



Priority Area 4: HEALTHY EATING AND ACTIVE LIVING (HEAL)



Long-Term Goal

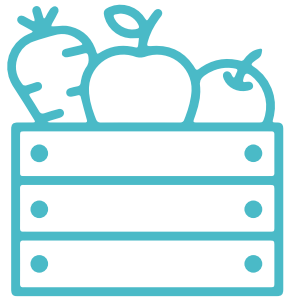







Improve prevention and management of Diabetes in New Mexicans*

(outcome) Prevalence of adult patients with HbA1c in poor control >9%

*Prevalence of people with HbA1c 5.7-6.4 (prediabetes), 6.5-9 (Diabetes), & >9 (Diabetes not in control)

“Our healthy eating and active living initiatives focus on access, infrastructure, policy, and education designed to improve the nutrition of NM residents and help them stay active, safely.”

– Presbyterian Community Health

Intermediate Goals	Strategy	Level of Influence	Key Objective	Programs	Key Performance Measures
 Increase consumption of fresh, locally grown fruits and vegetables among adults and youth in New Mexico	Nutrition and Health Education	Individual 	Increase in individual knowledge, skills and self-efficacy related to cooking skills, healthy nutrition practices and chronic disease self-management	Programs cross multiple levels of influence, which makes them powerful programs. <ul style="list-style-type: none"> Registered-dietitian-led nutrition/cooking classes Diabetes self-management 	<ul style="list-style-type: none"> # of class participants # of patient referrals to the Wellness Referral Center participant class satisfaction
	Healthy Food Environment	Institution 	Improved site level adoption and institutionalization of programs/practices that improve access to healthy food	<ul style="list-style-type: none"> Chronic disease self management Wellness Referral Center FreshRx Mobile Farmers Market Free Health Meals program 	<ul style="list-style-type: none"> Total lbs. of local, healthy food purchased by anchor intuitions # of home health aides trained in best practices in senior nutrition # of seniors connected to healthy meals
	Local Food Availability and Access	Community 	Improved local food distribution systems	<ul style="list-style-type: none"> Connecting Harvest to Health (senior nutrition program) Healthy Neighborhoods Albuquerque 	<ul style="list-style-type: none"> Total lbs. of local food purchased by intuitions increase in utilization of federal/state nutrition assistance programs
 Increase in the number of NM Adults and Youth meeting physical activity recommendations	Fitness Classes	Individual 	Increase individual knowledge, skills and self-efficacy related to ways to be physically active	<ul style="list-style-type: none"> Fitness classes (yoga, zumba) Wellness Referral Center Healthy Here – Active Living 	<ul style="list-style-type: none"> # of class participants # of patient referrals to the Wellness Referral Center participant class satisfaction
	Built Environment	Community 	Increase access to healthy environments for walking, biking and hiking		<ul style="list-style-type: none"> # linear new pedestrian miles
	Capacity Building and Partnerships	Cross-cutting 	Partner with county/tribal health councils and coalitions to increase healthy eating and active living opportunities prioritized by each community	<ul style="list-style-type: none"> Local health council/ coalition support and alignment Community health assessment and improvement plans 	<ul style="list-style-type: none"> Total funding provided # of priority initiatives # of community members reached/ participating

A program performance measure is a way we measure the success of the program either on the impact on communities or the way we deliver our programs.



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2020 – 2022 Goals	Outcome Measures
<p>COMMUNITY</p> <p>Increase consumption of fresh, locally grown fruits and vegetables among adults and youth in New Mexico.</p>	<p>youth and adult fruit and vegetable consumption </p> <p>18.9% of kids and 16.7% of adults consumed 5+ fruits or vegetables daily in 2017 (YRRS and BRFSS) 10-county area</p>
<p>HEALTH SYSTEM</p> <p>Improve HbA1c control in adult patients.</p>	<p>prevalence of adult patients with HbA1c in poor control >9% </p>

Programs and Strategies	Performance Measures
<p>Free Healthy Meals for Kids Increase youth access to free, year-round healthy meals.</p>	# of meals served
<p>Healthy Here Mobile Farmers Market</p> <ul style="list-style-type: none"> a. Increase access to and education about affordable, healthy, locally produced foods. b. Increase market opportunities for local farmers. c. Increase resident use of SNAP, WIC, and local benefits to buy market produce. d. Increase resident knowledge of resources for prevention self-management of chronic disease. e. Increase resident knowledge on how to prepare healthy meals that fit family needs. 	# of registered customers; amount of local food purchased; % of purchases made with incentives (Double Up Food Bucks); % of local produce sold
<p>Wellness Referral Center (WRC): Expand the Wellness Referral Center to help providers and clinical staff connect patients to resources for healthy eating, active living and chronic disease management.</p>	# patients referred to programs; % participated in programs
<p>Healthy Cooking Classes: Increase patient knowledge, skills and attitudes on healthy dietary behaviors and food preparation techniques.</p>	# of class participants; # classes offered
<p>Healthy Here – Active Living</p> <ul style="list-style-type: none"> a. Increase access to healthy environments for walking, biking and hiking. b. Increase participation in wellness referral center activity classes. 	# linear new pedestrian miles; # participants in all WRC-associated fitness classes; # fitness classes held at Community Health Resource Centers
<p>Chronic Disease Self-Management Workshops</p> <ul style="list-style-type: none"> a. Help identify and connect patients and community members to the best level of intervention for chronic disease self-management or prevention education and assistance. 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. 	# of workshop participants; # workshop leaders ; # of workshops
<p>Registered Dietitian Led Diabetes Self-Management Program Develop and implement diabetes self-management program.</p>	# billable visits (learning measure)
<p>NM HEART Disease and Stroke Prevention Contract Align health system and community interventions with the Department of Health (DOH) and CDC best practices.</p>	# referred to blood pressure cuff classes
<p>Connecting Harvest to Health/Conectando Cosechas con la Salud</p> <ul style="list-style-type: none"> a. Increase certified health home aids (HHAs) with knowledge, skills, confidence and experience lead dissemination of senior nutrition best practices. b. Increase preparation of nutritional, diet-appropriate meals for seniors by HHAs and senior meal programs. c. Increase consumption of nutritional, diet-appropriate meals among seniors. d. Increase in local food purchased/cooked/consumed. 	# HHAs trained; amount of local food purchased; # seniors assessed for nutrition needs; # seniors connected with meals; # growers supplying local produce
<p>Fresh Rx Increase patient access to fresh fruit and vegetables through provider prescriptions.</p>	# of patients and farmers markets participating in program; # of repeat patient visits; total amount of prescriptions redeemed
<p>Healthy Neighborhoods ABQ Develop partnerships and collaborative projects that leverage anchor institutions’ capacities to buy local and hire local, as well as promote business development in underinvested neighborhoods.</p>	# pounds of local food purchased across programs; % of anchor partners meeting annual goals
<p>Health Council and Local Initiative Support</p> <ul style="list-style-type: none"> a. Partner with the county and tribal health councils to increase healthy eating and active living opportunities prioritized by each community. b. Partner with local agencies to increase healthy eating and active living opportunities. 	total funding provided; # of priority initiatives; # of community members reached/participating



Presbyterian Healthcare Services
Community Health
Implementation Goals and Outcome Measures 2020-2022

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