



**Department
of Health**

2025-2030 Prevention Agenda

Planning and Implementing the NYS Prevention Agenda

**Elizabeth Whalen MD,MPH,DipABLM
(she/her/hers)
Medical Director
Office of Public Health**

**Zahra Alaali, MPH
(she/her/hers)
Prevention Agenda Coordinator
Office of Local Health Services**

2/24/2025

Ad Hoc Committee to Lead the State Health Improvement Plan

THE PREVENTION AGENDA

What is the Prevention Agenda?

- The New York's State Health Improvement Plan (SHIP)
- Sets public health priorities, goals, and actions
- Updated every six years
- Serves as the blueprint for state and local action to improve the health and well-being of every individual in New York
- Aims to reduce health disparities and improve health equity

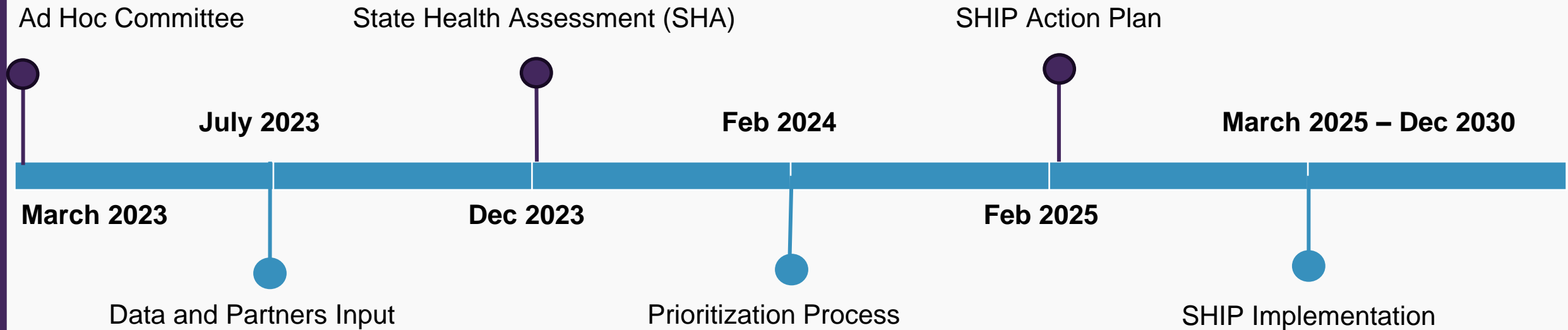


ACRONYMS USED IN THE PREVENTION AGENDA

Acronym	Meaning
CBO	Community-based organization
CHA	Community health assessment
CHIP	Community health improvement plan
CSP	Community service plan
LHD	Local health department
SDOH	Social determinants of health



PLANNING AND IMPLEMENTATION 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)

Partner 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 feedback from vested partners on selected priorities



Department
of Health

HOW WAS THE 2025-2030 PREVENTION AGENDA ACTION PLAN DEVELOPED?

Action Plans

- 200+ individuals assigned to workgroups based on areas of interest and expertise
- Experts in Social Determinants of Health, health equity, health disparities, and community members
- Action plan components (goals, objectives, interventions, indicators)

Implementation

- Implementation: March 2025- December 2030
- Continuous monitoring and Evaluation
 - Prevention Agenda Dashboard
 - Community Health Improvement Plans



Department
of Health

2025-2030 PREVENTION AGENDA FRAMEWORK

Overarching
Vision and 4
Foundations

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

- Health Equity
- Prevention Across the Lifespan
- Health Across All Policies
- Local Collaboration-Building

Domain

Priorities

Economic Stability

- Economic Wellbeing
- Poverty
- Unemployment
- Nutrition Security
- Housing Stability & Affordability

Social &
Community Context

- Mental Wellbeing & Substance Use
- Anxiety & Stress
- Suicide
- Depression
- Primary Prevention, Substance Misuse, & Overdose Prevention
- Tobacco/E-cigarette Use
- Alcohol Use
- Adverse Childhood Experiences
- Healthy Eating

Neighborhood & Built
Environment

- Safe & Healthy Communities
- Opportunities for Active Transportation & Physical Activity
- Access to Community Services & Support
- Injuries & Violence

Health Care Access & Quality

- Health Insurance Coverage & Access to Care
- Access to & Use of Prenatal Care
- Prevention of Infant & Maternal Mortality
- Preventive Services for Chronic Disease Prevention & Control
- Oral Health Care
- Healthy Children
- Preventive Services
 - Immunizations
 - Hearing Screening & Follow-up
 - Lead Screening
- Early Intervention
- Childhood Behavioral Health

Education Access & Quality

- Pre-K-12 Student Success & Educational Attainment
- Health & Wellness Promoting Schools
- Opportunities for Continued Education

5 Domains
representative
of key social
determinants of
health (SDOH)

24 Priorities
inclusive of SDOH
and specific health
and health care
system issues



Department
of Health

2025-2030 Prevention Agenda Action Plan



Five Domains focused on Social Determinants of Health (SDOH) in alignment with Healthy People 2030



24 Statewide Priorities with an overarching goal to reduce disparities and inequities over the next six years.



90 Measurable Objectives*

44 SMART Objectives
46 SMARTIE Objectives



90 Indicators to track progress



A list of **Evidence-Informed Interventions**

* The number of objectives is subject to change and will be updated as needed.

Action Plan Overview

2025-2030 Prevention Agenda

DOMAIN WORKGROUPS

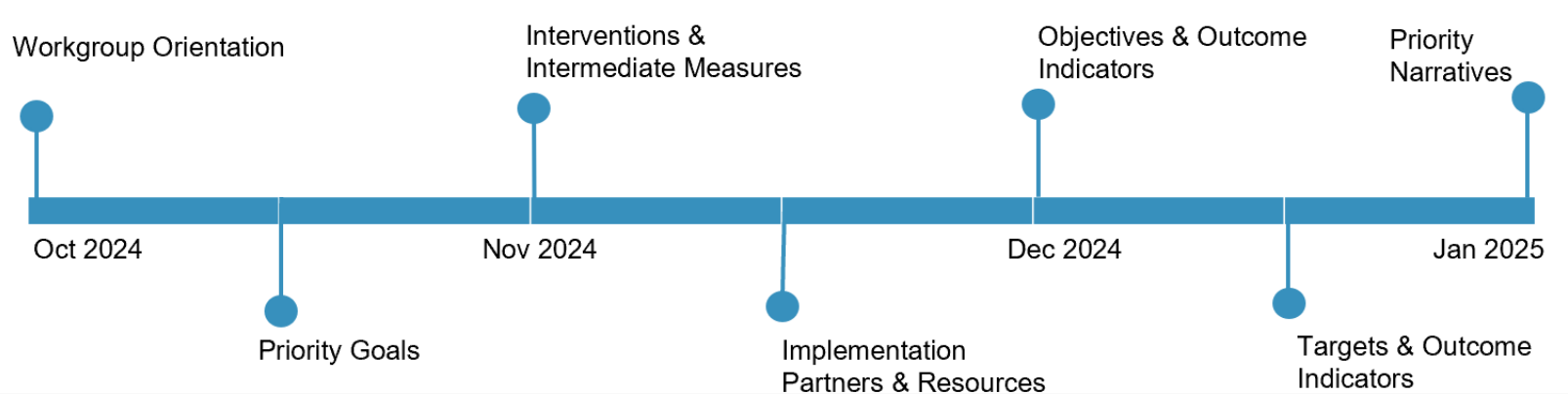
Purpose

Identify the Goals, Objectives, Indicators, and Interventions for each Domain

Who?

Experts in Social Determinants of Health, health equity, health disparities, and community members

When?



DOMAIN 1: ECONOMIC STABILITY



Domain Goal

All people in New York have the financial security and support needed to thrive



Priorities

Poverty

Unemployment

Nutrition Security

Housing Stability & Affordability



Action Plan

Priority Narrative

One Priority Goal

2 Objectives

1 Indicator

22 Interventions



POVERTY: GOAL AND IMPORTANCE

Goal: Identify, promote, and implement programs that address poverty.

What is Poverty and Why is it Important?

Socioeconomic disparity is directly linked to adverse health outcomes, negatively affecting physical and socioemotional health as well as educational development. New York State's poverty rate remains around 14%, slightly above the national average (11.1%) (USCB, 2025). Similarly, alternative poverty metrics, such as ALICE (Asset Limited, Income Constrained, Employed), reveal a significant portion of New York State households struggle to cover basic necessities like housing, childcare, food, and healthcare even though they are employed. These metrics indicate a substantial gap between income and the cost of living, highlighting the challenges faced by many in achieving financial security. Children and individuals over the age of 65 are particularly vulnerable to the negative health impacts of poverty. Poverty rates among older adults in New York State are significantly higher than those of the general population, highlighting the unique challenges faced by seniors in maintaining financial sustainability. These findings highlight a persistent issue within the state, prompting ongoing efforts to address the root causes and provide support to those living in poverty, and lift them out of these conditions.

New York State maintains a commitment to mitigating socioeconomic disparities among those living in the state. Reducing poverty does necessarily entail reinventing the wheel; a multitude of programs already exist embedded in communities. This state health improvement plan focuses on leveraging existing public health infrastructure and improving networking among and optimizing public awareness of these programs. Additionally, the focus on novel measures of poverty seek to broaden the perspective of local health departments, hospitals, and community-based organizations as they shape their policies and programs meant to reach/address families and individuals living in poverty.

Each Priority is introduced with:

- A Priority Goal.
- A narrative that describes the priority issue and its importance

POVERTY: OBJECTIVES & INDICATORS

General statement about desired result

SMART(IE) Objectives:					
1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.					
1.1 Reduce the percentage of <u>adults aged 65+</u> living in poverty from 12.2% to 11%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce the number of people living in poverty in NYS	Percentage of people living in poverty	ACS (American Community Survey)	Individuals and families living below the federal poverty threshold	13.6% (2024)	12.5% (2030)
			Subpopulation of Focus	Baseline	Target
			Adults aged 65+	12.2% (2024)	11% (2030)

Specific numbers that quantify desired outcome

The selected metric to track progress

Source of data

Priority Populations

Most recent data












POVERTY: INTERVENTIONS

Intervention were selected using rigorous criteria, including strength of evidence base, alignment with state and national health initiatives, and feasibility.

Featured Interventions:

- Evidence rating: Highly rated by an evidence registry, indicating credible evidence of effectiveness.
- Direct outcomes: The intervention produces outcomes that can be directly observed and evaluated using the tracking indicator for that priority area.

Legend	
Icon	Social Drivers/Domains
\$	Economic Stability
👥	Social & Community Context
🏠	Neighborhood & Built Environment
🩺	Health Care Access & Quality
📖	Education Access & Quality
Icon	Organizational Level
LHD	Local Health Department
H	Hospitals
O	Other (e.g., Community-based Organizations, State Agencies, Educational Institutions)

Interventions	Population of Focus	Age Range	Intermediate Measures
 Featured Intervention: Implement a comprehensive measure of poverty for county health needs assessments following the guidance of metrics similar to ALICE (Asset Limited Income Constrained Employed). ¹   	Population living under the burden of socioeconomic disparities.	All ages	Participation among community organizations in health assessments, track progress on data collection and collection methods
 Featured Intervention: Partner with organizations that provide services for older adults in rural areas (ex. Office for Aging, faith-based organizations, centers serving older adults, libraries, and CBOs) to reduce food insecurity for those living in poverty.  	Older adults	Ages 65+	Number of people receiving services.
 Incorporate educational programs that enhance recruitment for needed positions while mitigating disparities in recruitment efforts in the community. ³   	Adults enrolled in public benefits, high school age youth	Ages 16+	Employment rate by age group and industry.



Department of Health

POVERTY: PARTNERS & RESOURCES

Leading Partners

State Government Agencies:

NYS Office of Children and Family Services
NYS Office for Temporary and Disability Assistance
NYS Office for People with Developmental Disabilities
Empire State Development
NYS Department of Labor and Career One Stops
Local Departments of Social Services

Other Partners:

NYC Human Resources Administration, Local Departments of Social Services
Child Poverty Reduction Advisory Council
Medicaid Managed Care Health plans
High schools, hospitals, universities, occupational and technical education programs, workforce training programs
Legal agencies, law schools
Employers and businesses
United Way - ALICE and Family Resource Centers
Community Development Organizations
Federal Reserve
Local HeadStart programs
Soup kitchens, food pantries, regional food banks

Implementation Resources

[Promise Neighborhoods](#)

[United Way](#)

[NYS OSC Poverty Trends data](#)



**Department
of Health**

HEALTH EQUITY

The 2025-2030 Prevention Agenda prioritizes health equity in the following ways:

- **Addressing the root causes of disparities** by adopting the Healthy People 2030 SDOH framework
- **Defining SMART(IE) objectives** that are equitable and inclusive for individuals and groups at higher risk. All objectives set higher long-term targets for groups that experience disparities/ and inequity
- **Prioritizing evidence-informed interventions** that consider potential impacts on disparities and inequities by racial/ethnic, socioeconomic, geographic, and other characteristics.
- **Cross-sector collaboration and leveraging expertise**

Implementation

How Will the 2025 -2030 Prevention Agenda Be Implemented?

IMPLEMENTATION PARTNERS

The Prevention Agenda Objectives, Interventions and supporting activities provide flexible options for all communities to improve outcomes for individuals of all ages living in New York.

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
- Health care providers
- Community behavioral health providers
- Medicaid managed care plans
- Health insurance plans
- Housing organizations
- Philanthropic organizations
- Educational institutions
- Local agencies and community-based organizations
- Other

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



Department
of Health

SURVEY: CROSS-SECTOR COORDINATION

Overview: A survey to identify external organizations outside NYSDOH that plan to support Prevention Agenda priorities/goals

Purpose:

- Engage other organizations in implementing of the Prevention Agenda and strengthening coordination
- Establish a systematic approach to track implementation efforts



INTERAGENCY WORKGROUP: EXTENDING MEMBERSHIP

List of Ad Hoc Members

- ☐ NYS Office for the Aging
- ☐ NYS Department of Agriculture and Markets
- ☐ NYS Office of Alcoholism & Substance Abuse (OASAS)
- ☐ NYS Office of Mental Health
- ☐ NYS Department of State
- ☐ New York City Department of Health and Mental Hygiene (NYC DOHMH)
- ☐ New York State Association of County Health Officials (NYSACHO)
- ☐ Greater New York Hospital Association (GNYHA)
- ☐ Healthcare Association of New York State (HANYS)
- ☐ Medical Society of the State of New York (MSSNY)
- ☐ New York Health Plan Association
- ☐ New York State Conference of Local Mental Hygiene Directors
- ☐ New York State Dental Association
- ☐ New York State Business Council
- ☐ New York State Academy of Family Practice
- ☐ New York State Academy of Pediatrics
- ☐ United Hospital Fund
- ☐ Healthy Capital District
- ☐ American Cancer Society
- ☐ Association of Perinatal Networks of New York, Inc
- ☐ Center of Independence of the Disabled New York

INTERAGENCY WORKGROUP: EXTENDING MEMBERSHIP

List of Ad Hoc Members

- ☐ Hunger Solutions
- ☐ Let's get Immunized New York
- ☐ New York State Podiatric Medical Association
- ☐ AARP New York
- ☐ Spanish American Medical & Dental Society of New York
- ☐ John A. Hartford Foundation
- ☐ Housing Works
- ☐ Community Health Care Association of New York State
- ☐ Equality New York
- ☐ The New York Academy of Medicine
- ☐ Schuyler Center For Analysis & Advocacy
- ☐ Inclusive Alliance IPA Inc
- ☐ New York Health Foundation
- ☐ Primary Care Development Corporation
- ☐ Children's Defense Fund – New York
- ☐ MHANYS
- ☐ Greater Rochester Health Foundation
- ☐ Health Foundation of Western and Central New York
- ☐ Northeast Business Group on Health
- ☐ REACH CNY, Inc.
- ☐ S2AY Rural Health Network
- ☐ Long Island Health Collaborative
- ☐ NYU School of Global Public Health
- ☐ SUNY Albany SPH



Department
of Health

SURVEY QUESTIONS: CONTACT INFORMATION

- What is your full name?
- What is the best email address to contact you?
- What is the name of your organization?
- Type of organization



* Type of Organization:

- ☐ State Agency
- ☐ Local Government (City, Town, County)
- ☐ Statewide Organization
- ☐ Health Care Provider
- ☐ Community Behavioral Health Provider
- ☐ Housing Organization
- ☐ Health Care Plan
- ☐ Philanthropic Organization
- ☐ Educational Institution
- ☐ Community-Based Organization
- ☐ Faith-Based Community
- ☐ Private Sector (Businesses)
- ☐ Not-For-Profit
- ☐ Mental Health Provider
- ☐ Primary Care Provider
- ☐ Other (please specify)



Department
of Health

SURVEY QUESTIONS: IMPLEMENTATION MATRIX

Survey respondents will indicate which of the priority areas and goals their organization will support to advance the Prevention Agenda

Example 

For the **Economic Stability** domain, please select the priority area goals for which your organization will support implementation. Support is defined as resources your organization will contribute or allocate to this work, including funding, human resources, programs, partnerships and/or outreach, or other (please specify).

Please select all that apply for each priority area. If none apply, please select "None of the above".

*** Priority Area: Poverty**

Goal : Identify, promote, and implement programs that address poverty.

- ☐ Funding
- ☐ Human Resources
- ☐ Programs and Services
- ☐ Partnerships and/or Outreach
- ☐ Other (please specify)

☐ None of the above

SURVEY QUESTIONS: ADDITIONAL INFORMATION

- Does your organization have a local infrastructure to support the implementation of the Prevention Agenda priorities?
 - If yes, please describe any existing structure, partnerships, or resources in place
- If there are others from your organization who should receive future correspondence about Prevention Agenda updates, please list their full name and email address.
- Please provide any additional comments you would like to share.

COMMUNITY HEALTH IMPROVEMENT PLANNING



Local Health Departments must develop a Community Health Improvement Plan (CHIP) based on the findings of a Community Health Assessment (CHA).

- 6-year cycle with a mid-cycle assessment



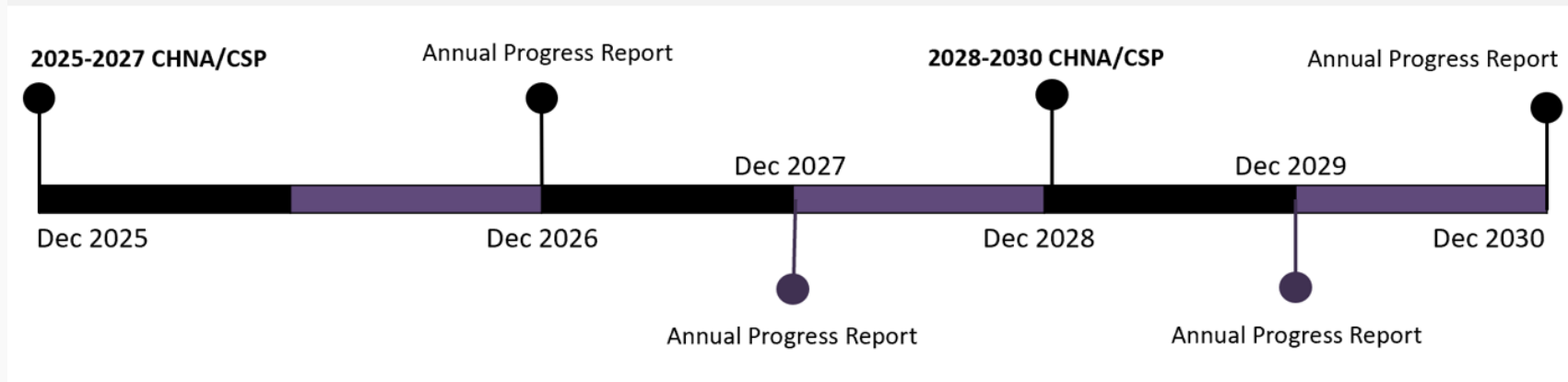
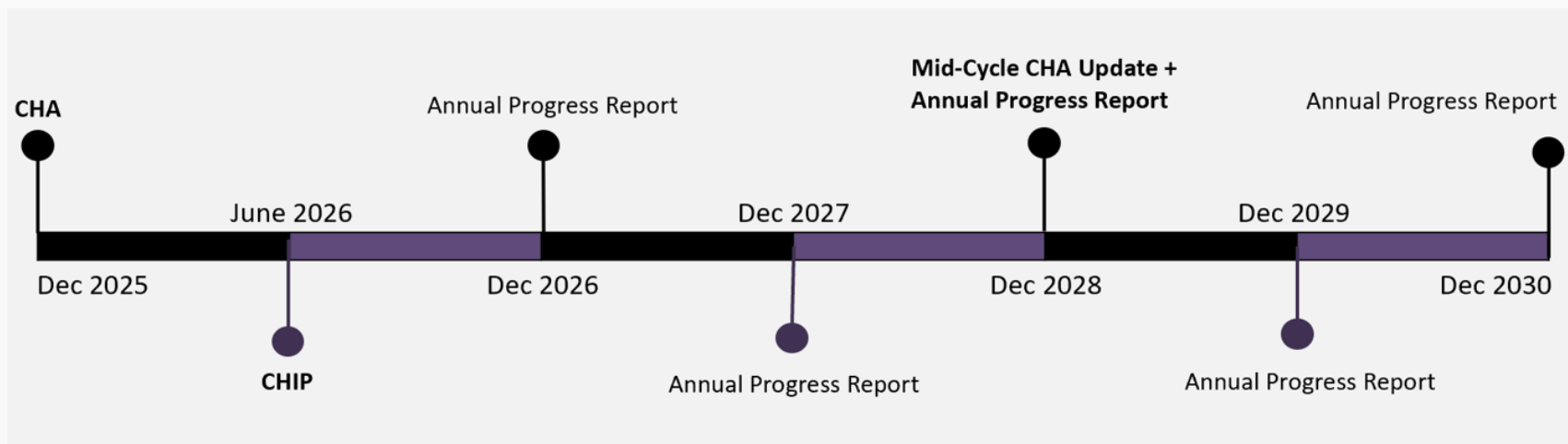
Hospitals must develop a Community Service Plan (CSP) based on the findings of a Community Health Assessment (CHA)

- Two 3-year cycles (2025-2027, 2028-2030) per IRS requirements



CHIP/CSP SUBMISSION TIMELINES

COMMUNITY HEALTH IMPROVEMENT PLAN/ COMMUNITY HEALTH ASSESSMENT



Department
of Health

Social Determinants of Health Interagency Workgroup

The Social Determinants of Health (SDOH) Interagency Workgroup was established to lead collaboration efforts at the state level.

Purpose:

- Promote a culture of health and equity across policy areas.
- Integrate health and equity into organizational practices.
- Facilitate collaboration to identify shared goals and opportunities to enhance performance.

SDOH INTERAGENCY WORKGROUP

Who?

- The NYSDOH's Inter-Agency Task Force on Health Equity and Diversity, Equity, and Inclusion will serve as base for the Prevention Agenda implementation planning group
- Experts in SDOH, health equity, health disparities, economics, and vulnerable populations

When?

- Quarterly meetings
- Initial meeting was held on February 4, 2025.
- Next meeting: May 27, 2025



NEW
YORK
STATE

Department
of Health

LIST OF TASKFORCE MEMBERS

List of Members

1. NYS Office for the Aging (NYSOFA)
2. NYS Office of Addiction Services and Supports (OASAS)
3. Department of Financial Services
4. NYS Office of Children and Family Services (OCFS)
5. NYS Department of Corrections and Community Supervision
6. NYS Division of Criminal Justice Services
7. NYS Division of Human Rights
8. NYS Department of Education (SED)
9. NYS Energy Research and Development Authority
10. NYS Homes and Community Renewal
11. NYS Department of Financial Services
12. NYS Department of Labor
13. NYS Office for People with Developmental Disabilities (OPWDD)
14. NYS Office for the Prevention of Domestic Violence (OPDV)
15. NYS Office of Mental Health
16. NYS Justice Center for the Protection of People with Special Needs
17. Department of Public Service
18. New York State Police
19. Executive Chamber
20. Civil Service
21. NYS Police DEI Office
22. NYS Department of Veterans' Services
23. NYS Department of Health

INTERAGENCY WORKGROUP: NEXT STEPS

- **Establish sub-workgroups as needed (e.g., domain workgroups)**
 - NYSDOH members
 - State Agency members
 - LHDs and hospitals
 - Community members: Individuals with expertise and lived experience related to groups facing high illness and death rates, and those knowledgeable about equity within public health and healthcare
- **In Years 1 and 2, efforts will focus on developing a compendium of activities and funding across the state to support Prevention Agenda implementers**

ROLES AND RESPONSIBILITIES

For each Domain of the Prevention Agenda, members will:

A. Develop recommendations and strategies to :

- i. Reduce Health Inequities – Address systemic barriers and implement targeted interventions.
- ii. Enhance Collaboration & Resource Allocation – Align agency efforts and streamline funding.
- iii. Improve Data Collection & Analysis – Close gaps, integrate intersectionality, and strengthen health data systems.

B. Track Progress – Contribute to annual reports and refine strategies based on lessons learned.

C. Strengthen Partnerships & Engagement – Plan activities, collaborate with key stakeholders, and involve health professionals, policymakers, community leaders, and individuals with lived experience.

COMMUNITY BENEFIT SPENDING

New Proposal:

- The NYS FY 2026 Executive Budget includes a Community Benefit Spending proposal as an amendment to Article VII legislation
- All non-profit hospitals must reinvest in their communities through community benefit spending

Key Requirement:

- The statute is a reporting requirement
- Specifically asks about coordinating with the LHDs and aligning their community benefit spending with the Prevention Agenda
 - How such community benefit expenses support the priorities of NYS, as outlined in guidance, including but not limited to the NYS's Prevention Agenda as developed by the Department

COMMUNITY BENEFIT SPENDING

Legislative Process:

- This is an executive proposal and requires approval from both houses.

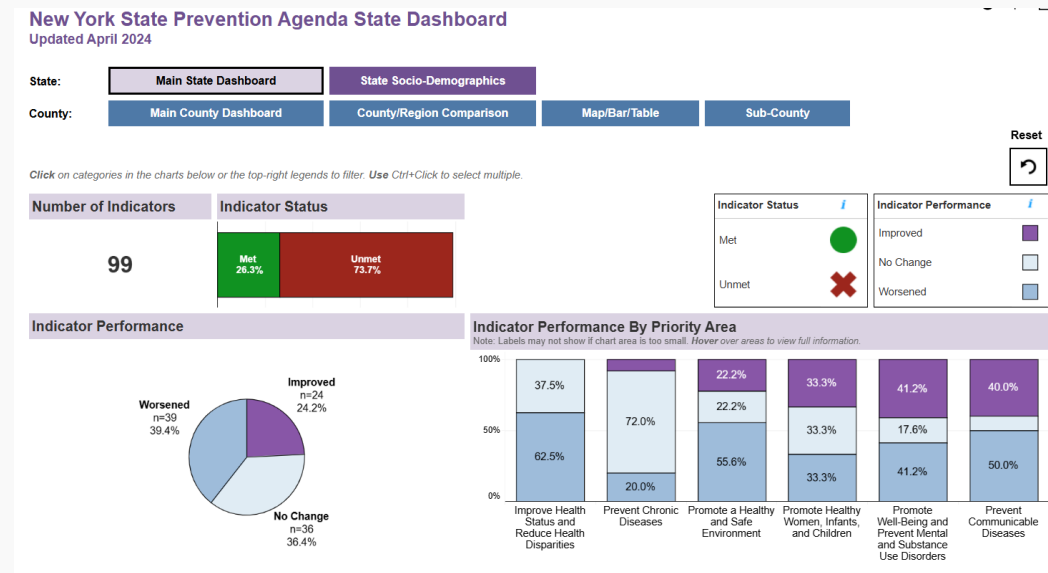
Public Health Impact: This has great potential to:

- Address social determinants of health
- Improve health equity
- Prevent certain diseases
- Promote well being

MONITORING AND EVALUATION – STATE LEVEL

The Prevention Agenda dashboard Provides:

- Overview of the most recent data and the 2030 targets for tracking indicators.
- Indicators grouped by Domain area with historical trends.
- Visualizations of indicators by socio-demographic characteristics (e.g., age, race, sex, geography, insurance, education).
- County Dashboard provides current data at county/sub-county levels, with maps, graphs, and comparisons, where available.



MONITORING AND EVALUATION – LOCAL LEVEL

Community Health Improvement Plans

- Review and evaluation of Community Health Assessments, Community Health Improvement Plans, Community Service Plans (CHAs/CHIPs/CSPs)
- Annual reporting requirements, including updates on intervention implementation and progress toward objectives
- Encouragement for extended monitoring and evaluation beyond required reporting

{ Thank You! }

Prevention Agenda Team

Elizabeth Whalen
Gina Gillooley
Bella Mazzetti
Alexander Morrison
Zahra Alaali

Dashboard Team

Eli Rosenberg
Trang Nguyen
Stephanie Mack
Changning Xu
Christopher Davis
Naila Kabiraj
Yunshu Li

Questions?

**Please contact us at
prevention@health.ny.gov**



**Department
of Health**

DOMAIN 1: ECONOMIC STABILITY



Domain Goal

All people in New York have the financial security and support needed to thrive



Priorities

Poverty
Unemployment
Nutrition Security
Housing Stability & Affordability

ECONOMIC STABILITY: UNEMPLOYMENT

SMART(IE) Objective:

- 2. Reduce unemployment among individuals ages 16 and older by from 6.2% to 5.5%**
2.1 Reduce unemployment among Black, non-Hispanic from 9.3% to 7.9%

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease the percentage unemployed	Percentage unemployed	ACS	Everyone aged 16 or older	6.2% (2022)	5.5% (2030)
			Subpopulation of Focus	Baseline	Target
			Black, non-Hispanic individuals (Ages 16+)	9.3% (2022)	7.9% (2030)



ECONOMIC STABILITY: NUTRITION SECURITY

SMART(IE) Objective					
3.0 Increase consistent household food security from 74% to 79%.					
3.1 Increase food security in households <u>with an annual total income of less than \$25,000</u> from 46.6% to 56.6%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase household food security	Percentage of households that were food insecure in the past 12 months	BRFSS (Behavioral Risk Factor Surveillance System)	Households experiencing food insecurity	26.0% (2022)	21.0% (2030)
			Subpopulation of Focus	Baseline	Target
			Households with an annual income of less than \$25,000	53.4% (2022)	43.4% (2030)



ECONOMIC STABILITY: HOUSING STABILITY & AFFORDABILITY

SMART(IE) Objective

4.0 Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000.

4.1 Increase the percentage of adults, with an annual income of less than \$25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 65.1% to 75.1%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the proportion of people who receive housing assistance.	Number of people living in HUD-subsidized housing in the past 12 months.	U.S. Department of Housing and Urban Development (HUD)	All low-income households	987,957 (2023)	1,092,000 (2030)
	Subpopulation Indicator	Data Source	Subpopulation of Focus	Baseline	Target
	Percentage of adults who were able to pay their mortgage, rent, or utility bills in the past 12 months.	BRFSS	Adults with an annual total income of less than \$25,000	65.1% (2022)	75.1% (2030)



Department
of Health

DOMAIN 2: SOCIAL & COMMUNITY CONTEXT



Domain Goal

All people in New York live in communities that foster and support optimal physical, mental, and social well-being.



Priorities

Anxiety & Stress
Depression
Suicide
Primary Prevention, Substance Misuse, and Overdose Prevention
Tobacco/E-Cigarette Use
Alcohol Use
Adverse Childhood Experiences
Healthy Eating

SOCIAL & COMMUNITY CONTEXT: ANXIETY & STRESS

SMART(IE) Objective					
5.0 Decrease the percent of adults who experience frequent mental distress from 15.9% to 15.0%. 5.1 Decrease the percent of adults in households <u>with an annual income of less than \$25,000</u> , who experience frequent mental distress from 21.0% to 19.0%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce the prevalence of anxiety and stress	Frequency of mental distress during the past month among adults, age-adjusted percentage	BRFSS	Adults	15.9% (2021)	15.0% (2030)
			Subpopulation of Focus	Baseline	Target
			Adults with household income less than \$25,000	21.0% (2021)	19.0% (2030)

SOCIAL & COMMUNITY CONTEXT: SUICIDE

SMART(IE) Objective					
6.0 Reduce the suicide mortality rate from 7.9% to 6.9%. 6.1 Reduce <u>adolescent suicide attempts</u> from 13.6% to 12.2% in NYC 6.2 Reduce <u>adolescent suicide attempts</u> from 9.4% to 8.5% for Rest of State (ROS).					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce suicide deaths	Suicide Mortality Rate	Vital Statistics	Everyone	7.9% (2021)	6.9% (2030)
	Subpopulation Indicator #1	Data Source	Subpopulation of Focus	Baseline	Target
	Percentage of high school students who attempted suicide one or more times during the past year - NYC	YRBSS (Youth Behavioral Risk Surveillance System)	High school students	13.6% (2023)	12.2% (2030)
	Subpopulation Indicator #2	Data Source	Subpopulation of Focus	Baseline	Target
	Percentage of high school students who attempted suicide one or more times during the past year - ROS	YRBSS (Youth Behavioral Risk Surveillance System)		9.4% (2023)	8.5% (2030)



SOCIAL & COMMUNITY CONTEXT: DEPRESSION

SMART(IE) Objective

7.0 Reduce the percent of adults with a major depressive episode during the past year from 6.6% to 5.6%.

7.1 Increase the percent of postpartum women who seek counseling after being told they have depression from 53.1% to 60.0%.

7.2 Increase the percent of postpartum women who receive a medication prescription after being told they have depression from 61.7% to 65.0%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce the percentage of adults with major depressive episodes	Percentage of adults with major depressive episodes during the past year	National Survey on Drug Use and Health (NSDUH)	Adults	6.6% (2021)	5.6% (2030)
	Subpopulation Indicators	Data Source	Subpopulation of Focus	Baseline	Target
	Percentage of women who were identified as having depression after birth who received counseling	Pregnancy Risk Assessment Monitoring System (PRAMS)	Postpartum women	53.1% (2022)	60.0% (2030)
	Percentage of women who were identified as having depression after birth who took a prescription medicine.			61.7% (2022)	65.0% (2030)



Department
of Health

SOCIAL & COMMUNITY CONTEXT: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

PRIMARY PREVENTION						
SMART Objective						
8.0 Reduce the number of high school students reporting alcohol use before the age of 13 from 17.2% to 15.5% - NYC.						
8.1 Reduce the number of high school students reporting alcohol use before the age of 13 from 13.6% to 12.2% - <u>Rest of State (ROS)</u> .						
Desired Outcome	Indicator	Data Source	Population		Baseline	Target
Decrease underage alcohol use	Percentage of students who had their first drink of alcohol before age 13 – NYC.	YRBSS	High school students	17.2% (2023)	15.5% (2030)	
			Subpopulation of Focus		Baseline	Target
			Percentage of students who had their first drink of alcohol before age 13 – ROS.		13.6% (2023)	12.2% (2030)



SOCIAL & COMMUNITY CONTEXT: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

PRIMARY PREVENTION					
SMART(IE) Objective					
9.0 Maintain (no increase) the rate of opioid analgesics prescriptions per 1,000 people at 273.1.					
9.1 Decrease the <u>percentage of patients who were opioid naïve and received an opioid prescription of more than seven days</u> per 1,000 people from 15.1 to 13.6.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce exposure to opioid prescriptions and high-risk prescribing	Opioid analgesic prescription rate per 1,000 population	New York Prescription Monitoring Program	Adults	273.1 (2023)	273.1 (2030)
			Subpopulation of Focus	Baseline	Target
			Patients who were opioid naïve and received an opioid prescription of > 7 days	15.1 (2023)	13.6 (2030)



SOCIAL & COMMUNITY CONTEXT: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

SECONDARY PREVENTION					
SMART(IE) Objective					
<p>10.0 Increase the number of unique individuals enrolled in OASAS treatment programs from 1,108.1 to 1,218.9.</p> <p>10.1 Increase the number of unique individuals enrolled in OASAS treatment programs, who reported any opioid as the primary substance at admission from 441.7 to 485.9.</p> <p>10.2 Increase the number of unique individuals enrolled in OASAS treatment programs, who reported alcohol as the primary substance at admission from 403.5 to 443.9.</p>					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase treatment for Substance Use Disorder	Unique individuals enrolled in OASAS treatment programs - rate per 100,000 population	OASAS Client Data System	People with Substance Use Disorder	1,108.1 (2023)	1,218.9 (2030)
			Subpopulation of Focus #1	Baseline	Target
			Individuals enrolled in Substance Use Disorder Treatment programs who reported any <u>opioid</u> as the primary substance	441.7 (2023)	485.9 (2030)
			Subpopulation of Focus #2	Baseline	Target
			Individuals enrolled in Substance Use Disorder Treatment programs who reported <u>alcohol</u> as the primary substance	403.5 (2023)	443.9 (2030)



SOCIAL & COMMUNITY CONTEXT: PRIMARY PREVENTION, SUBSTANCE MISUSE,
AND OVERDOSE PREVENTION

SECONDARY PREVENTION					
SMART Objective					
11.0 Increase the number of patients who received at least one buprenorphine prescription for opioid use disorder from 443.6 to 488.0.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase treatment for SUD	Patients who received at least one buprenorphine prescription for opioid use disorder - rate per 100,000 population	New York Prescription Monitoring Program	People with SUD	443.6 (2023)	488.0 (2030)



SOCIAL & COMMUNITY CONTEXT: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

TERTIARY PREVENTION					
SMART(IE) Objective					
12.0 Reduce the rate of overdose deaths involving drugs per 100,000 people from 32.3 to 22.6. 12.1 Reduce the rate of overdose deaths for <u>Black, non-Hispanic</u> residents per 100,000 people from 59.2 to 35.5.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce fatal drug overdoses	Overdose deaths involving drugs- rate per 100,000 population	NYS Vital Statistics	Adults	32.3 (2023)	22.6 (2030)
			Subpopulation of Focus	Baseline	Target
			Black, non-Hispanic residents	59.2 (2023)	35.5 (2030)



SOCIAL & COMMUNITY CONTEXT: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

TERTIARY PREVENTION					
SMART Objective					
13.0 Increase the number of naloxone kits distributed from 401,856 to 602,784.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Provide or increase access to naloxone to reduce overdose fatalities	Number of naloxone distributed	New York Community Opioid Overdose Prevention Program Dataset; New York Emergency Medical Services Data; New York Law Enforcement Naloxone Administration Dataset	Adults	401,856 (2023)	602,784 (2030)



SOCIAL & COMMUNITY CONTEXT: TOBACCO/E-CIGARETTE USE

SMART(IE) Objective					
14.0 Reduce the percentage of adults who use tobacco products from 9.30% to 7.91%.					
14.1 Reduce the percentage of youth who use tobacco products from 14.80% to 12.58%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease cigarette use among adults	Prevalence of cigarette smoking among adults	BRFSS	Adults 18+	9.30% (2023)	7.91% (2030)
			Subpopulation of Focus	Baseline	Target
			Youth who use tobacco products	14.80% (2022)	12.58% (2030)



SOCIAL & COMMUNITY CONTEXT: ALCOHOL USE

SMART(IE) Objective

15.0 Decrease the prevalence of binge or heavy drinking among all adults aged 18 years and older from 16.2% to 13.0%.

15.1 Decrease the prevalence of drinking by high school students from 16.8% to 13.4% in NYC, and from 23.9% to 19.1% for Rest of State (ROS).

15.2 Decrease the prevalence of drinking by high school students from 23.9% to 19.1%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce excessive alcohol use among adults	Prevalence of binge OR heavy drinking among adults	BRFSS	Adults	16.2% (2023)	13.0% (2030)
	Subpopulation Indicator	Data Source	Subpopulation of Focus	Baseline	Target
	Prevalence of drinking among high school students - NYC	YRBSS	Youth/ High school students	16.8% (2023)	13.4% (2030)
Reduce drinking among high school students	Prevalence of drinking among high school students - ROS	YRBSS	Youth/ High school students	23.9% (2023)	19.1% (2030)



SOCIAL & COMMUNITY CONTEXT: ADVERSE CHILDHOOD EXPERIENCES

SMART(IE) Objective					
16.0 Increase the percentage of adults who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met from 75.9% to 78.0%.					
16.1 Increase the percentage of <u>Hispanic adults</u> who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met from 61% to 63.1%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase protective factors reported by adults	Percentage of adults who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met.	BRFSS	Adults (Ages 18+)	75.9% (2021)	78% (2030)
			Subpopulation of Focus	Baseline	Target
			Hispanic Adults (Ages 18+)	61% (2021)	63.1% (2030)



SOCIAL & COMMUNITY CONTEXT: ADVERSE CHILDHOOD EXPERIENCES

SMART(IE) Objective					
17.0 Reduce the percentage of adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 26.6% in 2021 to 25%.					
17.1 Reduce the percentage of <u>Black, non-Hispanic adults</u> who, as a child, experienced three or more adverse childhood experiences (ACEs) from 30% in 2021 to 28.4%.					
17.2 Reduce the percentage of Hispanic adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 31% in 2021 to 28.4%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce the percentage of adults experiencing three or more adverse childhood experiences (ACEs)	Percentage of adults who, as a child, experienced three or more adverse childhood experiences (ACEs)	BRFSS	Adults (Ages 18+)	26.6% (2021)	25% (2030)
			Subpopulation of Focus	Baseline	Target
			Black, non-Hispanic Adults (Ages 18+); Hispanic adults	Black, non-Hispanic adults 30%; Hispanic adults 31% (2021)	Black, non-Hispanic adults 28.4% ; Hispanic adults 28.4% (2021)



SOCIAL & COMMUNITY CONTEXT: ADVERSE CHILDHOOD EXPERIENCES

SMART(IE) Objective

- 18.0** Reduce the rate of indicated reports of abuse/maltreatment per 1,000 children and youth ages 0-17 years from 11.5 in 2023 to 10.0.
- 18.1** Reduce the rate of indicated reports of abuse/maltreatment per 1,000 Black children and youth from 17.5 in 2023 to 16.0.
- 18.2** Reduce the rate of indicated reports of abuse/maltreatment per 1,000 Hispanic children and youth from 14.4 in 2023 to 12.9.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce indicated reports of abuse/maltreatment rate per 1,000 children and youth ages 0-17 years.	Indicated reports of abuse/maltreatment, rate per 1,000 children, aged 0-17 years.		Children and youth, 0-17	Rate 11.5 (2023)	Rate 10 (2030)
			Subpopulation of Focus	Baseline	Target
			Black children and youth	17.5 (2023)	16.0 (2030)
			Hispanic children and youth	14.4 (2023)	12.9 (2030)



SOCIAL & COMMUNITY CONTEXT: HEALTHY EATING

SMART(IE) Objective					
19.0 Decrease the percentage of adults who consume no fruits or vegetables daily from 33.8% to 32.1%.					
19.1 Decrease the percentage of adults <u>with an annual household income less than \$50,000</u> who consume no fruits or vegetables daily by 5% (data available starting 2024).					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increased consumption of nutritious foods recommended by the Dietary Guidelines	Percentage of adults who consumed fewer than one fruit and fewer than one vegetable daily (no fruits or vegetables)	BRFSS	Adults (Ages 18+)	33.8% (2021)	32.1% (2030)
			Subpopulation of Focus	Baseline	Target
			Adults in households that earn less than \$50,000 per year	Data available starting 2024	5% decrease from baseline (2030)



SOCIAL & COMMUNITY CONTEXT: HEALTHY EATING

SMART(IE) Objective					
20.0 Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%. 20.1 Increase the percentage of <u>Black, non-Hispanic infants</u> who are exclusively breastfed in the hospital from 34.1% to 35.8%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increased exclusive breastfeeding and <u>chestfeeding</u> among NYS infants	Percentage of infants who are exclusively breastfed in the hospital	NYS Birth Certificate Data, Vital Statistics	Infants (0-6 months)	45.9% (2021)	48.2% (2030)
			Subpopulation of Focus	Baseline	Target
			Black, non-Hispanic infants (0-6 months)	34.1% (2021)	35.8% (2030)



DOMAIN 3: NEIGHBORHOOD & BUILT ENVIRONMENT



Domain Goal

All people in New York have equitable access to healthy and safe neighborhoods.



Priorities

- Opportunities for Active Transportation & Physical Activity
- Access to Community Services & Supports
- Injuries & Violence

NEIGHBORHOOD & BUILT ENVIRONMENT: OPPORTUNITIES FOR ACTIVE TRANSPORTATION & PHYSICAL ACTIVITY

SMART(IE) Objective					
21.0 Increase the prevalence of physical activity among all adults ages 18 years and older from 73.9% to 77.6%.					
21.1 Increase the prevalence of physical activity among all adults ages 18 years and older <u>with an annual household income less than \$25,000</u> from 56.7% to 59.5%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase prevalence of physical activity in adults	Percentage of adults who are physically active	BRFSS	Adults (Ages 18+)	73.9% (2023)	77.6% (2030)
			Subpopulation of Focus	Baseline	Target
			Adults with an annual household income less than \$25,000	56.7% (2023)	59.5% (2030)



NEIGHBORHOOD & BUILT ENVIRONMENT: ACCESS TO COMMUNITY SERVICES & SUPPORT

SMART(IE) Objective

- 22.0 Increase the number of completed Climate Smart Communities certification actions that support community resilience to help communities across New York mitigate and adapt to climate change from 363 to 382.**
- 22.1 Increase the number of cooling centers locally accessible to individuals living in high heat vulnerable and/or disadvantaged communities from 698 to 768.**

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Ensure the availability and accessibility of cooling centers or other places where people can cool off during extreme heat events in high heat vulnerable areas and disadvantaged communities.	Count of Climate Smart Community Actions related to community resiliency;	Climate Smart Community Application Data	Everyone	363 (2023)	382 (2030)
	Subpopulation Indicator	Data Source	Subpopulation of Focus	Baseline	Target
	Count of cooling centers on Cooling Center Finder	NYSDOH Cooling Center Finder Data	Individuals in high heat vulnerable areas and disadvantaged communities.	698 (2023)	768 (2030)



NEIGHBORHOOD & BUILT ENVIRONMENT: INJURIES & VIOLENCE

SMART(IE) Objective					
23.0 Decrease the rate of emergency department visits of motor vehicle-related pedestrian injuries per 10,000 people from 4.7 to 4.5.					
23.1 Decrease the ratio of motor vehicle-related pedestrian injury emergency department visits of Black, non-Hispanic persons compared to White, non-Hispanic persons from 4.0 to 3.8.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease Motor Vehicle-Related Pedestrian Injuries	Rate of Emergency Department (ED) Visits of Motor Vehicle-Related Pedestrian Injuries per 10,000 New York Residents	SPARCS (Statewide Planning and Research Cooperative System)	Everyone	4.7 per 10,000 (2022)	4.5 per 10,000 (2030)
			Subpopulation of Focus	Baseline	Target
			Black, non-Hispanic	4.0 (ratio of rates, Black, non-Hispanic compared to White, non-Hispanic) (2022)	3.8 (2030)



NEIGHBORHOOD & BUILT ENVIRONMENT: INJURIES & VIOLENCE

SMART(IE) Objective					
24.0 Decrease the rate of emergency department visits of assaults per 10,000 from 42.2 to 40.1.					
24.1 Decrease the ratio of rates of assault-related emergency department visits of <u>Black, non-Hispanics</u> compared to <u>White, non-Hispanics</u> from 4.4 to 4.2.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease Assault-Related Injuries	Rate of Emergency Department (ED) Visits of Assault-Related Injuries per 10,000 New York Residents	SPARCS	Everyone	42.2 per 10,000 (2022)	40.1 per 10,000 (2030)
			Subpopulation of Focus	Baseline	Target
			Assault-related ED Visits Among Black, non-Hispanics	4.4 (ratio of rates, Black, non-Hispanics compared to White, non-Hispanics) (2022)	4.2 (2030)



DOMAIN 4: HEALTH CARE ACCESS & QUALITY



Domain Goal

All people in New York have access to timely, affordable, and high-quality health care services.



Priorities

Access to and Use of Prenatal Care
Prevention of Infant & Maternal Mortality
Preventive Services for Chronic Disease Prevention & Control
Oral Health Care
Preventive Services
Early Intervention
Childhood Behavioral Health

HEALTH CARE ACCESS & QUALITY: ACCESS TO AND USE OF PRENATAL CARE

SMART(IE) Objective					
25.0 Increase the percentage of birthing persons who receive prenatal care during the first trimester from 80.7% to 83.0%.					
25.1 Increase the percentage of <u>uninsured birthing persons</u> who receive prenatal care during the first trimester from 41.4% to 45.0%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percentage of birthing persons who receive prenatal care during the first trimester of pregnancy.	Percentage of births with early (1st trimester) prenatal care	Vital Statistics	Birthing persons	80.7% (2021)	83.0% (2030)
			Subpopulation of Focus	Baseline	Target
			Uninsured birthing persons	41.4% (2021)	45.0% (2030)

HEALTH CARE ACCESS & QUALITY: PREVENTION OF INFANT & MATERNAL MORTALITY

SMART(IE) Objective					
26.0 Decrease the rate of infant mortality per 1,000 live births from 4.1 to 3.5.					
26.1 Decrease the rate of <u>newborns with neonatal withdrawal symptoms/affected by maternal substance use</u> per 1,000 live births from 7.1 to 5.2.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease the rate of infant mortality	Infant mortality rate per 1,000 live births	Vital Statistics	Infants	4.1 (2022)	3.5 (2030)
	Subpopulation Indicator	Subpopulation Data Source	Subpopulation of Focus	Baseline	Target
	Rate of infants affected by maternal substance use per 1,000 live births	SPARCS	Newborns with NAS or are affected by maternal substance use	7.1 (2022)	5.2 (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTION OF INFANT & MATERNAL MORTALITY

SMART(IE) Objective					
27.0 Decrease the rate of maternal mortality per 100,000 live births from 19.8 to 16.1. 27.1 Decrease the rate of maternal mortality per 100,000 live births among Black, non-Hispanic birthing persons from 65.2 to 55.0.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease the rate of maternal mortality	Rate of maternal mortality per 100,000 live births	Vital Statistics	Birthing persons	19.8 (2017-2021)	16.1 (2030)
			Subpopulation of Focus 1	Baseline	Target
			Black, non-Hispanic birthing persons	65.2 (2018-2021)	55.0 (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTION OF INFANT & MATERNAL MORTALITY

SMART(IE) Objective

28.0 Decrease percentage of birthing persons who experience symptoms of perinatal mood and anxiety disorder (PMAD) from 11.9% to 9.9%.

28.1 Decrease percentage of birthing persons who experience depressive symptoms after birth from **X% to X%**.

28.2 Decrease percentage of birthing persons who report experiencing depressive symptoms during pregnancy from **X% to X%**.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease percentage of birthing persons who experience symptoms of PMAD during pregnancy and after birth	Percentage of birthing persons who experience symptoms of perinatal mood and anxiety disorder (PMAD)	Vital Statistics; PRAMS	Birthing persons up to 1-year postpartum	11.9% (2022)	9.9% (2030)
			Subpopulation of Focus 1	Baseline	Target
			Birthing persons who experience depressive symptoms after birth	TBD	TBD
			Subpopulation of Focus 2	Baseline	Target
			Birthing persons who report experiencing depressive symptoms during pregnancy	TBD	TBD



Department
of Health

HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES FOR CHRONIC DISEASE CONTROL & PREVENTION

SMART(IE) Objective

29.0 Increase the percent of adults ages 35+ who had a test for high blood sugar in the past year from 78.1% to 82.4%.

29.1 Increase the percent of younger adults ages 35-44 who had a test for high blood sugar in the past year from 62.4% to 65.5%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
(Increase screening/early detection) Percentage of adults who had a test for high blood sugar or diabetes within the past year, aged 35+ years	High blood sugar/Diabetes Screening	BRFSS	Adults ages 35+	78.1% (2023)	82.4% (2030)
			Subpopulation of Focus	Baseline	Target
			Younger adults ages 35-44	62.4% (2023)	65.5% (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES FOR CHRONIC DISEASE CONTROL & PREVENTION

SMART(IE) Objective					
30.0 Decrease the asthma emergency department visit rate per 10,000 among children ages 0-17 years from 93.8 to 89.1.					
30.1 Decrease the asthma emergency department visit rate per 10,000 among <u>Black, non-Hispanic children</u> ages 0-17 years from 235.9 to 212.3.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
(Management of diseases) Decrease the asthma emergency department visit rate per 10,000, ages 0-17	Asthma emergency department visit rate per 10,000, ages 0-17	SPARCS	Children ages 0-17	93.8 (2022)	89.1 (2030)
			Subpopulation of Focus	Baseline	Target
			Black, non-Hispanic children ages 0-17 years	235.9 (2022)	212.3 (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES FOR CHRONIC DISEASE CONTROL & PREVENTION

SMART(IE) Objective					
31.0 Increase the percent of adults ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%. 31.1 Increase the percent of adult <u>Medicaid members</u> ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
(Management of disease) Increase the percentage of adults with hypertension who are currently taking medication to manage their high blood pressure	Hypertension management	BRFSS	Adults ages 18+ with hypertension	77.0% (2023)	81.7% (2030)
			Subpopulation of Focus	Baseline	Target
			Medicaid members ages 18+ with hypertension	66.9% (2023)	75.5% (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES FOR CHRONIC DISEASE CONTROL & PREVENTION

SMART(IE) Objective					
32.0 Increase the percentage of adults ages 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80%. 32.1 Increase the percentage of adults <u>ages 45 to 54 years</u> who are up to date on their colorectal cancer screening based on the most recent guidelines from 54.7% to 62.2%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percentage of adults ages 45-75 who receive a colorectal cancer screening based on the most recent guidelines	Cancer Screening	BRFSS	Adults ages 45-75 years	71.6% (2023)	80% (2030)
			Subpopulation of Focus	Baseline	Target
			Adults ages 45-54 years	54.7% (2023)	62.2% (2030)



HEALTH CARE ACCESS & QUALITY: ORAL HEALTH CARE

SMART(IE) Objective					
33.0 Increase the percent of Medicaid enrollees with at least one preventive dental visit within the last year from 25.8% to 27.1%.					
33.1 Increase the percent of Medicaid enrollees <u>ages 2-20</u> with at least one preventive dental visit within the last year from 42.8% to 44.9%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percentage of Medicaid enrollees with at least one preventive dental visit within the last year	percentage of Medicaid enrollees with at least one preventive dental visit within the last year	NYS Medicaid Program	Medicaid enrollees	25.8% (2022)	27.1% (2030)
			Subpopulation of Focus	Baseline	Target
			Medicaid enrollees ages 2-20	42.8% (2022)	44.9% (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES

SMART(IE) Objective					
34.0 Increase the percentage of infants who received diagnostic hearing test after failing their newborn hearing screening from 23.4% to 35.1%. 34.1 Increase the percentage of infants who received diagnostic hearing test after failing their newborn hearing screening at 3 months of age from 15.6% to 23.4%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percentage of infants who received diagnostic hearing test after failing their newborn hearing screening	Percentage of infants who received diagnostic hearing test after failing their newborn screening	Early Hearing Detection and Intervention (EHDI)	Infants who received diagnostic hearing test after failing their newborn hearing screening	23.4% (2022)	35.1% (2030)
			Subpopulation of Focus	Baseline	Target
			Infants who received diagnostic hearing test after failing their newborn hearing screening by 3 months of age.	15.6% (2022)	23.4% (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES

SMART Objective

35.0 Increase the up to date seven-vaccine immunization rate for children 24—35 months from 59.30% to 62.30%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase seven-vaccine series rate	Reduce the difference in the 4:3:1:3:3:1:4 immunization series coverage by federal poverty level	NYSIIS, CIR	Children (Ages 24-35 months)	59.30% (2024)	62.30% (2030)



HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES

SMART Objective

36.0 Increase the percentage of 13-year-old adolescents with a complete HPV vaccine series from 25.70% to 28.70%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase on-time completion of HPV vaccine series by age 13 years	Percentage of 13-year-old adolescents with a complete HPV vaccine series	NYSIIS, CIR	Children and adolescents ages 9-13 years	25.70% (2024)	28.70% (2030)



Department
of Health

HEALTH CARE ACCESS & QUALITY: PREVENTIVE SERVICES

SMART Objective

37.0 Increase the percentage of children in a single birth cohort tested at least twice for lead before 36 months of age from 61% to 70%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percentage of children in a single birth cohort tested at least twice for lead before 36 months of age	Percentage of children in a single birth cohort tested at least twice for lead before 36 months of age	CHIRS	Infants and children in single birth cohort 0-36 months	61.0%	70.0%

HEALTH CARE ACCESS & QUALITY: EARLY INTERVENTION

SMART(IE) Objective					
38.0 Increase the percent of children under age three who have Individual Family Service Plans (IFSPs) from 13.0% to 14.0%.					
38.1 Increase the percent of <u>Black, non-Hispanic</u> children under age three who have IFSPs from 9.97% to 10.97%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percent of children who receive IFSPs by age 3.	Percent of children with an IFSP	NYS EIP Data System (NYEIS/EI-Hub)	Children under age 3	13% (2022)	14% (2030)
			Subpopulation of Focus	Baseline	Target
			Black, non-Hispanic Children under age 3	9.97% (2022)	10.97% (2030)



HEALTH CARE ACCESS & QUALITY: CHILDHOOD BEHAVIORAL HEALTH

SMART(IE) Objective					
39.0 Increase the percent of children ages 0-5 who are reported by their parent as exhibiting all four flourishing criteria from 72.2% to 79.42%.					
39.1 Increase the percent of children ages 0-5 <u>who live at 0-99% of the poverty level</u> who are reported by their parent as exhibiting all four flourishing criteria from 58.8% to 67.62%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percent of children 0-5 whose parent indicate they are flourishing all four of the flourishing criteria	Percent of children reported as flourishing in the NSCH survey	NSCH (National Survey of Children's Health)	Children (Ages 0-5)	72.2% (2023)	79.42% (2030)
			Subpopulation of Focus	Baseline	Target
			Children (Ages 0-5) in a household living between 0-99% of the poverty level	58.8% (2023)	67.62% (2030)



DOMAIN 5: EDUCATION ACCESS & QUALITY



Domain Goal

All people in New York have equitable access to quality education in an environment that supports physical and mental health.



Priorities

Health & Wellness Promoting Schools

Opportunities for Continued Education

EDUCATION ACCESS & QUALITY: HEALTH & WELLNESS PROMOTING SCHOOLS

SMART(IE) Objective					
40.0 Decrease the percentage of Chronic Absenteeism (defined as missing more than 18 days (>10%) per academic year) from 26.4% to 18.5%.					
40.1 Decrease rates of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) for those who are economically disadvantaged from 34.9% to 24.4%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease the percent of public school students who miss 10% or more school days in an academic year	Percent or rate of public-school students with >10% absenteeism	City Health Dashboard	Public school students	26.4% (2023)	18.5% (2030)
			Subpopulation of Focus	Baseline	Target
			Economically disadvantaged public school students	34.9% (2023)	24.4% (2030)



EDUCATION ACCESS & QUALITY: OPPORTUNITIES FOR CONTINUED EDUCATION

SMART(IE) Objective					
41.0 Increase the number of High School Seniors that attend a 2- or 4-year college from 70.2% to 77.2%. 41.1 Increase the number of High School Seniors <u>who are economically disadvantaged</u> that attend a 2- or 4-year college from 63.1% to 69.4%.					
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percentage of population aged 25 years and older with at least some college	Percentage of population aged 25 years and older with at least some college	ACS, Census	High school seniors	70.2% (2022-2023)	77.2% (2030)
			Subpopulation of Focus	Baseline	Target
			Economically disadvantaged high school seniors	63.1% (2022-2023)	69.4% (2030)

