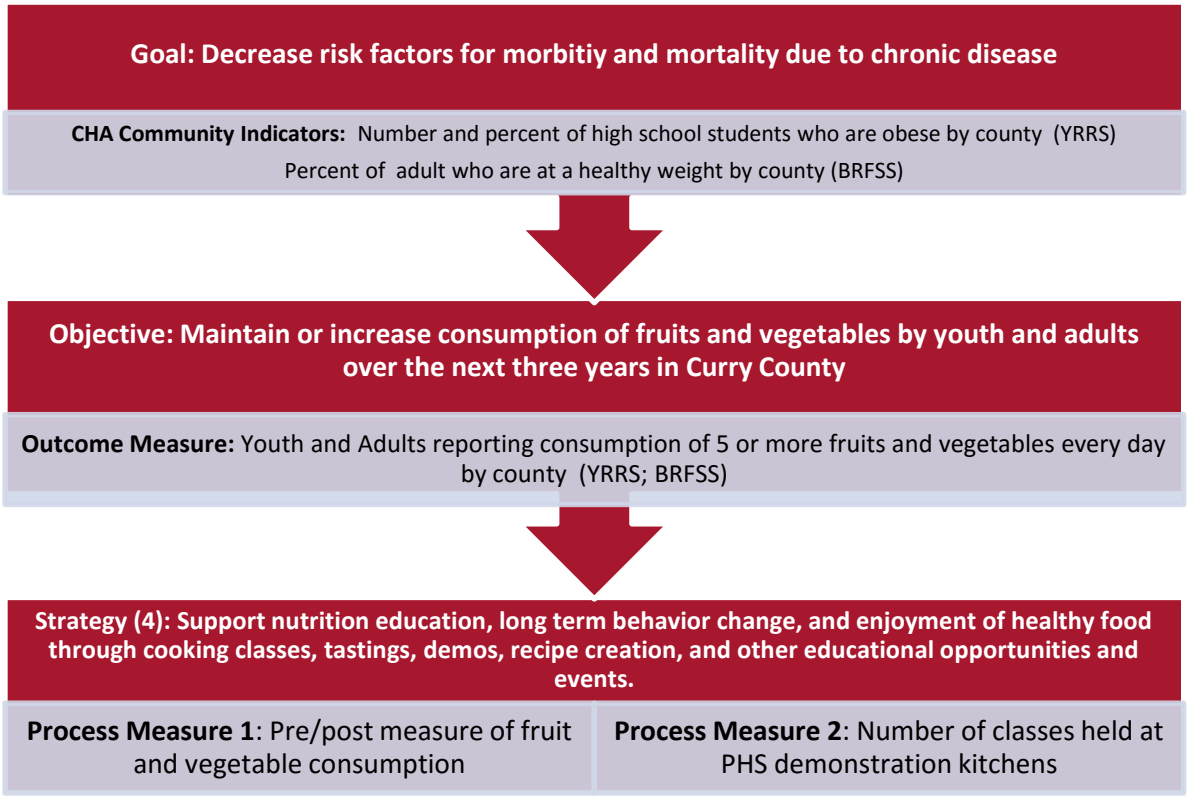
- Improving the nutrition of our residents by increasing availability of healthy foods, education, and enjoyment preparing and eating healthy food.

- Increasing the ability of local food producers to provide healthy food to individuals and institutions

- Increasing physical activity and improving infrastructure to promote safe and accessible places to exercise.

- Improving prevention and self-management of chronic disease among populations we serve.

The figure below illustrates the connection between the community health assessment, three year (or annual) measurable outcomes, and specific strategies or programs.



System Wide Strategies

1. Support health council and other groups' Healthy Eating and Active Living strategies and initiatives
    a. Coordinated strategy to inform, educate, and connect residents about available resources for healthy eating, active living, and chronic disease self-management
    b. Increase connections and collaborations among existing community resources to leverage resources, increase reach, efficiency, and efficacy
    c. Help build capacity to create healthy food availability, procurement, and production
    d. Support and encourage efforts that incorporate interpersonal, organizational, community, and policy components including those that focus on built environment, community well- being, and social determinants of health.
    e. Where applicable: Support efforts to build relationships and increase activities outside of the major city and improve health in rural and other areas of the county

2. Expand the Wellness Referral Center to help providers and clinical staff connect patients to resources for healthy eating, active living, and chronic disease management

3. Support increased physical activity through access to free or low-cost, safe, and supportive opportunities and places to exercise

4. Support nutrition education, long term behavior change, and enjoyment of healthy food through cooking classes, tastings, demos, recipe creation, and other educational opportunities and events.
    a. Include Registered Dietician as part of Presbyterian Community Health team
    b. Increase number of and utilization of teaching kitchens
    c. Support local and culturally appropriate cooking and nutrition education programs and classes

5. Increase access to and consumption of healthy foods
    a. Maintain and improve the Free Healthy Meals program in New Mexico
    b. Identify food insecure patients and connect them with community food resources
    c. Explore and expand innovative health system approaches to food insecurity and healthy food access including 'Food Farmacy' models

6. Support evidence-based or theory-driven chronic disease and/or diabetes management and prevention initiatives

7. Support local procurement and anchor institution efforts for Presbyterian operations and Presbyterian programs

8. Advance local community health leadership development and support community capacity building efforts in each county to maximize collective action and impact

9. Support opportunities for groups, councils, and collectives to share "Bright Spots" – or successful and replicable interventions, programs, or policies to advance Healthy Eating and Active Living efforts.

10. Promote equity and the elimination of health and healthcare inequities
    a. Investigate and promote cultural relevancy and language accessibility for community health improvement activities
    b. Broaden coalition of stakeholders and partners to better facilitate services and programs that address needs of medically underserved, low-income, or minority populations.

Strategies Unique to Curry County

1. Support health council and other groups' Healthy Eating and Active Living strategies and initiatives
    a. Mapping and distribution of trails and places to exercise

2. Identify and support opportunities for residents to learn about nutrition, cooking, and healthy food resources available in Curry County.

3. Increase access to healthy food for youth and families in Curry County

Increase the number of patients, community members, staff and their families participating in healthy cooking classes

4. Support development, maintenance, and use of community and school gardens in Curry County
    b. Provide in-kind support for garden space, water, infrastructure
    c. Support community garden as community gathering space, outdoor classroom
    d. Support harvest and distribution of healthy produce from gardens

5. Support Chronic Disease Self-Management Education including classes for cancer, diabetes, chronic pain, and more.

6. Reduce barriers for patients and providers to prevent and manage diabetes through education, clinical and community linkages, and by addressing social determinants

Impact

Presbyterian will continue to partner closely with local health councils and organizations to help implement the 2020-2022 plans. The intended impact of increased partnership is to increase capacity of local community conveners to align resources and efforts for efficiency, coordination, and sustainability. Plains Regional Medical Center, Community Health, and the health council will continue to form yearly action plans, identify feasible goal targets, and to implement strategies in the plans. Additionally these partners will continue to monitor progress and report on outcomes to Community Health. Community Health will identify and conduct specific and high yield program process, outcome, and impact evaluations as well as quality improvement activities according to capacity and demand. Specific evaluations include those of Day of Service, Healthy Meals for Kids, the Food Farmacy program, the Wellness Referral Center, Peer Support services, health-related social need screening and resource referral, and others. CHIP reports and results of these evaluations will be made available on www.phs.org and shared with the hospital board and community stakeholders.

Plan Adoption

This Community Health Implementation Plan was approved by the PRMC Board on May 29, 2019 and by the PHS Board Quality Committee on _____. PRMC, Community Health, and their partners will implement the CHIP throughout 2020-2022 with regular updates that will be posted on phs.org. If you have questions about the plan or would like to participate in the process, please contact Presbyterian Community Health at communityhealthteam@phs.org.