Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 4, 2018

Dear Hospital Chief Executive Officers and Local Health Department Commissioners and Directors:

I am writing to update you on our plans for updating the NYS Prevention Agenda for 2019-2024 and to transmit guidance for the next cycle of collaborative community health planning.

The next cycle of the Prevention Agenda is 2019-2024. The new vision of the Prevention Agenda 2019-2024 is to *be the healthiest state for people across all ages*. The Prevention Agenda 2019-2024 will maintain the current five priorities. The focus areas, goals and recommended evidence-based interventions and actions are being updated based on a current assessment of the population's health status and health challenges as well as input from stakeholders across the state.[1] The updated Prevention Agenda will include a major focus on addressing social determinants of health and incorporating evidence-based interventions and actions to address them, including strategies that can be implemented by a diverse set of health and non-health agencies and organizations. It will incorporate actions to improve health for people of all ages to ensure that we can achieve our vision. The updated plan will be released by the end of 2018. The next cycle for the collaborative community health planning cycle is for the 2019-2021 time period.

As in previous years, the NYS Department of Health is asking each local health department (LHD) and all partner hospitals/hospital systems in the county to work together along with other community partners to identify and address local health priorities associated with the NYS Prevention Agenda. NYS envisions that there will be shared ownership between local health departments and hospitals of all phases of the community health improvement process including the community health assessment, planning, investment, implementation and performance monitoring to assess progress.

LHDs and hospitals are strongly encouraged to develop one assessment and one plan per county by working together with other partners including the Population Health Improvement Programs (PHIPs) in their region. This collaborative approach will leverage the efforts and resources of all health organizations in a community toward shared community health goals, and improve effectiveness and reduce duplication in the assessment and planning effort.

Organization specific community health assessments and improvement plans will be accepted if the organizations can demonstrate collaboration in the identification of local priorities and selection of interventions to address those priorities. If a hospital is doing a hospital specific plan rather than a collaborative plan, the hospital should discuss its priorities, goals and proposed interventions with the local health department in its service area. This will help confirm that the hospital and health department have collaborated in the planning even if they are submitting individual plans.

Hospitals serving more than one county are urged to select and prioritize a high poverty neighborhood(s) for action in each county where they have a hospital, based on their community health assessment, rather than implement a general multi-county plan.

[1] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/background.htm

As in previous years, hospitals are also asked to reflect their Prevention Agenda efforts in their community benefit programs when completing the Internal Revenue Service Form 990 Schedule H. We are expecting that hospitals will continue to increase their investments in the Community Benefit categories of Community Health Improvement and Community Building, whose definitions include the kinds of activities needed to improve the health of communities. Our goal is that each hospital will align and increase its investments in evidence based interventions related to the Prevention Agenda.

The attached guidance describes the required information for the community health assessment and community health improvement plan. The completed documents will meet the State's requirements for a LHD Community Health Assessment and Community Health Improvement Plan (CHA-CHIP), and a hospital Community Service Plan (CSP). The completed documents can also be used in support of the community health assessment and community health improvement plans required by the Public Health Accreditation Board (PHAB) for those local health departments pursuing accreditation as well as the Internal Revenue Service requirement for hospitals to complete a Community Health Needs Assessment.[2]

Timetable for Prevention Agenda State and Local Planning Cycles

The next Community Health Assessment is for the 2019-2021 time period. LHDs and hospitals that want to start (and complete) the community health assessment this year are encouraged to use this guidance to start now. However, the community health improvement plan cannot be completed in 2018 because it needs to align with the updated Prevention Agenda 2019-2024 which will not be issued until December 2018. The plan is for the same three years as the assessment: 2019-2021. Given that LHDs and hospitals will be devoting time to assessment and planning, implementation of the new plan can start during the second half of the 2019 year. One-year updates will not be due in 2019 because the planning activities undertaken in 2019 to support the Prevention Agenda will already be described in the CHIP/CSP.

Timeframe	Activity	Due Date
January – December, 2018	LHDs and hospitals implement year 3 of current plan.	One-year updates are due December 2018
March 2018	NYS releases guidance for next assessment and planning cycle.	
April – December, 2018	LHDs and hospitals can begin community health assessment now. (Hospitals should consider their own tax years and federal requirements for completing IRS CHNA.)	Completed community health assessments are due December 2019 but can be submitted earlier.
December 2018	Public Health and Health Planning Council issues updated Prevention Agenda for 2019-2024.	
January - December, 2019	Complete community health assessment and develop community health improvement plan for 2019-2021.	Completed assessments and plans are due December 2019 One-year update for 2019 not required.
2020-2021	Continue implementation of workplan for 2019-2021.	One-year updates are due in December 2020 and December 2021.
2022-2024	Next cycle of local community health planning	December 2022

[2] Please note that while NYSDOH believes the components we are requiring in the assessment and plan will enable a hospital to meet the IRS obligations, we cannot assure that completing the components required by NYS DOH will fulfill the IRS requirements.

Thank you for your continued commitment to improve the health of New Yorkers. If you have any questions, please contact the Office of Public Health Practice at prevention@health.ny.gov or 518 473-4223.

Sincerely,

Bradley Hutton, M.P.H.
Deputy Commissioner
Office of Public Health

Guidance and Template for
NYS 2019-2021 Community Health Assessment and Community Health Improvement Plan and Community Service Plan

Required Components

Cover Page

1. Identify county/counties or service area covered in this assessment and plan
2. Participating Local Health Department(s) (LHDs) and contact information
3. Participating Hospital/Hospital System(s) and contact information
4. Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals

A. Executive Summary

(Maximum four double-spaced pages. This report should be posted on your public website(s) and shared with community partners.)

Include succinct statements that answer the following questions:

1. What are the Prevention Agenda priorities and the disparity you are working on with your community partners including the LHD and hospital(s) for the 2019-2021 period?
2. What data did you review to identify and confirm existing priorities or select new ones?
3. Which partners are you working with and what are their roles in the assessment and implementation processes? How are you engaging the broad community in these efforts?
4. What specific evidence-based interventions/strategies/activities are being implemented to address the specific priorities and the health disparity and how were they selected?
5. How are progress and improvement being tracked to evaluate impact? What process measures are being used?

B. Community Health Assessment

1. **A description of the community being assessed.** This could be one county or several counties or parts of several counties in a regional assessment.[1] The assessment should include a succinct narrative and geographical description of:

   a. the demographics of the population served (such as gender, race, age, income, disabilities, mobility, educational attainment, home ownership, employment status, health insurance status and access to a regular source of care, immigrant/migrant status, etc.); and

   b. the health status of the population and the distribution of health issues, based on the analysis of demographic factors above. Special emphasis should be placed on identifying issues related to health disparities and high-risk populations and high need neighborhoods within the service area.

   Please include the most current data for relevant health indicators, as well as charts and graphs that illustrate changes over time. The analysis should compare data by race/ethnicity, age and gender, where appropriate. The report should capture critical aspects of the data, but not every detail.

[1] If a regional assessment is conducted, the health needs of each individual county must be identified.

2. **Identification of the main health challenges facing this community and a discussion of the contributing causes of the health challenges, including the broad determinants of health.** This discussion should include:

   a. behavioral risk factors;
   b. environmental risk factors (the natural and built environment);
   c. socioeconomic factors;
   d. policy environment (e.g., smoke-free parks, menu labeling, zoning for walkable communities, etc.); and
   e. other unique characteristics of the community that contribute to health status.

3. **A succinct summary of the assets and resources that can be mobilized and employed to address health issues identified.** These may include both the target populations and the services they would receive, including those provided by the local health department; hospitals; health care providers; community-based organizations; businesses; academia; the media; and resources available through other sectors of government. For example, a local park can offer opportunities for physical activity. Similarly, local farmers' markets can emphasize healthy food options, and a school district can partner to provide health education.

   Documentation of the process and methods used to conduct the assessment, the sources and time periods of data used, how the preliminary findings of the assessment were distributed to the community-at-large, and how the community's input was sought.

C. Community Health Improvement Plan/Community Service Plan

1. Identification of at least two priorities,[2] and a description of the process and criteria that were used to identify them in collaboration with community partners including LHDs and hospitals. At least one of these priorities must address a disparity and promote health equity. In this section, provide a description of the community engagement process that was used to select new or confirm existing priorities.

2. For each of at least two priorities, identify the goal(s) and objectives, the intervention strategies and activities you are now implementing or will in the future, and process measures with measurable and time-framed targets that will be used to track progress over the three-year period. Interventions must be evidence-based or promising practices.[3] The summary can include activities currently underway and/or new strategies to be implemented. Process measures must be selected to track progress in implementing the strategies.

---

[2] This could include two focus areas from one Prevention Agenda Priority (i.e. tobacco and chronic disease self-management from *Prevent Chronic Disease*), or one focus area from *Prevent Chronic Disease*, and one focus area from *Promote a Healthy and Safe Environment*.

[3] 'Evidence-based' or 'best-practice' interventions are supported by a body of evidence that they are effective. Because evidence is limited for many public health interventions, we want to see interventions based on the best possible science. If an intervention is not yet described in the literature, then the LHD or hospital should have some evidence to describe how it is having an impact. For sources of evidence based interventions please use the Prevention Agenda website and scientific literature identified in the resource section below.

For each health priority that is currently addressed or will be in the next cycle, provide a work plan[4] that:

a. Describes the actions the hospital intends to take to address the health issue and the anticipated impact of these actions;
b. If relevant, the specific geographic location where the intervention will be focused.
c. Identifies the specific resources the hospital will commit to address the health need. This can include spending that is reported to the IRS for community health improvement. *Additional information on what to include and a template for reporting resources will be issued at a later date.*
d. Describes the actions the LHD intends to take to address the health need and the anticipated impact of these actions;
e. Identifies specific resources the LHD will commit to address the health need;
f. Describes the roles and resources of other participants, stakeholders, local governmental agencies, or community-based organizations including business, academia, etc., in addressing the priority; and
g. States whether the action(s) will address a health disparity and, if so, how.

3. Briefly describe the process that will be used to maintain engagement of local partners over the next three years, and the process that will be used to track progress and make mid-course corrections.

4. Briefly describe plans for the dissemination of the Executive Summary to the public and how the plan will be made widely available including identifying the website where it can be located.

[4] Please submit the workplan using the Excel format that will be provided.

RESOURCES

Sources for Evidence Based Interventions

The Prevention Agenda https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm

The Community Guide (Community Preventive Services Task Force)
https://www.thecommunityguide.org/task-force-findings

County Health Rankings – What Works for Health
http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

CDC 6/18 Initiative https://www.cdc.gov/sixeighteen/

CDC Health Impact in Five Years https://www.cdc.gov/policy/hst/hi5/index.html

CDC Community Health Improvement Navigator https://wwwn.cdc.gov/chidatabase

Substance Abuse and Mental Health Services Administration National Registry of Evidence-based Programs and Practices https://www.samhsa.gov/nrepp?_sm_au_=iHVVZpZ0Q8L1rspF

Successful Interventions to Reduce Health Disparities https://www.cdc.gov/mmwr/ind2016_su.html

The Cochrane Database http://www.cochranelibrary.com/

Examples of Assessments and Plans:

Albany County 2016-2018 Community Health Improvement Plan:
http://www.albanycounty.com/Libraries/Department_of_Health/Albany_County_CHIP_123020162_0.sflb.ashx

Albany Medical Center Community Service Plan:
http://www.amc.edu/aboutus/documents/Albany_Medical_Center_Community_Service_Plan_2014-2017.pdf

Chautauqua County Community Health Improvement Plan, 2014-2017, a collaborative LHD-Hospital Plan including Chautauqua County Health Network, TLC Health Network, and Brooks Memorial, Women's Christian Association and Westfield Memorial Hospitals
http://www.co.chautauqua.ny.us/DocumentCenter/View/938

2016-2018 Delaware County: Community Health Assessment and Improvement Plan and Community Service Plans, a collaborative LHD-hospital plan including UHS Delaware Valley, Margaretville, O'Connor and Tri Town Regional Hospitals http://delawarecountypublichealth.com/wp-content/uploads/2014/12/Delaware-County-Community-Health-Assessment-Update-FINAL.pdf

Orange County Department of Health: https://www.orangecountygov.com/DocumentCenter/View/162

NYU Langone Medical Center: https://nyulangone.org/our-story/community-health-needs-assessment-service-plan

Data resources:

New York State Prevention Agenda Tracking Indicator Dashboard
The New York State Prevention Agenda Dashboard is an interactive visual presentation of the most current Prevention Agenda tracking indicator data at state and county levels. It can be used to monitor progress toward meeting the Prevention Agenda 2018 objectives.

Sub-County Health Data Reports for County Health Rankings-Related Measures (2016)
These reports provide data for 11 health measures at sub-county levels, including sub-county populations (such as race/ethnicity, age group, Medicaid status, education level) and sub-county geographies (ZIP codes and minor civil divisions where data are available). These reports can be used to assess community health needs, to plan health interventions, and specifically to identify health disparities within counties.

Community Health Indicator Reports
This site links the previous Community Health Data Set (CHDS) and Community Health Assessment Indicators (CHAI), with nearly 300 health-related indicators available. State and county trend data are available for most indicators. The top part of this site allows the user to access indicator data for all counties in the state by health topic areas. The bottom part of this site provides access to individual county profiles of these health topic areas with direct links to county historical (trend) data.

County Health Indicators by Race/Ethnicity (CHIRE)
CHIRE provides selected public health indicators by race/ethnicity for New York State and counties. Data related to births, deaths, and hospitalizations are presented.

New York State 2017 Health Equity Reports
The New York State 2017 Health Equity Reports present data on health outcomes, demographics, and other community characteristics for select cities and towns with a 40% or greater non-White population throughout New York State. Each town or city specific report contains data associated with the priority areas of the Prevention Agenda, as well as social determinant indicators such as housing, educational attainment and insurance coverage.

U.S. Census Bureau
The U.S. Census Bureau webpage provides links by topic, geography or data system or survey to a vast array of information available from the U.S. Census.

US Census Bureau - American Fact Finder
The Census Bureau, through American Fact Finder, provides access to data from the Decennial Census, American Community Survey, Annual Population Estimates Program and other economic and business-related surveys. The Fact Finder data system allows a user to search for data by topic, geography (state, county, town, and city), race/ethnic groups and industrial codes.

Additional resources can be found at:
https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/sources.htm