



**Department
of Health**

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

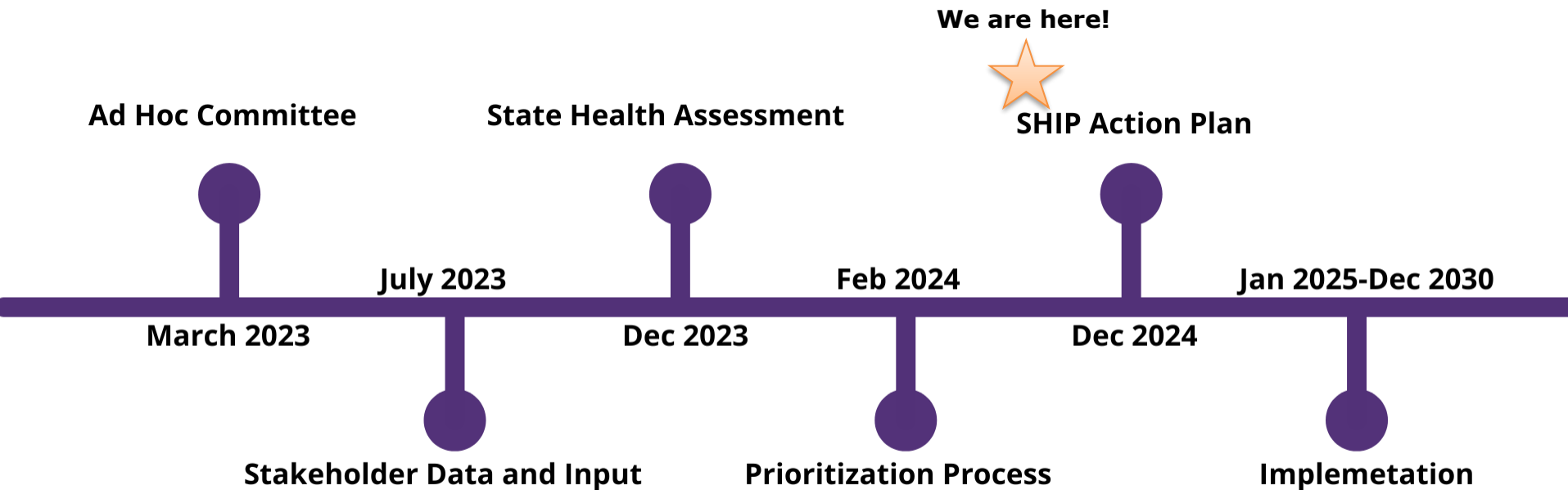
NYS Public Health Committee

October 16, 2024

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2025-2030 Prevention Agenda Timeline



2025-2030 Prevention Agenda Framework

Vision	Every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan
Foundations	<div>Health Equity</div> <div>Prevention Across the Lifespan</div> <div>Health Across All Policies</div> <div>Local Collaboration-Building</div>
Domain	Priorities
Economic Stability	<div>Economic Wellbeing</div> <div> <input type="checkbox"/> Poverty <input type="checkbox"/> Unemployment <input type="checkbox"/> Nutrition Security <input type="checkbox"/> Housing Stability and Affordability </div>
Social and Community Context	<div>Mental Wellbeing and Substance Use</div> <div> <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 </div>
Neighborhood and Built Environment	<div>Safe and Healthy Communities</div> <div> <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 </div>
Health Care Access and Quality	<div>Health Insurance Coverage and Access to Care</div> <div> <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) <div>Healthy Children</div> <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 </div>
Education Access and Quality	<div>PreK-12 Student Success And Educational Attainment</div> <div> <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) </div>



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?

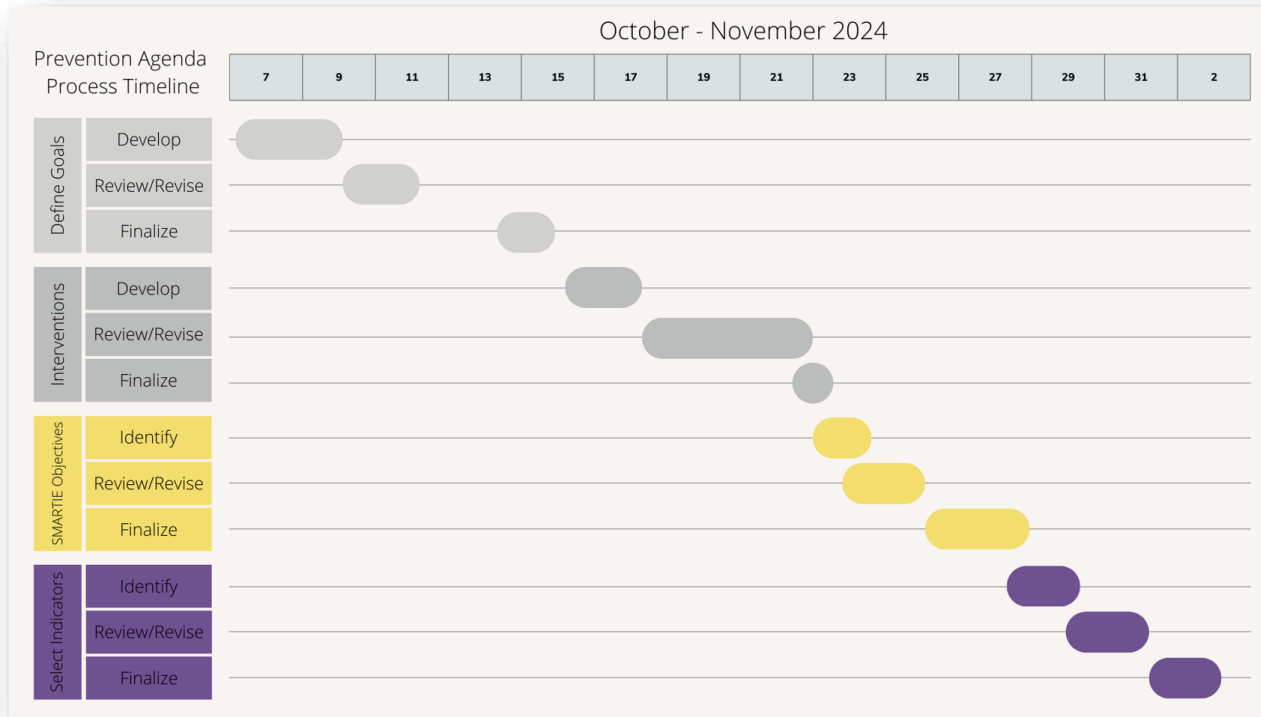
July- October 2024.

Workgroup Structure

Workgroups	# Participants	Priority Areas	Priority Areas	Priority Areas
D1W1	22	Poverty	Unemployment	
D1W2	22	Nutrition Security	Housing Security and Affordability	
D2W1	23	Anxiety and Stress	Suicide	Depression
D2W2	24	Drug Misuse and Overdose Including Primary Prevention	Tobacco/e-cigarette Use	Alcohol Use
D2W3	21	Adverse Childhood Experiences		
D2W4	21	Healthy Eating		
D3W1	24	Opportunities for Active Transportation and Physical Activity	Access to Community Services and Support	Injuries and Violence
D4W1	24	Access to and Use of Prenatal Care	Prevention of Infant and Maternal Mortality	
D4W2	25	Preventive Services for Chronic Disease Prevention and Control	Oral Health Care	Preventive Services
D4W3	22	Early Intervention	Childhood Behavioral Health	
D5W1	22	Health and Wellness Promoting Schools	Opportunities for Continued Education	



Process Timeline



Action Plan Order of Operations



Workgroup Roles

Domain Leads

- Set vision, goals & objectives
- Attend workgroup meetings
- Attend meetings with NYSTEC and PA Team
- Monitor progress
- Ensure alignment

Workgroup Leads

- Lead planning process for designated priority areas
- Attend workgroup meetings
- Collect and document inputs
- Assign tasks (for offline work)
- Monitor progress
- Provide feedback on draft deliverables

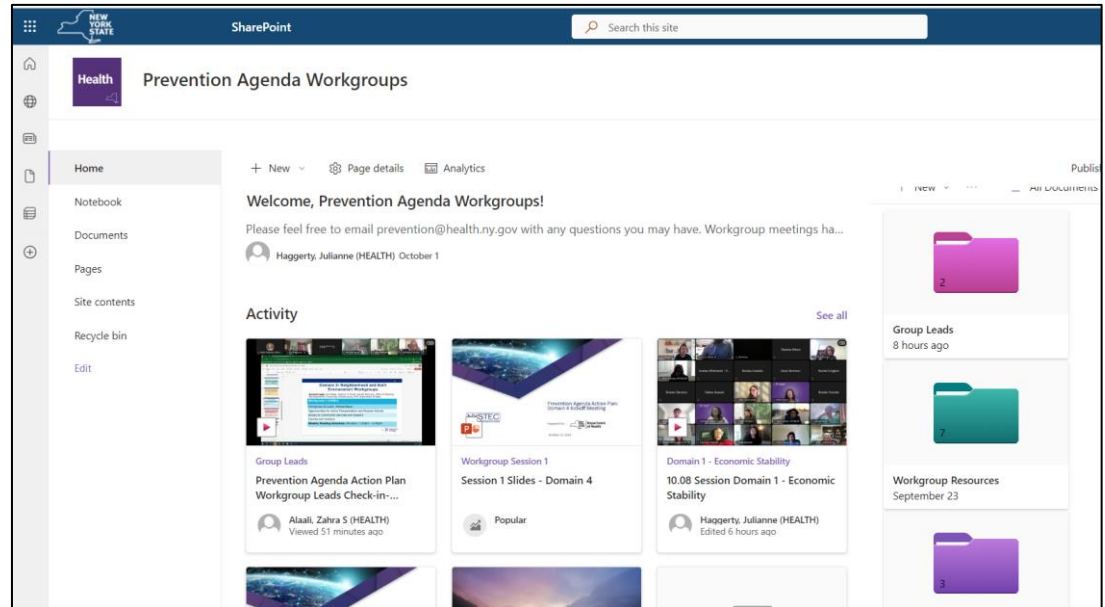
Workgroup Members

- Participate in weekly meetings
- Complete assigned tasks offline
- Document inputs in worksheet
- Submit worksheet 24 hours before weekly meeting
- Provide feedback on draft objectives, strategies, and measures

Tools and Resources

Tools and Resources

- [Prevention Agenda Workgroups SharePoint](#)
 - Action Plan Tools
 - Resources



Standardized Worksheets

Priority Objective & Intervention Worksheet

Domain 1: Economic Stability

Priority Area: Poverty

1. Priority Overview – In 350 words or less, explain why this priority is important for NYS and include any relevant data.

2. Priority Goal – For this priority, create one goal that defines what you aim to accomplish. The goal should be broad statements that describe the desired results. Please note: the universal goal for all priorities is to reduce disparities and inequities within the next six (6) years.

3. Objectives – Describe specific outcomes including elements in the SMARTIE Framework described below. Please note that each priority should have at least one objective, but NO more than three. All objectives should align with the [HYPERLINK "https://www.cdc.gov/cancer/ncccp/pdf/smartie-objectives-508.pdf"](https://www.cdc.gov/cancer/ncccp/pdf/smartie-objectives-508.pdf) and should be:

• Specific	• Measurable
• Achievable	• Relevant
• Time-bound	• Inclusive
• Equitable	

Objective

Objectives are statements describing a specific outcome to be achieved and are a tool for measuring progress over time in a way that fosters transparency, accountability and continuous quality improvement.

1.

➤ Priority Objective & Intervention Worksheet

- Collect info during workgroup meetings
- Document inputs for offline work
- Rolls up to action plan template

SMARTIE Objectives Resources

S

SPECIFIC: What does your program hope to accomplish?

M

MEASURABLE: Did you establish benchmarks?

A

ACHIEVABLE: Does your program have the capacity to achieve the objective?

R

REALISTIC: Does the objective reflect population of focus?

T

TIMEBOUND: Did you establish a deadline?

I

INCLUSION: Do you have representation from socially and economically marginalized individuals and groups?

E

EQUITY: Did you include an element of justice?

Selection Criteria- Indicators

Criteria	Criteria Definition/Explanation	Classification ⁱ
Inclusivity	Have key stakeholders, including public health professionals, community members, and policymakers, been consulted in the selection of indicators?	Guiding
Number of Indicators	For each SMARTIE objective, One to three indicators should be selected.	Guiding
Relevance	Indicator that is key to measure the implementation and intervention impacts	Must
Measurability and consistency	Data are quantifiable and collected consistently over time	Must
Ongoing availability	Data are available on a regular basis (monthly, quarterly, annually or biannually)	Must
Geographic availability	Data are available at county or below county level	Must
Actionability	Results can inform decision-making and guide necessary adjustments to strategies	Consideration
Timeliness	Data are available for timely monitoring progress and identifying challenges	Consideration
Disparity Measurement (prioritizes indicators that can measure health disparities)	Data can be disaggregated by race, ethnicity, gender, socioeconomic status, and other relevant demographics to assess health disparity and equity	Consideration
Healthy People 2030	Data are comparable with HP2030 objectives for comparison	Consideration
Public Understanding	Are the indicators easy for the public to understand, thereby promoting transparency and public engagement with the SHIP's progress?	Consideration

Selection Criteria- Interventions

Criteria	Criteria Definition/Explanation	Classification'
Feasibility	Strategies that provide the best opportunities for cost effective results.	Guiding
Level of Implementation	Selected strategies can be implemented across different sectors and settings, including individuals, organizations/agencies/institutions, and policies. For the action plans, strategies will be grouped into three organizational levels: <ul style="list-style-type: none"> Strategies for hospitals. Strategies for health departments. Strategies for other organizations. 	Guiding
Magnitude	Potential to have a significant or large impact on the population's health.	Guiding
Sustainability	Changes resulting from the Evidence-Based Intervention are likely to beyond the course of the interventions, such as changes that are part of the institutions' workflow.	Guiding
Number of Strategies	For each priority area, select 6 to 10 strategies per organizational level. Priority (ranking) of strategies is given to interventions with higher impacts and/or implementing feasibility, and sustainability.	Guiding
Featured Strategies	The list of strategies should include two "featured strategies" for each priority area. Featured strategies must have these characteristics: <ul style="list-style-type: none"> Evidence rating: Highly rated by an evidence registry, indicating credible evidence of effectiveness. Direct outcomes: The strategy produces outcomes that can be directly observed and evaluated using the tracking indicator for that priority area. 	Guiding
Feasibility	Strategies that provide the best opportunities for cost effective results.	Guiding
Type	Evidence-based strategies/preventions must provide the source(s) such as publications. If an evidence base is not available, best or promising practices can be used.	Must
Focus on Prevention or Access	<ul style="list-style-type: none"> Primary prevention, including upstream activities that address SDOH. Secondary prevention, including screening and early intervention. Access to care, including innovative settings or methods (such as school-based health or telehealth). 	Must
Close the Health Equity Gap	Strategy is likely to reduce disparities	Must
CDC's Hi-5 and/or 6/18 Initiatives	Ensures alignment with high-impact strategies recommended by the CDC.	Consideration
Co-benefits	Has the potential to impact multiple SHIP priorities or outcomes.	Consideration
Alignment with Existing NYS Initiatives	Aligns with existing plans, programs, or initiatives in New York State.	Consideration



Community Health Improvement Planning Guidance

Terminology

- **Community Health Assessment (CHA)** - a comprehensive picture of a community's current health status, factors contributing to higher health risks or poorer health outcomes, and community resources available to improve health.
 - Also Known as Community Health Needs Assessment (CHNA)
- **Community Health Improvement Plan (CHIP)** – a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process, conducted by LHDs.
- **Community Service Plan (CSP)** - a collaborative effort to address public health needs by assessing, planning, implementing, and monitoring strategies, conducted by hospitals/hospital systems.

<https://www.cdc.gov/public-health-gateway/php/public-health-strategy/public-health-strategies-for-community-health-assessment-health-improvement-planning.html>
https://www.health.ny.gov/prevention/prevention_agenda/community_service_plan.htm

LHD and Hospital Requirements

	Requirements
Local Health Departments (LHDs)	<ul style="list-style-type: none">• 10NYCRR40-2.40 Local health departments shall work with community partners to conduct a CHA and a CHIP• Six-year cycle: Beginning January 1, 2025, LHDs must complete assessments and improvement plans on an aligned six-year cycle, with a mid-cycle assessment update.
Hospitals (Tax-exempt 501(c)(3) charitable hospitals)	<p>The Internal Revenue Service (IRS) requires tax-exempt hospitals to conduct a CHNA and adopt an implementation strategy to address the identified needs every three years.</p> <p>Three-year cycle: Hospitals will continue to complete assessments and plans on an aligned 3-year cycle (2025-2027; 2028-2030)</p>



Community Health Planning Guidance Now Available

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Community Health Planning Guidance

Local Community Health Planning

[Letter and Community Health Planning Guidance 2025-2030](#)

This cover letter and guidance provide an overview of New York's specific requirements for the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Community Service Plan (CSP). It also outlines the roles of hospitals and local health departments (LHD) in implementing the 2025-2030 Prevention Agenda, New York State's health improvement plan.

[Letter and Community Health Planning Guidance and Template for 2022-2024](#)

This cover letter and guidance describes the goals for collaborative planning, and the required elements of a local Community Health Assessment, Community Health Improvement Plan and Community Service Plan for local health departments and hospitals based on the 2019-2024 Prevention Agenda. Please use the [blank template](#) to complete the workplan. The Community Health (Needs) Assessment and the completed workplan template must be submitted by December 31, 2022 to prevention@health.ny.gov.

[Local Health Department Contacts](#)

Directory of local health department community health assessment and health improvement plan liaison contact information.

[New York State Department of Health Public Health Contractors](#)

Map and listing of public health contractors that can support local Prevention Agenda activities.



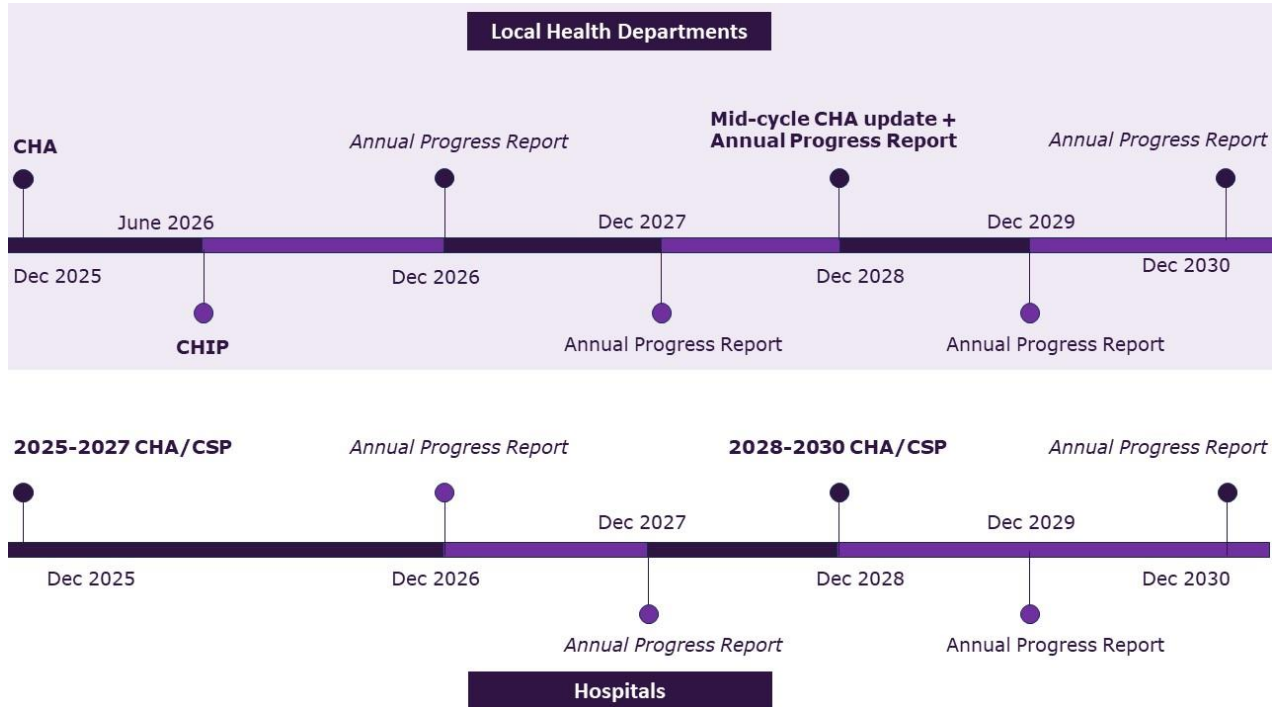
Department
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Timeline for CHA/CHIP/CSP Submissions

Year #	Time	LHDs	Hospitals
Y1	Dec 2025- June 2026	<ul style="list-style-type: none"> • Submit the CHA by December 2025. • Submit the CHIP either: <ul style="list-style-type: none"> ◦ At the same time as the CHA by December 2025; OR ◦ Following the CHA submission, no later than June 2026. 	<ul style="list-style-type: none"> • Submit the 2025-2027 CHA/CSP by December 2025.
Y2	Dec 2026	<ul style="list-style-type: none"> • Submit CHIP progress report by December 2026. 	<ul style="list-style-type: none"> • Submit CSP progress report by December 2026.
Y3	Dec 2027	<ul style="list-style-type: none"> • Submit CHIP progress report by December 2027. 	<ul style="list-style-type: none"> • Submit CSP progress report by December 2027.
Y4	Dec 2028	<ul style="list-style-type: none"> • Submit the mid-cycle CHA update to assist hospitals with their IRS-required CSP, if applicable • Submit CHIP progress report by December 2028. 	<ul style="list-style-type: none"> • Submit the 2028-2030 CHA/CSP by December 2028
Y5	Dec 2029	<ul style="list-style-type: none"> • Submit CHIP progress report by December 2029. 	<ul style="list-style-type: none"> • Submit CSP progress report by December 2029.
Y6	Dec 2030 End of Cycle	<ul style="list-style-type: none"> • Submit CHIP progress report by December 2030. 	<ul style="list-style-type: none"> • Submit CSP progress report by December 2030.



Timeline for CHA/CHIP/CSP Submissions



CHA/CHIP/CSP Submissions

The CHA/CHIP/CSP guide strongly encourages:

- LHDs and hospitals to collaborate on a joint CHA/CHIP.
- Hospitals to submit IRS Form 990 Schedule H to NYSDOH annually.
- Increased hospital investment in Community Health Improvement and Community Building.
- Identifying resources and relevant Prevention Agenda activities, including spending for community health improvement reported to the IRS.
- One of the three selected priorities should include a social determinant of health, such as poverty, unemployment, nutrition security, housing stability, or affordability.
 - All selected Priorities should be informed by the CHA.

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.

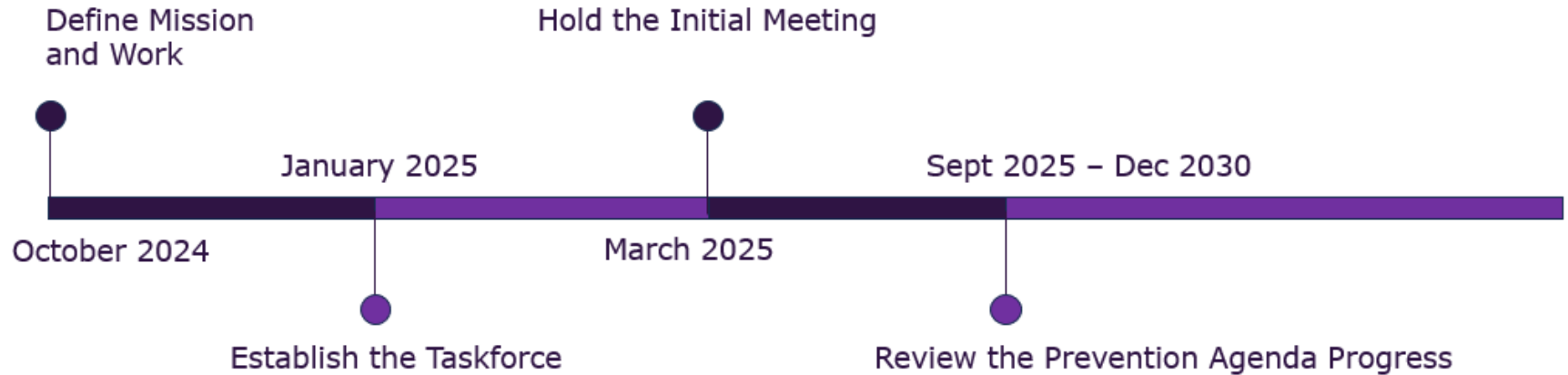
Who?

- 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**

Appendix

LHD and Hospital Requirements

	National Requirements	New York State Requirements
Local Health Departments (LHDs)	As a prerequisite of accreditation by the Public Health Accreditation Board (PHAB), LHDs must conduct a community health assessment (CHA) and develop a community health improvement plan (CHIP) at least every five years.	<p>Six-year cycle: Beginning January 1, 2025, LHDs must complete assessments and plans on an aligned six-year cycle, with a mid-cycle assessment update.</p> <p>Reporting: By December 31, 2025, LHDs must submit assessment plans to NYSDOH for 2025-2030. The CHIP can be submitted in one of two ways:</p> <p><u>Option 1:</u> Submit the CHIP together with the CHA by December 31, 2025.</p> <p><u>Option 2:</u> If not submitted with the CHA, the CHIP must be submitted separately by June 30, 2026.</p>
Hospitals (Tax-exempt 501(c)(3) charitable hospitals)	The Internal Revenue Service (IRS) requires tax-exempt hospitals to conduct a community health needs assessment (CHNA) and adopt an implementation strategy to address the identified needs every three years.	<p>Three-year cycle: Hospitals will continue to complete assessments and plans on an aligned 3-year cycle (2025-2027; 2028-2030)</p> <p>Reporting: By December 31, 2025, hospitals must submit assessments and plans to NYSDOH for 2025-2027.</p> <p>Community benefit expenditures: Hospitals are encouraged to submit Schedule H of IRS Form 990 to NYSDOH annually, including any attachments.</p>



CHIP/CSP Required Components for Submission

- Cover Page
- Table of Contents
- Executive Summary
- Community Health Assessment that includes descriptions of:
 - Community demographics
 - Health status
 - Community assets and resources
- Community Health Improvement Plan / Community Service Plan that includes:
 - Major community health needs
 - Priority setting and action plans
 - Partner engagement process
 - Plans for dissemination to the public
- 2025-2030 Prevention Agenda Workplan

Joint vs. Individual Plans

Joint Plans

- LHDs and hospitals within the same county or community collaborate with other partners to develop a single assessment and plan.
- This results in one assessment document and one plan document for the community, with all the local health departments and all participating hospitals named as leading entities.

Individual Plans

- Individual plans may be collaborative and might include joint community health assessments, but all collaborating parties still submit separate plans.
- If a hospital chooses an individual plan, the priorities, goals, and interventions should align with the local health department in its service area, and discussions should take place to ensure collaboration.

Alignment with Prevention Agenda: Priority Setting

	Prevention Agenda	CHIP/CSP
Priorities	The Prevention Agenda has 24 priorities that include social determinants of health, health behaviors, access to care, and health outcomes.	<p>Select at least three priorities from the Prevention Agenda list. Selection of at least one of the following social determinants of health is strongly encouraged:</p> <ul style="list-style-type: none">• Poverty• Unemployment• Nutrition Security• Housing Stability and Affordability• Health and Wellness Promoting Schools• Opportunities for Continued Education <p>Priorities should be informed by the CHA.</p>

Alignment with Prevention Agenda: Using SMARTIE Objectives to Track Progress

	Prevention Agenda	CHIP/CSP
Tracking progress with SMARTIE objectives	<p>Objectives are statements describing a specific outcome to be achieved.</p> <ul style="list-style-type: none">• SMARTIE objectives are specific, measurable, achievable, realistic time-bound, Inclusive, and Equitable.• SMARTIE objectives must include an indicator — a specific metric or measure used to quantify an outcome, typically expressed as a number, percent, or rate.	<p>For each selected priority:</p> <ul style="list-style-type: none">• Choose at least one SMARTIE objective.• For each identified objective, select at least one indicator to track progress.



Alignment with Prevention Agenda: Evidence-Based Interventions

	Prevention Agenda	CHIP/CSP
Interventions	The Prevention Agenda includes a menu of evidence-based interventions or promising practices for each priority area.	Select evidence-based or promising practice interventions for each identified priority. If the selected intervention is not yet described in the literature, the LHD or hospital should provide evidence demonstrating its impact.

Alignment with Prevention Agenda: Equity

	Prevention Agenda	CHIP/CSP
Equity	Health equity is a key principle of the Prevention Agenda. Achieving measurable improvements requires a multi-sector, community-engaged approach focused on priority populations, setting universal targets, selecting effective strategies, and ensuring proper implementation.	For each selected priority, identify priority populations, select strategies likely to reduce disparities and inequities, and allocate and tailor resources to communities where the need is greatest.

