Healthcare Trustees of New York State

SOCIAL DETERMINANTS OF HEALTH:
A PRIMER FOR HEALTHCARE TRUSTEES

WHAT ARE SOCIAL DETERMINANTS OF HEALTH AND HOW DO THEY IMPACT YOUR COMMUNITY?

The range of personal, social, economic and environmental factors that influence health status are known as determinants of health.

Social determinants of health are non-medical factors such as housing, nutrition, income, education, transportation, social isolation, health literacy and access to care and healthy food, all of which can affect health and healthcare outcomes.

SDH greatly impact the health status of the people who live and work in our communities, and drive healthcare disparities. According to The Robert Wood Johnson Foundation, "Good health begins in the places where we live, learn and work and play."

What is happening in New York?

The *Prevention Agenda 2019-2024* is New York state's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and to reduce health disparities for populations who experience them. In partnership with more than 100 organizations across the state, including HANYS, the vision of the *Prevention Agenda* is for New York to become the "healthiest state in the nation for people of all ages."

The *Prevention Agenda* is based on a comprehensive statewide assessment of health status and health disparities, changing demographics and the underlying causes of death and disease. All nonprofit hospitals in the state are working on the *Prevention Agenda,* implementing public health approaches that improve the health of entire populations and eliminate health inequities, including addressing SDH.

Since 2012, the New York State Department of Health has invested in capital projects, supportive housing and other services targeted to high-utilizers of Medicaid. DOH established its Bureau of Social Determinants of Health in 2017 with a goal of incorporating community-based organizations and addressing SDH to improve the quality of care and health outcomes for vulnerable populations and to increase Medicaid efficiency.

BEST PRACTICE CASE STUDIES

Some hospitals and healthcare systems are developing innovative partnerships to address SDH and build a future of sustainable population health initiatives. Below are some examples of how healthcare organizations in New York are partnering to address SDH.

Catholic Health Services of Long Island's *Healthy Sundays* program

Catholic Health Services of Long Island, a nonprofit, mission-based organization, established its *Healthy Sundays* outreach network and Bishop McHugh Health Centers in 2005 to provide preventive health screenings and education to members of medically underserved communities on Long Island.

Partnering with more than 40 churches and community centers across Nassau and Suffolk counties, *Healthy Sundays* addresses prevalent medical conditions – such as hypertension, diabetes and obesity – to improve quality of life and decrease morbidity and mortality. Educational materials and health screenings are offered, including blood pressure and body mass index, along with free flu vaccinations.

In 2018, 44 free events were held, with more than 1,800 individuals screened, including 1,300 who received flu vaccinations. As a result, more than 150 Long Island residents received referrals for follow-up care.

For more information, contact Patricia Gilroy, manager, community outreach, CHS, at (516) 705-2595.

> "It is important for trustees to understand how the social determinants of health impact the health of their communities. Building partnerships today to address social determinants of health can create the potential to work together in new ways over time to not only improve the health of our communities but to also address health inequity issues in our society."
>
> **VICTOR AYALA**
> BOARD MEMBER, ONE BROOKLYN HEALTH
> CHAIR, HTNYS DIVERSITY AND INCLUSION COMMITTEE

Northwell Health's *Food as Health* program

The *Food as Health* program at Northwell Health's Long Island Jewish Valley Stream hospital is a novel, evidence-based and integrated hospital approach to improving health outcomes by addressing food insecurity for at-risk patients. The FAH program collaborates with food access community-based organizations, food vendors and internal health system stakeholders to decrease food insecurity, hospital readmissions and avoidable emergency department visits. It also aims to improve patient health and engagement by addressing food insecurity through three service options: a hospital-based food resource center, mobile food pantry and medically tailored home delivered meals from the *God's Love We Deliver* program.

Patients experiencing food insecurity are identified through the evidence-based Children's HealthWatch™ Hunger Vital Sign survey. Since the program launch on July 9, 2018, through December 2018, FAH has screened 801 patients, 228 of whom were positive for food insecurity. Eighty-eight percent of patients identified as eligible for the FAH onsite resource center have been enrolled. Through the end of 2018, 4,000 pounds of fresh produce were distributed to patients attending the onsite resource center. Patient experience scores have improved as well.

For additional information, contact Nancy Cooperman, MS, RD, CDN, vice president, community health, Northwell Health, at ncopper@northwell.edu.

HTNYS will feature additional SDH case studies in its monthly **From the HTNYS Executive Director – Trends** emails.

HOW CAN TRUSTEES HELP?

- Understand what is happening in your community, where SDH problems are and how your organization can help the community begin to solve them.
- Learn how your organization is looking at population, demographic and socioeconomic trends.
- Ask your hospital or health system CEO what he or she is working on related to the *Prevention Agenda* and addressing SDH and disparities.
- Obtain a high-level overview of key data that highlight obstacles to addressing SDH.
- Inquire if your healthcare organization is already collaborating with community-based organizations, businesses, schools and others to begin to address how these social determinants are impacting your communities. Identifying and creating community-wide interventions through partnerships is an effective way to advance community health and address SDH.

MORE ON BACK ➔

RESOURCES

HTNYS Online Diversity and Inclusion Toolkit
htnys.org/education/board_diversity

The American Hospital Association and Association for Community Health Improvement
Social Determinants of Health Series
aha.org/ahahret-guides/2017-06-21-social-determinants-health-series-food-insecurity-and-role-hospitals

Robert Wood Johnson Foundation
rwjf.org/en/our-focus-areas/topics/social-determinants-of-health.html

Centers for Disease Control and Prevention
cdc.gov/socialdeterminants

New York State Prevention Agenda Dashboard
webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard

City Health Dashboard
cityhealthdashboard.com

For additional information or copies of this document, please call (518) 431-7717 or email Elizabeth Maze, HTNYS project specialist, at emaze@hanys.org.

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