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

"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*

| 2020 – 2022 Goals | Outcome Measures | Programs and Strategies | Performance Measures |
|---|---|---|---|
| **COMMUNITY**<br>Reduce household food insecurity for patients, members and in the community. | household food insecurity rate by county<br>14.6% of households in the 10 counties Presbyterian serves currently experience Food Insecurity (2017, NMIBIS Food Insecurity Report). | **Facilitate Presbyterian Equity Strategy**<br>a. Make health equity a strategic priority.<br>b. Develop structure and processes to support health equity work.<br>c. Deploy specific strategies to address the multiple determinants of health on which healthcare orgs can have impacts. | # 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 |
| **HEALTH SYSTEM**<br>Identify Health System Health Equity opportunities through better utilization of SDOH segmentation. | prevalence of SDOH measures among patients/members | **Lead Presbyterian through Comprehensive SDOH Plan**<br>**Address Health Related Social Needs of Patients**<br>a. Implement Accountable Health Communities.<br>b. Support coordinated internal and community strategies to inform and connect individuals to social services and resources; resource directories.<br>c. Increase clinical opportunities to identify social needs.<br>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.<br>e. Increase number of Community Health Workers who are able to help address health-related social needs.<br>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**<br>a. Increase high-risk patient access to and consumption of healthy foods.<br>b. Increase # of high-risk patients who meet their health goals.<br>c. Increase patient and provider satisfaction. | 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**<br>Partner with the county and tribal health councils to impact specific social determinants of health prioritized by each community. | total funding provided; # of priority initiatives; # of community members reached |

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