### Priority Area 2: **SOCIAL DETERMINANTS OF HEALTH**

**COMMUNITY**
- Reduce household food insecurity for patients, members and in the community.
  - Household food insecurity rate by county: 14.6% of households in the 10 counties Presbyterian serves currently experience Food Insecurity (2017, NMIBIS Food Insecurity Report).

**HEALTH SYSTEM**
- Identify Health System Health Equity opportunities through better utilization of SDOH segmentation.
  - Prevalence of SDOH measures among patients/members

### 2020 – 2022 Goals

#### Outcome Measures

<table>
<thead>
<tr>
<th>Program</th>
<th>2020 – 2022 Goals</th>
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</table>
| **Facilitate Presbyterian Equity Strategy** | a. Make health equity a strategic priority.  
b. Develop structure and processes to support health equity work.  
c. Deploy specific strategies to address the multiple determinants of health on which healthcare orgs can have impacts. |
| **Lead Presbyterian through Comprehensive SDOH Plan** | a. Implement Accountable Health Communities.  
b. Support coordinated internal and community strategies to inform and connect individuals to social services and resources; resource directories.  
c. Increase clinical opportunities to identify social needs.  
d. Increase access to resources, referrals and navigation for persons who have low income, are on Medicaid and received 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. Provide continuing medical education, offer community health worker certification classes, and provide other opportunities to increase knowledge about social determinants of health. |
| **Food Farmacy** | a. Increase high-risk patient access to and consumption of healthy foods.  
b. Increase # of high-risk patients who meet their health goals.  
c. Increase patient and provider satisfaction. |
| **Health Council and Local Support** | Partner with the county and tribal health councils to impact specific social determinants of health prioritized by each community. |

### Programs and Strategies

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### Performance Measures

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<th>Measures</th>
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<tbody>
<tr>
<td><strong>Facilitate Presbyterian Equity Strategy</strong></td>
<td># of patients screened, # of AHC beneficiaries screened; # of health-related social needs identified, % high risk enrolled in CHW navigation; # of new PHS clinical locations screening for HRSNs, % of NowPow active users; % patients, members and program participants with identified social needs; # new state-certified Community Health Workers</td>
</tr>
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| **Lead Presbyterian through Comprehensive SDOH Plan** | Address Health Related Social Needs of Patients  
a. Implement Accountable Health Communities.  
b. Support coordinated internal and community strategies to inform and connect individuals to social services and resources; resource directories.  
c. Increase clinical opportunities to identify social needs.  
d. Increase access to resources, referrals and navigation for persons who have low income, are on Medicaid and received 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. Provide continuing medical education, offer community health worker certification classes, and provide other opportunities to increase knowledge about social determinants of health. |
| **Food Farmacy** | total visits to the Food Farmacy; # of patients actively participating; % served at Community Health Resource Center; % served at PMG at Las Estancias |
| **Health Council and Local Support** | total funding provided; # of priority initiatives; # of community members reached |

*These programs and measures are implemented and reported through other Presbyterian departments

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*The conditions in which people are born, grow, live, work, and age. They may enhance or impede the ability of individuals to attain their desired level of health.*

– World Health Organization