



Department  
of Health

# **Prevention Agenda 2025-2030: New York State Health Improvement Plan**

NYS Public Health and Health Planning Council

September 12, 2024

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*(she/her/hers)*

Medical Director

**Office of Public Health**

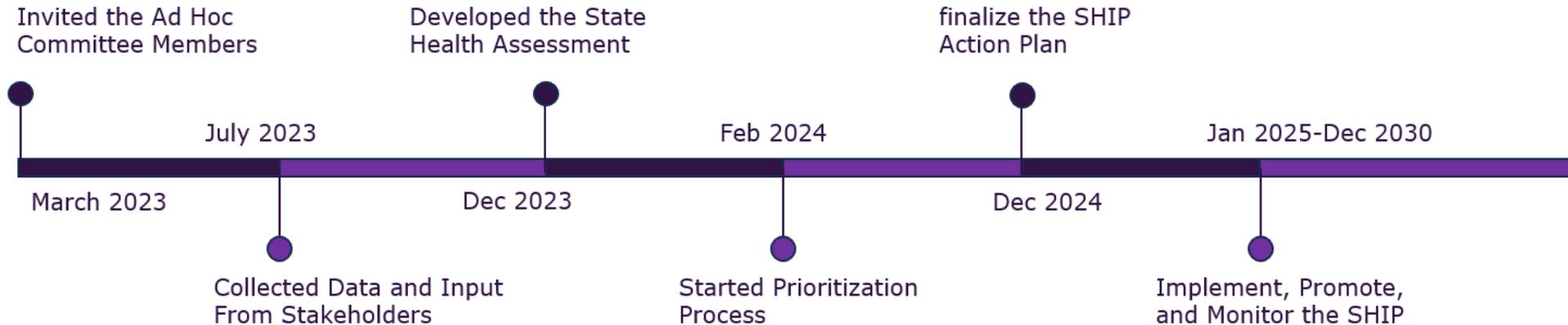
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*(she/her/hers)*

Prevention Agenda Coordinator

**Office of Public Health Practice**

# 2025-2030 Prevention Agenda Timeline



# How Was the 2025-2030 Prevention Agenda Developed?

## State Health Assessment

- **New York State Data Profiles** (e.g., birth, death, hospital records, program statistics, U.S. Census, and national survey)
- **2019-2024 Prevention Agenda progress**
- **Local Health Departments and Hospitals Plans** (112 plans from 58 LHDs and 185 hospitals)

## Stakeholder Engagement

- **Steering Committee** made up of subject matter experts from over 38 centers, divisions, and programs across NYSDOH
- **Ad Hoc Committee** Includes 120+ representatives from 48 agencies across various sectors beyond health
  - **Local Health Departments and NYS Association of County Health Officials**
  - **Non-profit Hospitals and Hospital Associations**
  - **State Agencies** (e.g.; OMH, OASAS, DOS, NYSOFA and others)
  - **Local agencies and community-based organizations**

## Prioritization

- **Online survey completed in Feb 2023 (230 participants)**
- **Collected stakeholders feedback on selected priorities**

# Key Findings

## Key Findings

- **Top Health Concerns:** The top priority list encompasses a range of issues, from socioeconomic factors to specific health conditions
  - **Economic Wellbeing**
  - **Mental Wellbeing and Substance Use**
  - **Safe and Healthy Communities**
  - **Maternal and Child Health**
  - **Healthcare Insurance Coverage and Access to Care**
  - **Education Access and Quality**

# Recommendations

- The Social Determinants of Health (SDOH) are critical areas of need in New York

## **Integrate SDOH into the 2025-2030 Prevention Agenda priorities to:**

- **Address direct and indirect factors influencing health, and**
- **Reflect needs of the community**
- **Consistent with approach of Healthy People 2030**

# NYS DOH Proposal...

- 1. Prevent Chronic Diseases
- 2. Promote a Healthy and Safe Environment
- 3. Promote Healthy Women, Infants and Children
- 4. Promote Well-Being and Prevent Mental and Substance Use Disorders
- 5. Prevent Communicable Diseases

## 2019-2024 Prevention Agenda



Social Determinants of Health



- 1. Economic Stability
- 2. Social and Community Context
- 3. Neighborhood and Built Environment
- 4. Health Care Access and Quality
- 5. Education Access and Quality

## 2025-2030 Prevention Agenda

# A SDOH Framework Supports...

**Holistic  
Approach**

**Addressing  
Root Causes**

**Health Equity**

**Intersectoral  
Collaboration**

**Preventive  
Approach**

**Community  
Empowerment**

# NYSDOH's Updated Mission, Vision, and Values

Mission, Vision and Values	
<b>Mission</b> 	<b>Vision</b> 
To protect and promote health and well-being for all, building on a foundation of health equity.	New York is a healthy community of thriving individual and families.
<b>Values</b> 	
Public Good • Integrity • Innovation • Collaboration • Excellence • Respect • Inclusion	
<b>Definition of Health</b>	
Health is a state of optimal physical, mental and social well-being.	
<b>Statement on Health Equity</b>	
Health equity is foundational to everything we do to help all people achieve optimal physical, mental and social well-being. Everyone at the Department of Health shares responsibility for achieving health equity and eliminating health disparities.	

# Prevention Agenda 2025- 2030

# 2025-2030 Prevention Agenda Framework

<b>Vision</b>	Every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan
<b>Foundations</b>	Health Equity
	Prevention Across the Lifespan
	Health Across All Policies
	Local Collaboration-Building
<b>Domain</b>	<b>Priorities</b>
<b>Economic Stability</b>	<b>Economic Wellbeing</b> <input type="checkbox"/> Poverty <input type="checkbox"/> Unemployment <input type="checkbox"/> Nutrition Security <input type="checkbox"/> Housing Stability and Affordability
<b>Social and Community Context</b>	<b>Mental Wellbeing and Substance Use</b> <input type="checkbox"/> Anxiety and Stress <input type="checkbox"/> Suicide <input type="checkbox"/> Depression <input type="checkbox"/> Drug Misuse and Overdose Including Primary Prevention <input type="checkbox"/> Tobacco/ E-cigarette Use <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Adverse Childhood Experiences <input type="checkbox"/> Healthy Eating
<b>Neighborhood and Built Environment</b>	<b>Safe and Healthy Communities</b> <input type="checkbox"/> Opportunities For Active Transportation and Physical Activity <input type="checkbox"/> Access to Community Services and Support <input type="checkbox"/> Injuries and Violence
<b>Health Care Access and Quality</b>	<b>Health Insurance Coverage and Access to Care</b> <input type="checkbox"/> Access to and Use of Prenatal Care <input type="checkbox"/> Prevention of Infant and Maternal Mortality <input type="checkbox"/> Preventive Services for Chronic Disease Prevention and Control <input type="checkbox"/> Oral Health Care (e.g., routine preventive care, community water fluoridation, dental sealants, and access to dental services for Medicaid covered population) <b>Healthy Children</b> <input type="checkbox"/> Preventive Services (e.g.; immunization, hearing screening and follow up, and lead screening) <input type="checkbox"/> Early Intervention <input type="checkbox"/> Childhood Behavioral Health
<b>Education Access and Quality</b>	<b>PreK-12 Student Success And Educational Attainment</b> <input type="checkbox"/> Health and Wellness Promoting Schools (e.g.; timely immunization, healthy school meals, social emotional learning, and counselling and mentoring including avoidance risky substances) <input type="checkbox"/> Opportunities for Continued Education (e.g.; high school completion programs, transitional and vocational programs, literacy initiatives, and reskilling and retraining programs)

Includes the  
Top 24  
Selected  
Health Issues



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# Foundations

**Health Equity:** Focus on structural racism and implicit bias as social drivers of health.

**Prevention Across the Lifespan:** Promote health and prevent disease through evidence-based interventions, addressing social determinants and health inequities at every stage of life.

**Health in All Policies:** Promote an interdisciplinary, multi-sector collaboration.

**Local Collaboration-Building:** Work collaboratively with stakeholders and community members to achieve SHIP goals.

# Overarching Goals

Domain	Overarching Goal
Economic Stability	All people in New York have the financial security and support needed to thrive
Social and Community Context	All people in New York live in communities that foster and support optimal physical, mental, and social well-being
Neighborhood and Built Environment	All people in New York have equitable access to healthy, and safe neighborhoods
Health Care Access and Quality	All people in New York have access to timely, affordable, and high-quality health care services
Education Access and Quality	All people in New York have equitable access to quality education in an environment that supports physical and mental health



# Prevention Agenda 2025-2030

The NYSDOH will provide the following for each of the five domains:

- **One overarching goal**
- **1-3 objectives for each of the priorities**
- **Indicators to track progress**
- **Evidence-based interventions**
  - For hospitals, health departments, and other organizations
  - Resources for implementation
  - Identification of populations/age groups affected
  - Partners/organizations that play leading or supporting roles

# Domain Workgroups

## Purpose

Identify the goals, objectives, indicators, and interventions for each domain.

## Who?

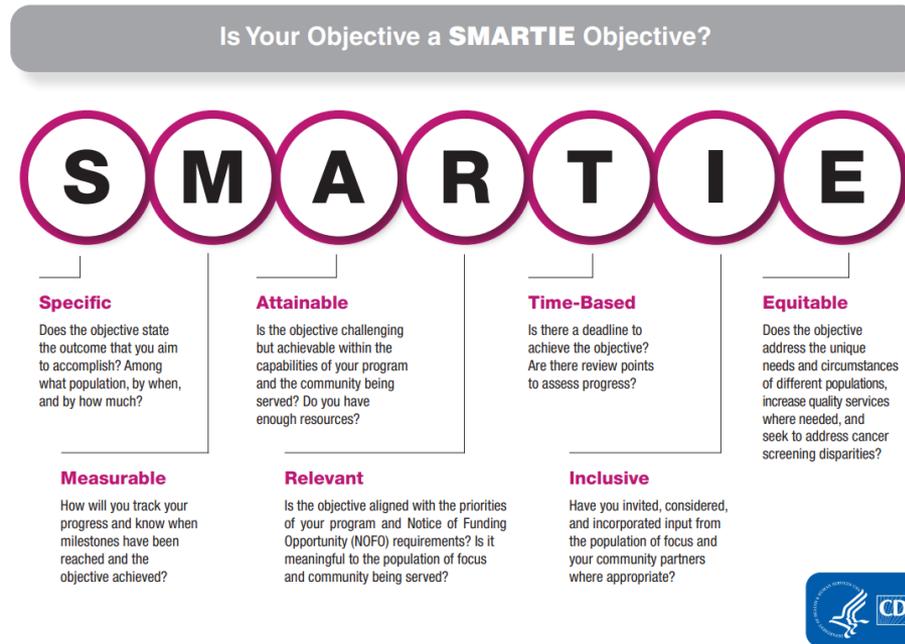
Workgroups are comprised of organizations and members from the Ad Hoc Committee, including NYSDOH programs, LHDs, hospitals, subject-matter experts, and community members.

## When?

July- October 2024.

# SMARTIE Objectives

The SMARTIE Objectives Framework will be used to ensure that objectives are precise:



# How Will the 2025 -2030 SHIP Be Implemented?

The SHIP menu of objectives, strategies and approaches provides flexible options for all communities to improve outcomes for New Yorkers of all ages.

## State and Local Partners:

**Many partners at the state and local level contribute to achieving the vision of the Prevention Agenda, including:**

- Local health departments
- Hospitals
- State agencies
- Statewide organizations
- Healthcare Providers
- Community behavioral health providers
- Housing organizations
- Medicaid managed care plans
- Philanthropy
- Schools
- Local agencies and community-based organizations

Public and private partners must work together to achieve Prevention Agenda goals



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# How Will the 2025 -2030 SHIP Be Implemented?

- SHIP strategies will be implemented as part of:
  - Community health improvement efforts led by local health departments
  - Hospital activities, investments and community benefit expenditures
  - Actions and investments by other community partners.
  - New York's Certificate of Need (CON)
- Strengthen collaboration between hospitals and local health departments
  - Ensure stronger alignment of hospital community investments and local health department priorities.
- Establishing cross-sector partnerships:
  - Implement strategies and interventions to advance the Prevention Agenda and improve the health of individuals of all ages
  - Identify assets, resources, and evidence-based or best-practice interventions

Cycle	2019-2024	2025-2030
<b>Time</b>	6years	6 years
<b>Focus</b>	Major public health areas with a focus on addressing disparities and promoting health equity	Health Equity
<b>Objectives</b>	SMART	SMARTIE
<b>Submission Cycle</b>	Every three years for both LHDs and hospitals	LHDS every 6 years Hospitals every 3 years (per federal requirement)
<b>Priority Selection</b>	<ul style="list-style-type: none"> <li>• Two Prevention Agenda priorities with one focus area each, or one priority with two focus areas</li> <li>• One priority must address a disparity and promote health equity</li> </ul>	<ul style="list-style-type: none"> <li>• Three priorities under one or more SDOH domain</li> </ul>
<b>Collaboration</b>	<ul style="list-style-type: none"> <li>• Hospitals should align priorities with the county LHD</li> <li>• Encouraged joint CHAs/CHIPs/CSPs</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals should align priorities with the county LHD</li> <li>• Encouraged joint CHAs/CHIPs/CSPs               <ul style="list-style-type: none"> <li>• Involvement of local communities in assessment, selection, design, prioritization, and implementation</li> </ul> </li> </ul>
<b>Interagency Collaboration</b>	<ul style="list-style-type: none"> <li>• Ad Hoc (interagency workgroup)- Planning the Prevention Agenda</li> </ul>	<ul style="list-style-type: none"> <li>• Ad Hoc (interagency workgroup)- Planning the Prevention Agenda</li> <li>• Developing interagency workgroup to address SDOHs</li> </ul>

# SDOH Interagency Workgroup

## Establishment and Proposed Timeline

### Purpose

- Promote a government culture that prioritizes health and equity for New Yorkers across policy areas.
- Incorporate health and equity into state agency practices.
- Provide a forum for agencies to identify shared goals and opportunities to enhance performance through collaboration.

### Who?

- Explore opportunities for existing interagency councils to create a working group to perform this function.

# SDOH Interagency Workgroup

## Establishment and Proposed Timeline



**Questions?**  
**Please contact us at**  
**[prevention@health.ny.gov](mailto:prevention@health.ny.gov)**

# Appendix

# Weighted Voting Survey

**Purpose:** To help prioritize the 44 public health issues proposed for inclusion in the 2025-2030 Prevention Agenda.

**Method:**

- Weighted Voting Survey based on seven criteria.
- Weights allow to examine data in a way that includes the responses of every single person who answered a question.

# Weighted Voting Survey

## **Criterion 1: Severity of the Problem**

Refers to whether the identified issue can reduce life quality, limit opportunities, or cause serious health outcomes such as disability or death.

## **Criterion 2: Size of The Problem**

Refers to whether the identified issue affects a large number of individuals and has the potential for a significant impact on the health of the community.

## **Criterion 3: Disproportionate Effects Among Subgroups**

Refers to worse health outcomes caused by the issue in specific subgroups, defined by age, race, ethnicity, income, gender, or geography, compared to others.

## **Criterion 4: Economic and Social Cost**

Refers to the consequences of not addressing the issue, which include increased monetary costs (i.e., healthcare and social service expenses) and social costs (i.e., loss of productivity, reduced quality of life, etc.)

# Weighted Voting Survey

## **Criterion 5: Life-span Effect**

Refers to a health issue arising at a certain life stage having the potential for lasting impacts and/or serving as a proxy for other related behavioral or social problems.

## **Criterion 6: Feasibility**

Refers to the practicality and adequacy of logistics, including the cost, resources, and interventions needed for the state to effectively address the issue.

## **Criterion 7: Availability of Evidence-Based Interventions**

Refers to whether evidence-based interventions or strategies to prevent or manage the health issue are available and can be implemented with relative ease.

# Weighted Voting Survey

## How to Calculate the Total weighted Average Score?

Criterion 1	No Impact $X_1 W_1$	Mild $X_2 W_2$	Moderate $X_3 W_3$	Severe $X_4 W_4$	Extreme $X_5 W_5$	Total Participants	Weighted Average
Poverty	$2 \times 1 = 2$	$4 \times 2 = 8$	$22 \times 3 = 66$	$65 \times 4 = 260$	$86 \times 5 = 430$	179	$(2+8+66+260+430)/179 = 4.28$

The rating average is calculated as follows, where:

$$(x_1 w_1 + x_2 w_2 + x_3 w_3 \dots x_n w_n) / \text{Total number of Responses}$$

$w$  = weight of answer choice

$x$  = response count for answer choice

# Survey Results- Rank of All Health Issues

Rank	Issue	Rank	Issue	Rank	Issue
1	Poverty	16	Anxiety and Stress	31	Hepatitis C
2	Prenatal Care and Maternal Mortality	17	Adverse Childhood Experiences	32	Sexually Transmitted Infections (STIs)
3	Nutrition Security	18	Oral Health	33	HPV Vaccine for Adolescents
4	Drug Overdose Death	19	Injuries and Violence	34	Built and Indoor Environments
5	Health Insurance Access	20	Education Access	35	Social Cohesion
6	Housing Stability and Affordability	21	Safe Community	36	Climate Change
7	Infant Mortality	22	Tobacco/ E-cigarette Use	37	Outdoor Air Quality
8	Healthy Eating	23	Lead Poisoning	38	Healthcare Associated Infections
9	Suicide	24	Language Access	39	End of Life Care and Planning
10	Children Receive Appropriate Screening and Services	25	Human Immunodeficiency Virus (HIV)	40	Indoor Radon
11	Depression	26	Teen Pregnancy	41	Cannabis Use
12	Early Intervention	27	Alcohol Consumption	42	Foodborne Illness
13	Unemployment	28	Water Quality	43	Compulsive Gambling
14	Healthy Aging Ecosystem (i.e., preventive services for chronic disease and associated risk factors)	29	Healthy Schools' Environment	44	Tickborne Diseases
15	Physical Access and Proximity to Health Services	30	Access to Exercise Opportunities		

# Weighted Voting Survey

## Limitations

- **Response Rate**
- **Subjectivity in Weight Assignment**
- **Non-response Bias**

# Food Insecurity

## Essex County

### The Well Fed Essex County Collaborative

**Location:** Essex County

- **Partnership with** Essex County Health Department, Cornell Cooperative Extension, ADK Action, University of Vermont Health Network, Local Farms, and others
- **Focus on** increasing healthy food access for all people in Essex County, with a focus on vulnerable residents through mutually reinforcing projects.

**PROJECTS**

Visit our projects page to learn about additional projects



**Farmacy**

The Farmacy's mission is to increase access to local, healthy food for all residents by adding a farm store into an existing business that doesn't traditionally offer food.

[LEARN MORE](#)



**Food Pantry Conversion**

The Healthy Pantry Conversion project involves improving the availability and promotion of healthy foods into local food pantries.

[LEARN MORE](#)



**Wellness RX**

The cheapest foods available can cause diet related disease. Wellness RX is a referral program treating illness through nutrition and vouchers for fresh foods.

[LEARN MORE](#)



**WIC & SNAP**

WIC provides wholesome food, nutrition education, and community support for income-eligible women who are pregnant or post-partum, infants, & children.

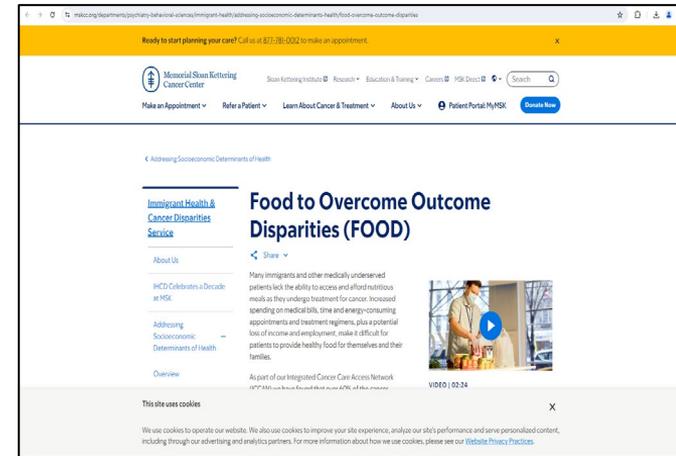
[LEARN MORE](#)

# Food Insecurity

## Memorial Sloan Kettering Cancer Center New York

### Food to Overcome Outcome Disparities (FOOD)

- **Location:** 13 pantries co-located in cancer clinics serving patients in Manhattan, Queens, Brooklyn, the Bronx, and Long Island.
- **Partnership with** NYC Food Bank, New York Common Pantry, Green Bronx Machine, and others.
- **Focus on:** Patients with Cancer.
- **Services:**
  - **Free Food Distribution:** Offers fresh fruits, vegetables, and healthy options low in sodium and sugar to help patients manage chronic conditions.
  - **Provider Training Course:** Educates healthcare providers on the importance of addressing food insecurity in clinical interactions with patients.



# SDOHs

## NYC Department of Health and Mental Hygiene

### NYC Neighborhood Health Atlas

**Location:** NYC.

**Focus on** providing data on about 100 measures related to health and social factors for 188 neighborhoods.

**Goal:** Promotion of health and health equity in NYC neighborhoods.

#### Data:

1. Demographics (such as race, age, country of origin)
2. Social and economic conditions (education, poverty, disabilities)
3. Health outcomes (hospitalizations, rates of communicable diseases, premature mortality)
4. Health care (health insurance status, number of primary care providers, Medicaid enrollment)
5. Housing (density, rent burden)
6. Neighborhood conditions (air quality, number of tobacco retailers, crime complaints)

5/24, 3:32 PM NYC Neighborhood Health Atlas - NYC Health

Menu Translate This Page

 NYC Health

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Health Topics Neighborhood Health Emergency Prep Publications

### New York City Neighborhood Health Atlas

Health outcomes are influenced by social factors, such as education, economic opportunity and environment. Due to these factors, New Yorkers in some neighborhoods live longer, healthier lives than those in other areas. The New York City Neighborhood Health Atlas provides data on about 100 measures related to health and social factors for 188 neighborhoods. The data provide a comprehensive and granular view of neighborhood health and its potential determinants, serving as a useful resource for the promotion of health and health equity in our neighborhoods.

#### Atlas Measures

The Neighborhood Health Atlas' measures relate to health and neighborhood characteristics, including:

- Demographics (such as race, age, country of origin)
- Social and economic conditions (education, poverty, disabilities)
- Health outcomes (hospitalizations, rates of communicable diseases, premature mortality)
- Health care (health insurance status, number of primary care providers, Medicaid enrollment)
- Housing (density, rent burden)
- Neighborhood conditions (air quality, number of tobacco retailers, crime complaints)

#### Neighborhood Tabulation Areas

The Neighborhood Health Atlas defines neighborhoods as Neighborhood Tabulation Areas (NTAs). NTAs are statistical areas constructed by the City to analyze and estimate the populations of small areas. Each NTA consists of census tracts that lie strictly within a Public Use Microdata Area. These areas roughly correspond to the city's Community Districts. NTAs have assigned names and boundaries corresponding to historical neighborhoods that people can easily identify, and they provide detailed and reliable data. You can get more information about NTAs from the Department of City Planning.

If you have any questions about the Neighborhood Health Atlas, email [NeighborhoodAtlas@health.nyc.gov](mailto:NeighborhoodAtlas@health.nyc.gov).

Enter the Neighborhood Health Atlas

<https://www.nyc.gov/health/neighborhood-health/nyc-neighborhood-health-atlas> 1/1

# SDOHs

## *Erie County Health and Human Service Departments* **The Live Well Erie Initiative**

**Location:** Erie County.

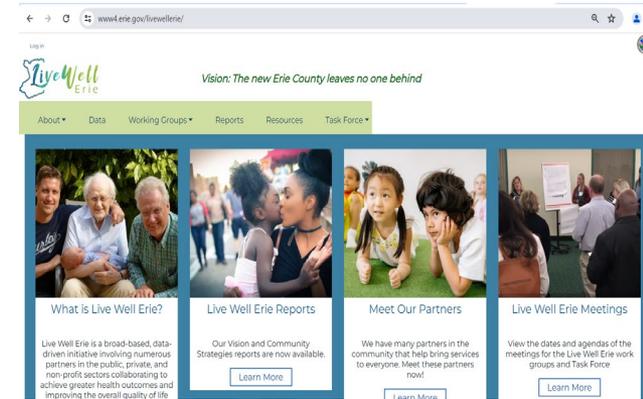
**Partnership with** community-based organizations, private, non-profit, academic, and philanthropic sectors.

**Focus on:** Children, Working Families, Seniors.

**Goal:** Improving the quality of life for Erie County residents.

### **Five Guiding Principals:**

1. A clear focus on the social determinants of health;
2. An integration of the Racial Equity Impact Analysis;
3. An invitation for innovative thinking;
4. An opportunity for the modernization of service delivery;
5. An expectation of partnership and collaboration.



### **Meaningful improvements in the SDOHs**

# SDOHs

## Seven Valleys Health Coalition

**Location:** Cortland County.

**Partnership with** Cortland County Health Department, Guthrie Cortland Medical Center, and Family Health Network of Central New York.

**Goal:** Identify unmet needs and addressing local health issues at a local level.

### Services:

- Helping people access healthcare services
- Providing counseling and education (e.g., prevention and management of chronic health conditions, food waste, oral health, breastfeeding, and others).
- 2-1-1 CORTLAND



#### Our Mission

The mission of SVHC is to cultivate local solutions and collaborative actions that advance the health and well-being of the Cortland community.



#### Our Vision

We envision a community in which all individuals are empowered to lead healthy and fulfilling lives.



#### Our Goals

- ONE:** Identify unmet needs and develop plans to meet those needs.
- TWO:** Create an integrated health and human service delivery system that assures entry and avoids unnecessary duplication of services, particularly for the under-served.
- THREE:** Coordinate efforts to provide needed programs without duplication and with cooperation and mutual resources.
- FOUR:** Investigate and generate financial resources to meet the health care needs of the community.
- FIVE:** Develop formal linkages between providers through management or participation agreements.

# SDOHs

## *NYC Department of Health and Mental Hygiene*

### HealthyNYC Campaign

**Location:** NYC.

**Partner** with City agencies, health care institutions, private and nonprofit businesses, community- and faith-based organizations, state and federal leadership, and other.

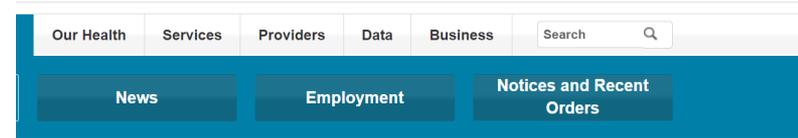
#### HealthyNYC Goals

Goals across all drivers

#### Priority Strategies

To achieve the goals:

- Increase access to and quality of health care, mental health supports and health insurance options.
- Increase access to employment options.
- Address racial disparities in the way care is provided.
- Support community-led programming on health literacy, and increase community health worker presence in communities.
- Promote economic development.
- Improve access to affordable housing.
- Foster community investment in achieving HealthyNYC goals.



## HealthyNYC: New York City's Campaign for Healthier, Longer Lives

New Yorkers are healthier when they live in a city that is healthier. As we emerge from the COVID-19 public health emergency, New Yorkers are sicker — and are dying too soon.

Life expectancy — the average number of years a person can expect to live from the time of their birth — has dropped dramatically, from 82.6 years in 2019 to 78 years in 2020. This represents the biggest and fastest drop in lifespan in a century.

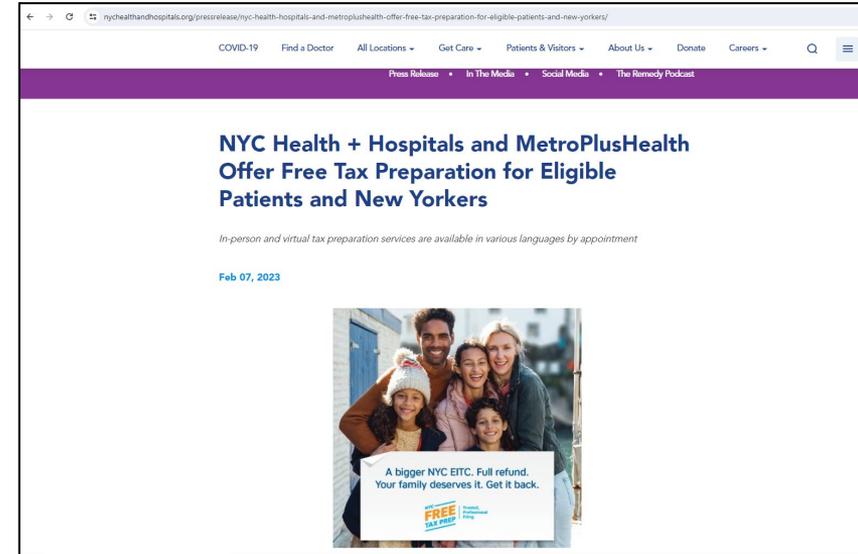
The decreases in life expectancy were not experienced equally among all New Yorkers. The largest decreases were among Black and Latino New Yorkers. For Black New Yorkers, the

# Poverty Intervention

## NYC Health + Hospitals

### Department of Consumer and Worker Protection's (DCWP) NYC Free Tax Prep initiative

- **Location:** Multiple Locations in Bronx, Brooklyn, Manhattan, and Queens.
- **Partnership with** BronxWorks, Grow Brooklyn, Urban Upbound, and Code for America's GetYourRefund initiative
- **Focus on:** New Yorkers who earned <\$56,000 or less and are filing on their own or families who earned \$80,000 or less.
- **Service:** virtual and In-person tax preparation.



# Housing

## Mount Sinai Linkage House

**Location:** East Harlem.

- **Partnership with** the Community Association of the East Harlem Triangle, Inc., Union Settlement Association, and the Greater Emmanuel Baptist Church.
- **Focus:** low-income, elderly, and people with Alzheimer in East Harlem.
- **Services:**
  - Link the residents with safe and affordable housing.
  - Provide access to quality health care, educational programs, and recreational activities.

The screenshot shows a web browser window displaying the Mount Sinai website page for Linkage House. The page title is "Linkage House". The content includes a paragraph describing the driving force behind Linkage House, a paragraph about the name "Linkage House", and a list of bullet points detailing the program's objectives and services. The page also features a sidebar with navigation links for "Alzheimer's Disease", "Linkage House", "Services", "Doctors", and "Hours".

**Linkage House**

The driving force behind Linkage House, as conceived by Mount Sinai faculty, was the conviction that the health of older people is profoundly influenced by the physical and psychological quality of their surroundings. In 1993, following a feasibility study of alternative housing models, the School joined the Community Association of the East Harlem Triangle, Inc., Union Settlement Association and the Greater Emmanuel Baptist Church to sponsor housing for the elderly in East Harlem with core funding from the U.S. Department of Housing and Urban Development. Linkage House took in its first residents in May 1997.

The name "Linkage House" reflects the shared vision of the sponsors: to link the residents with safe and affordable housing, to link residents to the community through a variety of programs and to link the generations through educational and recreational activities. Its objectives are:

- To increase the availability of affordable housing for low-income, elderly residents of East Harlem.
- To provide meaningful roles for older people through shared activities with other residents and through intergenerational programs that would at the same time expand the availability of after-school care for East Harlem children ages five through twelve.
- To improve access to health care.

Linkage House has become home to people who would otherwise spend their older years in isolation in substandard conditions without adequate healthcare, as illustrated by these profiles of residents (names have been changed):

- Mrs. Morgan, a 60-year-old African American woman, had three strokes and suffers from partial paralysis. She was sleeping on a small, uncomfortable couch in her sister's apartment, her alcoholic sister and her boyfriend were abusive to her. With one child in Chicago, Mrs. Morgan lacked a supportive social network. Now she lives at Linkage House with the assistance of a home attendant six hours a day. She joins in all sponsored activities at the residence, shops, takes walks with her attendant, and is finally having much needed dental work because she wants to look more attractive.
- At 66, Mr. Rodriguez lived in the back room of a barbershop in East Harlem. When he moved into Linkage House, he was depressed and had a stooped posture. His only belongings fit into a small shopping cart. Through donations arranged by the Linkage House social services team, he received a bed, linens, towels, and other necessities to furnish his apartment. Mr. Rodriguez is now well functioning and attends a nearby lunch program for older adults.



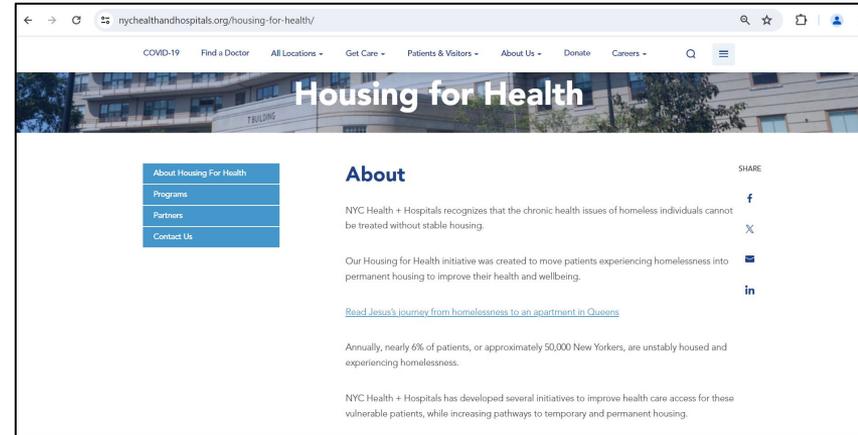
# Housing

## NYC Health + Hospitals

### Housing for Health

**Location:** East Harlem.

- **Partnership with** community-based organizations, City and State housing and homelessness agencies, NYC Housing Development Corporation, NYC Department of Social Services, and others.
- **Focus on:** Patients experiencing homelessness.
- **Services:**
  - Offer temporary housing for patients experiencing homelessness who have been discharged from an acute care facility but still need specialized care not available in shelters.
  - Provide personalized support to assist patients in finding and applying for permanent housing that meets their specific needs.



# Employment/Education

## Montefiore Medical Center Community Health Worker Institute (CHWI)

**Location:** Bronx.

- **Partnership with** 1199 healthcare union and Hostos Community College
- **Services:**
  - Provide training and education to CHWs
  - Conducts research on SDOH and the impact of CHWs
    - Gather and analyze data on SDOH and health status.
- **CHWI enhances Patient Care & Increases Job Opportunities**

montefiore.org/body.cfm?id=1738&action=detail&ref=2330

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Montefiore News Releases

Community Health Worker Institute at Montefiore Fills Gaps Between Medical & Social Needs

August 15, 2023

*Investments in Local Community Experts Enhance Patient Care & Increases Job Opportunities*

Bronx, NY—August 15, 2023—The delivery of healthcare services, while important, represents only 20% of the factors that contribute to a person's health status. In contrast, social determinants of health (SDOH)—conditions that people are born into, work and live in that impact health outcomes (e.g. housing, transportation, education)—are widely recognized as having the most significant influence on a person's health. Despite their importance, SDOH are understudied and resources to address them within the healthcare system are rare. But that's starting to change.

The Community Health Worker Institute (CHWI) at Montefiore, launched in 2021, is establishing a model to address SDOH within an academic health system. The CHWI embeds local experts, known as [community health workers \(CHWs\)](#), into clinical teams to fill the gaps between medical care and social services in the Bronx.

"By having a community health worker as part of the clinical team, they can effectively get to the root of health problems and identify real-world solutions that can significantly improve the health and well-being of our patients," said Kevin Fiori, M.D., M.P.H., M.S., director of CHWI and a pediatrician and researcher at Montefiore Health System and Albert Einstein College of Medicine.

**Building the Workforce**

Reflecting the background, language, and lived experience of the Bronx community they serve, the CHWs at Montefiore are frontline public health workers who serve as trusted members of the community. In partnership with 1199, the largest healthcare union in the nation and Hostos Community College, one of only two New York State Department of Labor-accrediting institutes for CHW education, CHWs receive rigorous training and ongoing education, so they are well-equipped to identify patients' social needs and work with them to secure the necessary services. These partnerships also create a pipeline of employment opportunities.

"To walk in a person's shoes and empathize about experiences is the secret sauce that is sometimes missing in U.S. healthcare – it is a genuineness that can't be fabricated, and is something we need more of," said Dr. Fiori, who is also associate professor of family and social medicine and of pediatrics at Einstein. "Our CHWs enable people to open up so we can learn about challenges impeding their family's health."

For example, a CHW may learn there is mold in a patient's home that is exacerbating their child's asthma. The CHW will alert the medical team to the underlying mold problem, but also helps the patient address their unsafe housing conditions.