THE 2025-2030 NEW YORK STATE 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

Public Health and Health Planning Council - Ad Hoc Committee Meeting

AGENDA

Prevention Agenda Background

The 2025-2030 Prevention Agenda Framework

Implementation and Monitoring

Prevention Agenda Dashboard

ACRONYMS & TERMS

- **SHIP**: State Health Improvement Plan
- **CHIP**: Community Health Improvement Plan
- **CSP**: Community Service Plan
- **CH(N)A**: Community Health (Needs) Assessment
- **LHD**: Local Health Department
- **PHAB**: Public Health Accreditation Board
- **SDOH**: Social Determinants of Health
- **ACEs**: Adverse Childhood Experiences
- **SMART/IE:** Specific, Measurable, Achievable, Relevant, Time-bound/Inclusive, Equitable
- **NYSDOH:** New York State Department of Health
- **HUD:** Housing and Urban Development
- **CON:** Certificate of Need
- **IRS:** Internal Revenue Service

RELEASE OF THE 2025-2030 PREVENTION AGENDA

OFFICIALLY ANNOUNCED IN A PRESS RELEASE ON JULY 17, 2025

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

NEW YORK STATE DEPARTMENT OF HEALTH LAUNCHES THE 2025-2030 PREVENTION AGENDA

Six-Year Plan Serves as a Blueprint for Community Action to Improve Health Statewide

ALBANY, N.Y. (July 17, 2025) – The New York State Department of Health today announced the launch of the 2025-2030 Prevention Agenda.

The Prevention Agenda is New York's State Health Improvement Plan (SHIP) and serves as a framework for coordinated state and local action to improve the health for all people in New York and reduce health disparities with a strong emphasis on prevention.

"Health is shaped by many factors beyond traditional medical care, and improving the health of our communities requires addressing those broader determinants," **said State Health Commissioner Dr. James McDonald**. "The goal of New York's Prevention Agenda is to improve population health and reduce health disparities by preventing problems before they start and tackling the root causes that impact well-being — in partnership with local governments, health care providers, and community organizations across the state."

The development of the 2025–2030 Prevention Agenda priorities were shaped through a collaborative process that emphasized stakeholder engagement, data-driven decision-making, and alignment with health equity principles to ensure the Prevention Agenda reflects the needs of communities across New York State. A cross-disciplinary team was engaged to develop a shared vision for the Prevention Agenda and inform the selection of health and health-related priorities.

The New York State Department of Health in collaboration with the Public Health and Health Planning Council, and local partners, recognizes the importance of fostering cross-sector collaborations to achieve collective impact in addressing the priorities outlined in the Prevention Agenda.

The 2025–2030 Prevention Agenda shifts its focus from overall health outcomes to reducing health disparities and advancing health equity, allowing more proactive focus on preventative actions that address root causes of injury and illness. This shift is also aligned with the New York State Department of Health's vision and its commitment to ensure that every individual can attain their highest level of health across the lifespan.

The 2025-2030 Prevention Agenda is designed to be used by health departments, hospital systems, and other organizations at the state and local levels. It prioritizes evidence-informed interventions that consider potential impacts on disparities and inequities by racial/ethnic, socioeconomic, geographic, and other characteristics. Its success depends on strong, sustained partnerships and innovative use of available resources.

New York State Public Health and Health Planning Council Vice Chair Jo Ivey Boufford, M.D. said, "The Public Health Committee has been deeply involved in the development of the new Prevention Agenda on behalf of the NYS Public Health and Health Planning Council which has endorsed the plan. The Committee has also worked with NYSDOH to convene a statewide group of over 120 representatives from 48 agencies to provide input on the new plan through its Ad Hoc Committee on the Prevention Agenda. We look forward to overseeing the progress on the Agenda and are enthusiastic about the potential for other State agencies to join NYSDOH in addressing the broader determinants of health.

THE PREVENTION AGENDA

What?

- NYS's State Health Improvement Plan (SHIP).

Why?

- The Prevention Agenda serves as a roadmap for both state and local action to improve the health and well-being of all New Yorkers and to reduce health disparities. State health departments pursuing and/or maintaining Public Health Accreditation Board (PHAB) accreditation must publish a SHIP.

Who?

- Created by New York State Department of Health (NYSDOH) with partners
- Implemented by Local Health Departments (LHD), hospitals, and other organizations

When?

- A new Prevention Agenda is published every 6 years

HISTORY OF THE NEW YORK STATE PREVENTION AGENDA

Cycle	# Priorities	NYS Ranking	Key Activities
2008–2012	**10** (including access to care)	**28th** healthiest	• LHDs & hospitals completed collaborative assessments and implementation plans aligned with Prevention Agenda • *Having 10 priorities made it difficult to foster collaboration between hospitals and LHDs.*
2013–2018	**5** (prevention-focused)	**15th** healthiest	• LHDs and hospitals strongly urged to collaborate and co-develop a joint assessments and implementation plans. • NYSDOH provided feedback & required annual progress reports. • Community benefit spending linked to Prevention Agenda & Delivery System Reform Incentive Payment (DSRIP) program
2019–2024	**5** (prevention-focused)	**23rd** healthiest	• Adopted Health Across All Policies & Age-Friendly NY frameworks • *COVID-19 shifted LHD priorities*

2025-2030 PREVENTION AGENDA FRAMEWORK

Overarching Vision and 4 Foundations

5 Domains representative of key Social Determinants of Health (SDOH)

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

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

NEW YORK STATE 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.

84 Measurable Objectives

- **42 SMART** Objectives
- **42 SMARTIE** Objectives

84 Indicators to track progress

A list of **Evidence-Informed Interventions**

Action Plan Overview

2025-2030 Prevention Agenda

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

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 people aged 65+ 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)

General statement about desired result

The selected metric to track progress

Source of data

Priority Populations

Most recent data

Specific numbers that quantify desired outcome

NEW YORK STATE Department of Health

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.

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] LHD H O	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. LHD O	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] LHD H O	Adults enrolled in public benefits, high school age youth	Ages 16+	Employment rate by age group and industry.

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)

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

Implementation

How Will the 2025 -2030 Prevention Agenda Be Implemented?

HOW IS THE PREVENTION AGENDA IMPLEMENTED?

1	**Community Health Improvement**	▪ Align LHDs' and hospitals' efforts with Prevention Agenda priorities through Community Health Assessments, Community Health Improvement Plans, and Community Service Plans (CHAs/CHIPs/CSPs).
2	**Certificate of Need (CON) Applications**	▪ Designed to control costs, improve quality, and ensure access to care. ▪ Request information from **Not-for-profit hospitals** on how proposed projects address Prevention Agenda priorities and objectives.
3	**Hospitals' Community Benefit Spending**	▪ Non-profit hospitals receive tax exemptions in exchange for reinvesting those funds into community benefits (e.g., financial assistance for patients, subsidized care for underinsured populations, public health programs addressing social determinants of health).
4	**Interagency Collaboration**	▪ Actions and investments by other state and community partners. ▪ Cross-sector collaboration.

Joint planning

- Submitting **one** assessment and health improvement plan for both the LHD(s) and hospital(s) within the same county.

Community Benefit

- Reflect Prevention Agenda efforts in the community benefit forms.
- Increase investments in the Community Health Improvement and Community Building categories.
- Align and increase investments in evidence-based interventions related to the Prevention Agenda.

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

8/21/2024

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

Thank you for your interest in improving population health in New York. This guide, developed by the Office of Public Health Practice in the New York State Department of Health (NYSDOH), provides 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.

The Prevention Agenda serves as a roadmap for both state and local action to improve the health and well-being of all New Yorkers and to reduce health disparities. As in previous years, the NYSDOH requests each LHD and partner hospitals/hospital systems within the county to align priorities and collaborate with community partners. Collaboration between LHDs and hospitals, and alignment between state and local entities, will allow for more effective and efficient health improvement activities. These local collaborative efforts are crucial for achieving the Prevention Agenda's vision: ensuring that every individual in New York State can attain their highest level of health, regardless of background or circumstances, throughout their lifespan.

The NYSDOH designed this guidance to help LHDs pursuing accreditation meet the national public health standards set by the Public Health Accreditation Board (PHAB). Additionally, hospitals can use this document to support the Internal Revenue Service (IRS) requirement to complete a Community Health Needs Assessment (CHNA). However, we cannot assure that completing the components required by NYSDOH will fulfill the PHAB or IRS requirements. Entities should independently verify that both PHAB and IRS requirements are met, rather than relying solely on this guide.

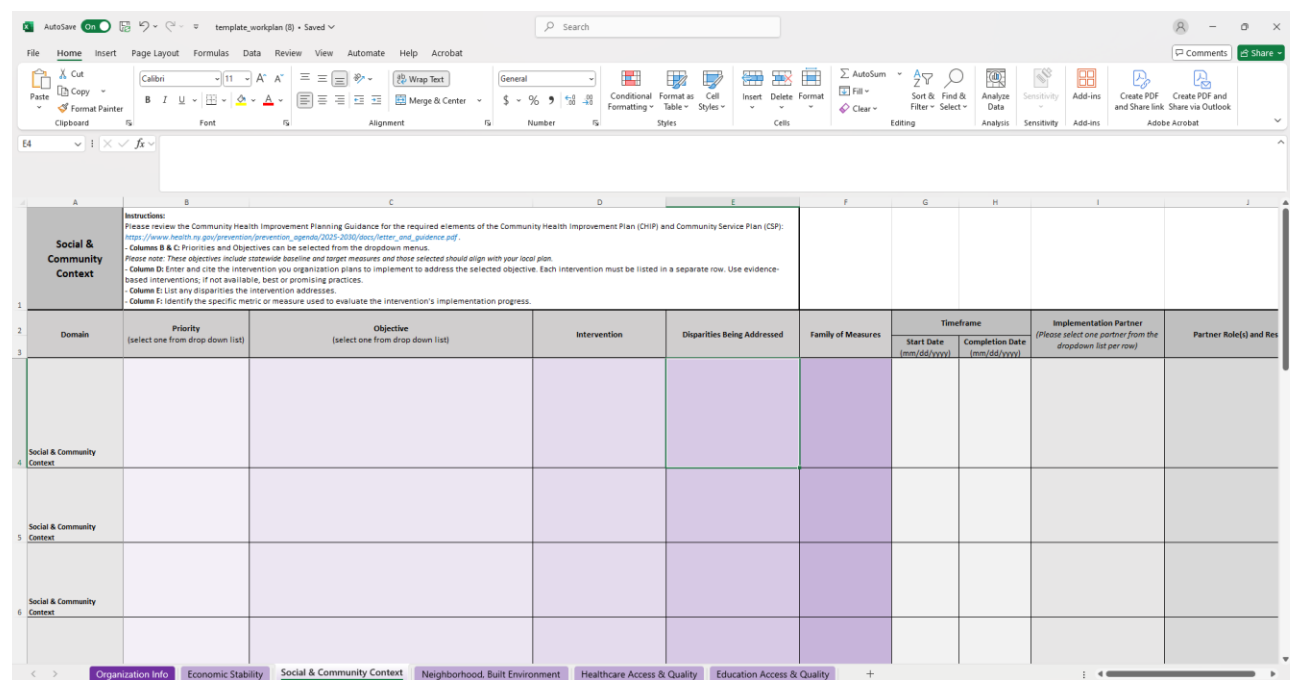
Thank you for your continued commitment to improve the health of New Yorkers. If you have any questions, please contact the Office of Public Health Practice at prevention@health.ny.gov or 518 473-4223 for further clarification.

Sincerely,

Zahra S Alaali, MPH
Prevention Agenda Coordinator
Office of Public Health Practice

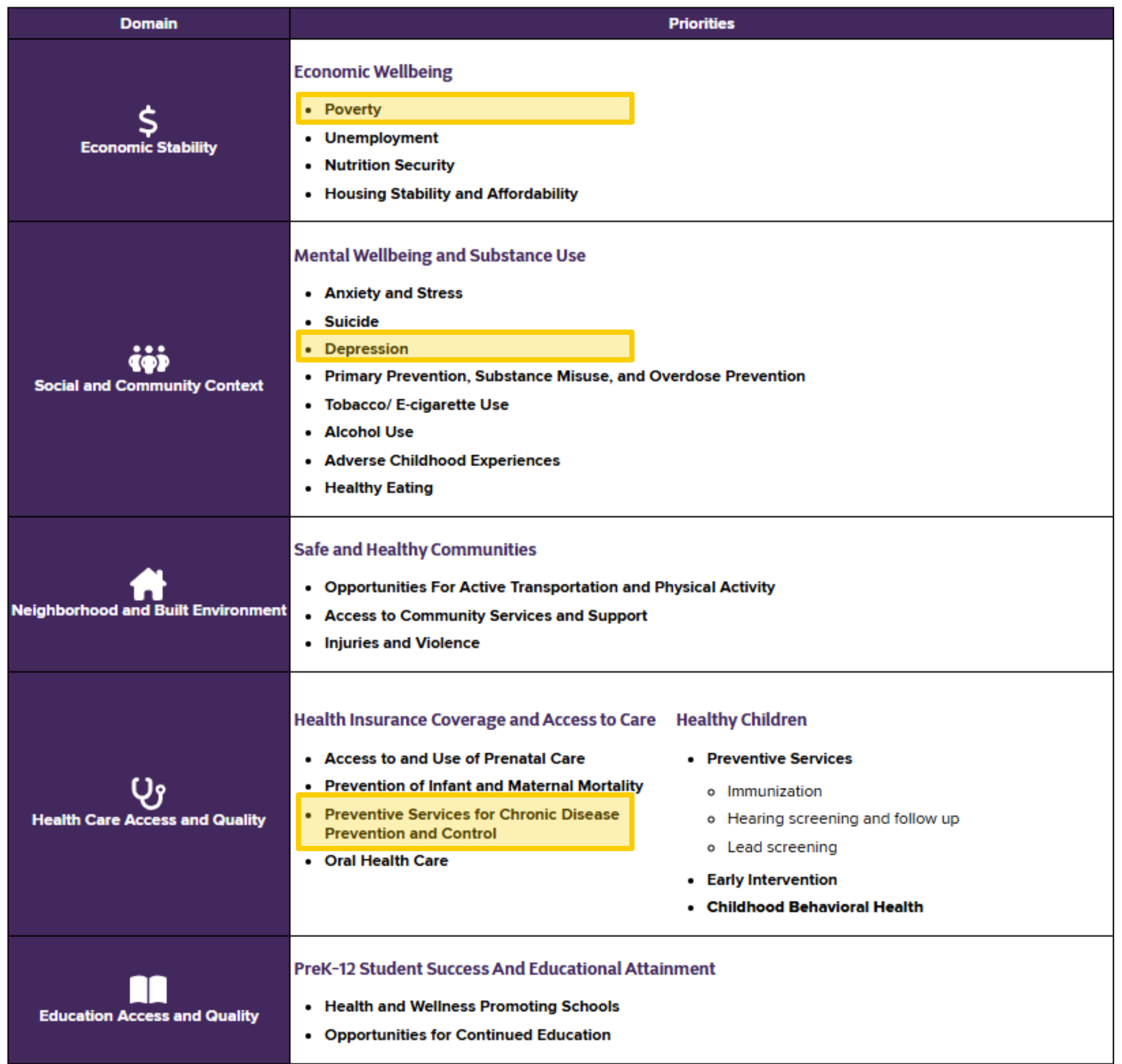
Alignment with the 2025-2030 Prevention Agenda

- **Priorities**: Select at least 3 priorities from the Prevention Agenda list.
  - At least 1 should address a Social Determinant of Health (SDOH).
- **Objectives**: Select 1 or more objectives for each priority.
  - At least two objectives must be SMARTIE, specifically addressing populations experiencing disparities (Subpopulation of Focus).
- **Interventions**: Identify evidence-based intervention for each priority.



COMMUNITY HEALTH IMPROVEMENT PLANNING

EXAMPLE OF PRIORITIES SELECTION



Domain	Priorities
Economic Stability	**Economic Wellbeing** • Poverty • Unemployment • Nutrition Security • Housing Stability and Affordability
Social and Community Context	**Mental Wellbeing and Substance Use** • Anxiety and Stress • Suicide • Depression • Primary Prevention, Substance Misuse, and Overdose Prevention • Tobacco/ E-cigarette Use • Alcohol Use • Adverse Childhood Experiences • Healthy Eating
Neighborhood and Built Environment	**Safe and Healthy Communities** • Opportunities For Active Transportation and Physical Activity • Access to Community Services and Support • Injuries and Violence

Health Care Access and Quality	**Health Insurance Coverage and Access to Care**
	• Access to and Use of Prenatal Care
	• Prevention of Infant and Maternal Mortality
	• Preventive Services for Chronic Disease Prevention and Control
	• Oral Health Care
	Healthy Children
	• Preventive Services
	  ○ Immunization
	  ○ Hearing screening and follow up
	  ○ Lead screening
	• Early Intervention
	• Childhood Behavioral Health

Education Access and Quality	**PreK-12 Student Success And Educational Attainment** • Health and Wellness Promoting Schools • Opportunities for Continued Education

COMMUNITY HEALTH IMPROVEMENT PLANNING

SUBMISSION TIMELINE

NEW YORK'S CERTIFICATE OF NEED (CON)

EXAMPLE OF CON REVIEW

Date: 07/28/2025

CON Number and Facility Name: [redacted]

Description:

The [redacted], located in New York County, requests approval for the development of their new building ([redacted] to provide cancer care services. The project aims to expand their current infrastructure to meet the increasing needs of their patient population.

[redacted] is implementing multiple interventions to support the priorities of the 2019-2024 New York State Prevention Agenda, including:

- Prevent Chronic Diseases

The proposed project does not explicitly advance the Prevention Agenda priority that was identified in the most recent Community Service Plan. However, it does support Prevention Agenda efforts in the reduction and prevention of chronic disease by increasing patient access to cancer screenings and tobacco cessation programs.

As per the latest available report, [redacted] spent $15,273,613 on community health improvement services in 2022, representing 0.22% of total operating expenses.

Recommendation: **Approved**

HOSPITALS' COMMUNITY BENEFIT SPENDING
NY PHL §2805-A

October 1, 2025 — Effective Date of the Law

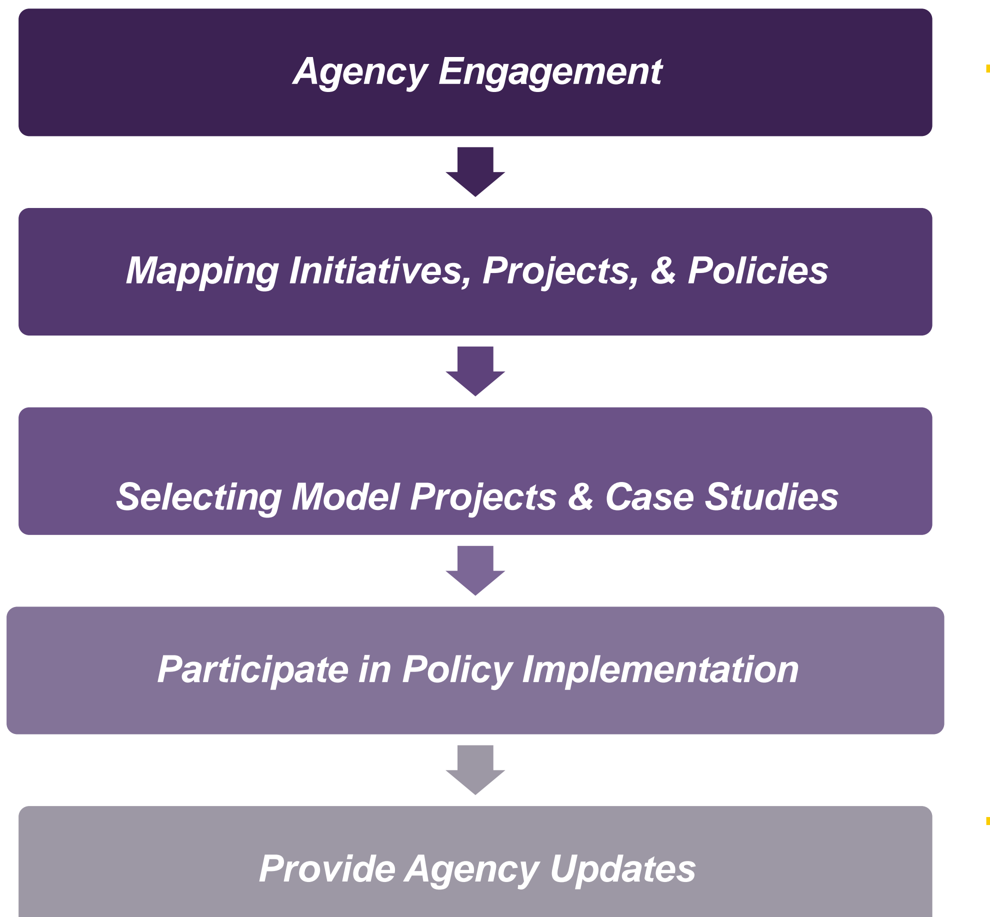
By July 1, 2026 (and annually thereafter): Hospitals must file with the Commissioner:

- A completed copy of the most recent Form 990 as submitted to the Internal Revenue Service (IRS).
- Supporting information used to complete Form 990, in a format prescribed by the Department, showing community benefit spending.
- If a hospital is not required to file Form 990, it must still submit equivalent community benefit spending information.

By October 1, 2026 (and annually thereafter): The Department must:

- Compile and publish the community benefit report on its website.
- Deliver the report to the Governor, legislative leaders, and relevant legislative committees

INTERAGENCY COLLABORATION



Interagency Taskforce

INTERAGENCY COLLABORATION
IMPLEMENTATION MATRIX

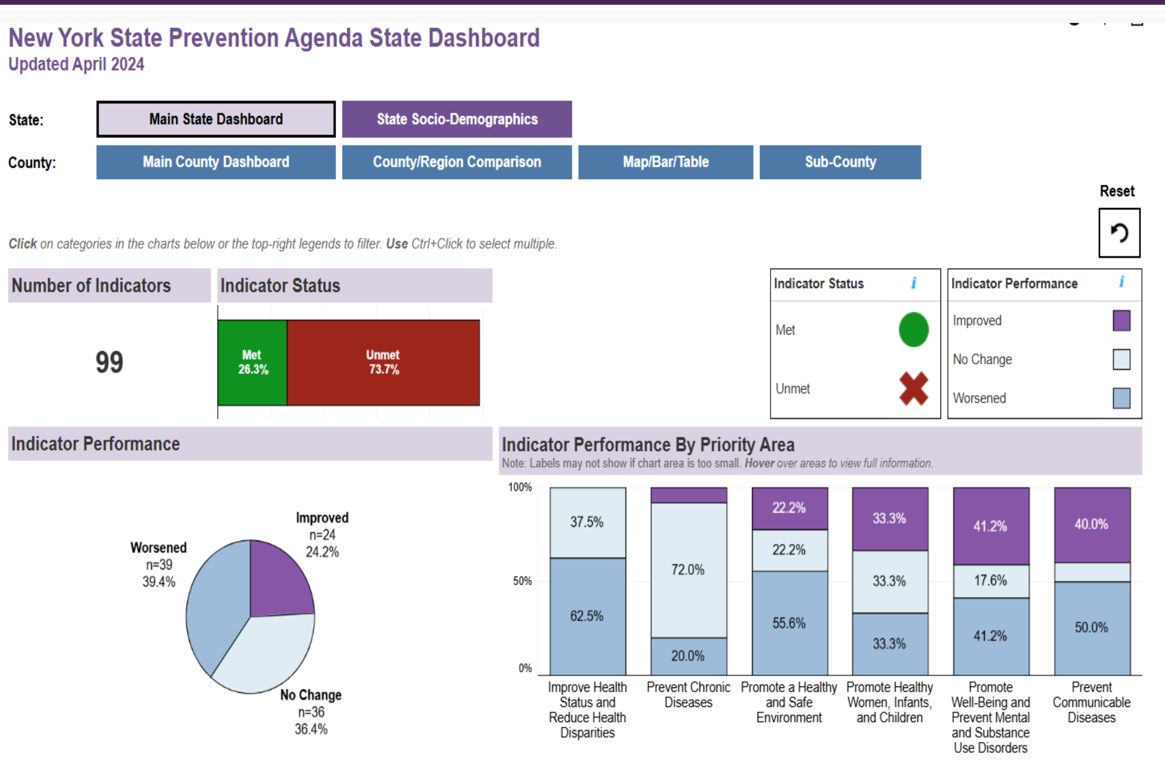
Organization	Economic Stability: Poverty	Unemployment	Nutrition Security	Housing Stability & Affordability	Social and Community Context: Anxiety & Stress	Suicide	Depression	Primary Prevention, Substance Misuse, & Overdose Prevention	Tobacco/E-Cigarette Use	Alcohol Use	Adverse Childhood Experiences	Healthy Eating	Neighborhood and Built Environment: Opportunities for Active Transportation and Physical Activity	Access to Community Services and Support	Injuries and Violence	Healthcare Access and Quality: Access to and Use of Prenatal Care	Prevention of Infant and Maternal Mortality	Preventative Services for Chronic Disease Prevention and Control	Oral Health Care	Preventative Services	Early Intervention	Childhood Behavioral Health	Education Access and Quality: Health and Wellness Promoting Schools	Opportunities for Continued Education
AHRC Nassau	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■
APTA New York	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Blueprint 15	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
CDPHP																								
Center for Independence of the Disabled, New York	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Erie 1 BOCES	■		■		■	■	■	■	■	■	■	■	■	■				■				■	■	■
Greater New York Hospital Association	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Health Foundation for Western and Central NY			■	■	■	■		■			■		■	■	■	■			■	■	■	■	■	■
Healthcare Association of New York State (HANYS)	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
The Institute for Family Health	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
The John A Hartford Foundation			■	■	■	■		■	■	■		■	■	■	■		■	■		■				
Medical Society of the State of New York (MSSNY)	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■
New York State Association of County Health Officials (NYSACHO)	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
New York College of Podiatric Medicine																	■	■			■			
New York State Office of Mental Health	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
NYC Health & Hospitals			■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■		
The New York Health Plan Association (NYHPA)	■		■																					
NYS Office of Children and Family Services	■	■	■	■																				
Primary Care Development Corporation	■																							
REACH CNY, Inc	■		■		■	■		■			■	■		■	■	■			■		■	■		
Suburban Hospital Alliance of NYS/Long Island Health Collaborative			■		■	■	■	■	■	■	■	■	■	■	■		■	■				■	■	

State & Regional Organizations Collaborating with NYSDOH to Advance Prevention Agenda Priorities

The matrix will be updated as additional collaborations are established

MONITORING AND EVALUATION

The Prevention Agenda Dashboard



Community Health Improvement Plans

- Review and evaluation of LHDs' and Hospitals' CHAs/CHIPs/CSPs
- Annual reporting requirements, including updates on intervention implementation and progress toward objectives
- Encouragement for extended monitoring and evaluation beyond required reporting

WEBSITE FOR 2025-2030 CYCLE

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

NEW YORK STATE An official website of New York State. Here's how you know

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

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What Is the Prevention Agenda?

The Prevention Agenda is New York's State Health Improvement Plan (SHIP). It is a six-year initiative aimed at improving the health status of individuals in New York and reducing health disparities through a strong emphasis on prevention. The Prevention Agenda outlines key health priorities and how these priorities will be addressed to improve the health and wellbeing of all individuals in New York.

The Prevention Agenda is a framework for local public health agencies, hospitals, government agencies, community-based organizations, health care providers, advocates, educators, policymakers, and other critical partners to promote action, maximize resources, and prioritize strategies that advance health.

Prevention Agenda Dashboard

The New York State Prevention Agenda Dashboard is an interactive tool that visually presents the most current indicator data used to track progress on the State's Health Improvement Plan at both the state and county levels. It serves as a key resource for monitoring how communities across New York are advancing toward the Prevention Agenda objectives.

Prevention Agenda 2019-2024 Dashboard

The Prevention Agenda dashboard will be updated to align with the 2025-2030 priorities and indicators once all data has been made available.

What Is New About the 2025-2030 Prevention Agenda?

The 2025-2030 Prevention Agenda adopts a broad perspective, emphasizing factors that influence health beyond traditional health outcomes, prevention strategies, medical care, and public health systems. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare. Addressing these issues is crucial for reducing health disparities.

UPCOMING RESOURCES

Technical Assistance Webinar

- **Focus**: Supporting implementation of the 2025–2030 Prevention Agenda
- Details and registration link will be shared soon

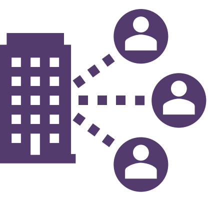
Local Health Department (LHD) Health Equity RFA

- **Focus**: Technical assistance and capacity building
- Up to $400K; contract Sept–Nov

Local Health Department (LHD) *Health Equity Consultant* RFA

Meredith R. Patterson, MPH, CPH
(she, her, hers)
Regional Office Liaison
Division of Public Health Infrastructure

RFA FOCUS



Local Health Department (LHD) Health Equity RFA

- **Focus**: technical assistance and capacity building to support LHDs, hospitals, and community-based partners in implementing the 2025–2030 Prevention Agenda
- **Funding**: up to $400k; initial contract Sept. - Nov. 2025 w/ planned renewal through Nov. 2026

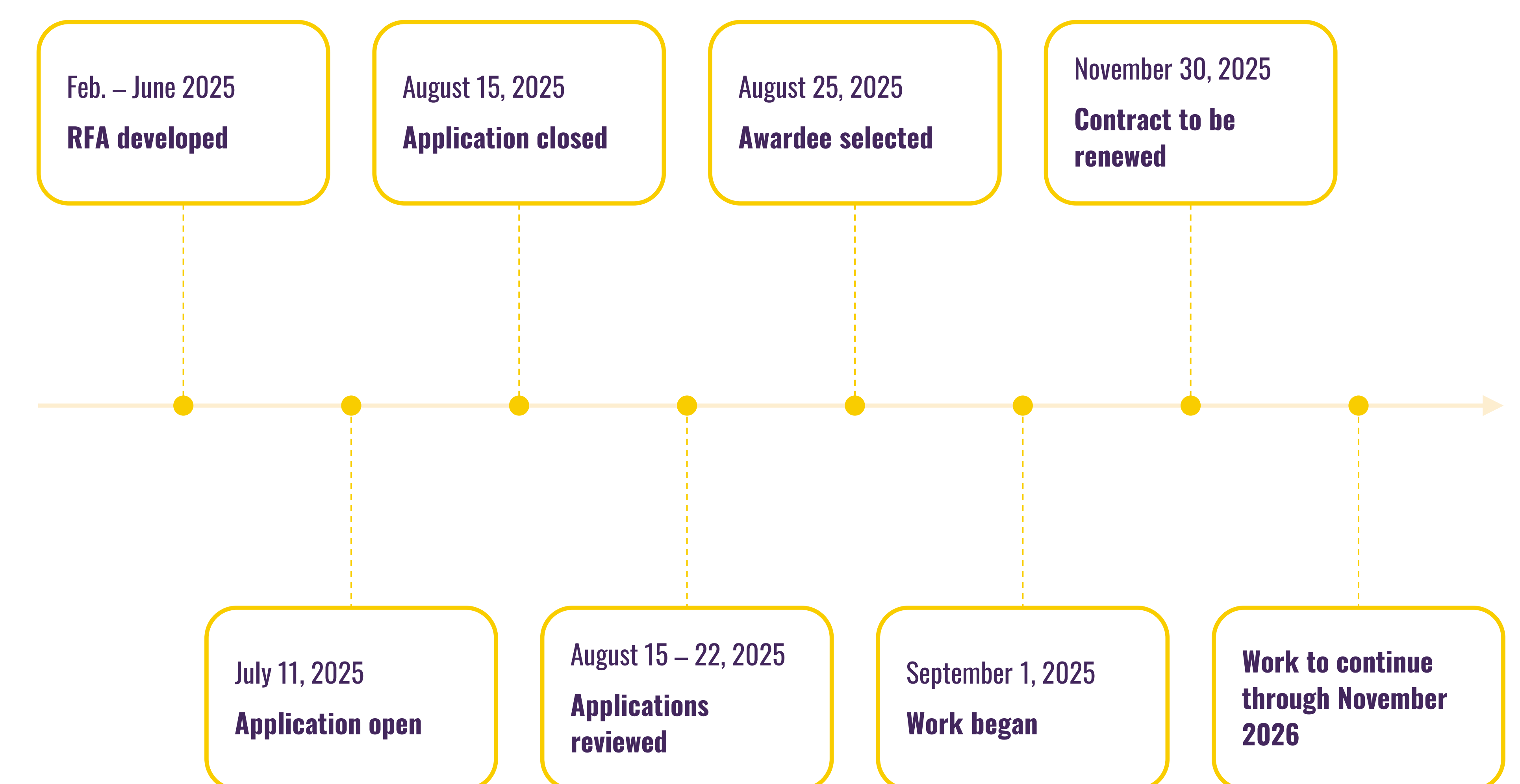
RFA GOAL

The goal of this RFA is to advance health equity by addressing the social determinants of health, strengthening partnerships between LHDs, hospitals, and community-based organizations, providing technical assistance and capacity-building, tracking progress, and developing tools and resources to support statewide best practices.

SCOPE OF WORK

- **Build Partnerships:** connect LHDs, hospitals, CBOs, and other stakeholders to work together on health priorities
- **Provide Technical Assistance & Training:** guide organizations on planning, implementing, and evaluating health strategies
- **Develop Resources:** create standardized tools, guides, training materials, and an online resource hub
- **Support Plan Implementation:** help organizations align community health plans with Prevention Agenda priorities
- **Monitor & Report Progress:** track activities, interventions, and outcomes; submit reports and data to NYSDOH
- **Promote Shared Learning:** host workshops, regional forums, and peer-learning opportunities to share best practices

RFA TIMELINE



NEW YORK STATE | Department of Health
Wadsworth Center

The 2025–2030 Prevention Agenda Dashboard Development Update

Christopher F. Davis PhD, MPH, CPH
(*He, Him, His*)
Population Health Data Manager
Office of Science

Step 1: Data collection of the 92 tracking indicators (February-May 2025)

- Collected state level, county level, data by SES, and subcounty data, where available, plus relevant footnotes
- Over 20 data sources/programs
- Public data, DOH program specific data, outside DOH program specific data

- Careful checking of the data submissions resulted in further communications with programs for updates/corrections

State Indicator Order	County Indicator Order	ind_id	Indicator Code	s_ind	c_ind	Indicator Title	PA 2025-2030 Domain	PA 2025-2030 Domain Priority Area	NYS Baseline Rate	PA 2030 Objective	Frequency of updates	Coverage	Coverage_code
						General Health Indicators							
1	1	paA1_0	paA1	s1	c1	Percentage of deaths that are premature (before age 65 years)	General Health Indicators	Improve Health Status and Reduce Disparities	23.6	22.4	Annually	NYS	0
1.1	1.1	paA1.1_0	paA1.1	s2	c2	Premature deaths (before age 65 years), difference in percentages between Black, non-Hispanic individuals and White, non-Hispanic individuals	General Health Indicators	Improve Health Status and Reduce Disparities	19.4	18.4	Annually	NYS	0

DASHBOARD DEVELOPMENT TIMELINE

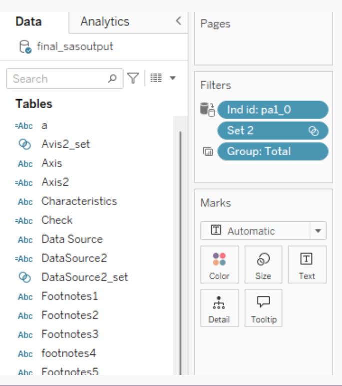
Step 2: Processing, analyzing, and formatting the data (April-July 2025)

- Data were received, processed, and checked for quality
- Data were analyzed and consistently formatted for visualization development
- Some improvements made this cycle (a few more subcounty indicators, new regional groupings available)

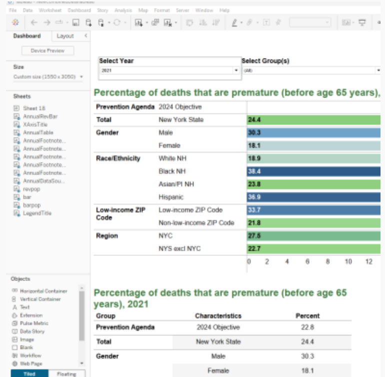
Step 3: New dashboard development and testing: August–September 2025

- Visualization development using TABLEAU software
- Testing for functionality and data validity by development teams, data owners, and program staff

```
/*
paA1 - Percentage of premature deaths (before age 65 Years)
*/

PROC IMPORT DATAFILE= "\\dohfile02\phig\PHIGDATA\PreventionAgenda\Data\&folderYear\Output\paa1_demo.xls"
out=paa1_demo dbms=xls replace;
sheet='sheet1';
RUN;

PROC IMPORT DATAFILE= "\\dohfile02\phig\PHIGDATA\PreventionAgenda\Data\&folderYear\Output\paa1_zip.xls"
out=paa1_zip dbms=xls replace;
sheet='sheet1';
RUN;

data paa1_0;
    set paa1_zip (rename=(Indicator=Ind_id_0 Demographic=Group Category_Description=Characteristics Rate__Percentage=rate_percent))
        paa1_demo(rename=(Indicator=Ind_id_0 Demographic=Group Category_Description=Characteristics Rate__Percentage=rate_percent)) ;

    if characteristics="Total" and group^="Region" then delete;
    if characteristics="PA 2030 Objective" then delete;
run;

data sasout.paa1_ses;
    length Ind_id $8. Year $9. Group $100. Characteristics $100. rate_percent 8. rate_percent_tx $20. Footnotes1 $300. Footnotes5 $600.;
    set paa1_0;
    if Ind_id_0 eq "paA1" then Ind_id = "paA1_0";
    if Characteristics= "Total" then do;
        Group="Total";
        Characteristics = "New York State";
    end;
    rate_percent_tx=strip(Rate__Percentage_Text);

    if group eq "Race/Ethnicity" and Characteristics^='Hispanic'
        then Footnotes1 = "White/NH = White non-Hispanic.  Black/NH = Black or African American non-Hispanic.  AsianPI/NH = Asian, Pacific Islander non-Hispanic.";
    if group eq "Region" then Footnotes1 = "NYC = New York City. NYS excl NYC = New York State excluding New York City.";

    if Characteristics= "Low-income ZIP code" then Footnotes5 = "Most recent population estimates directly from the US Census are used to calculate rates for gender, race and
ethnicity, and region. Population estimates prepared by Claritas are used to calculate rates for the Income ZIP Code groups. Assignment of ZIP Code to low-income
or non-low-income is from ACS data. Low-income ZIP Codes are those in which 20% or more of the population, for whom poverty status is determined, has a family income that
falls below the Census Bureau poverty threshold (American Community Survey, 2018-2022)";

    format _all_;
    informat _all_;

    keep ind_id year group Characteristics rate_percent rate_percent_tx footnotes1 footnotes5;
run;

* removing the working files used to create this one ;
proc datasets library=work;
delete paa1_0 paa1_demo paa1_zip;
```



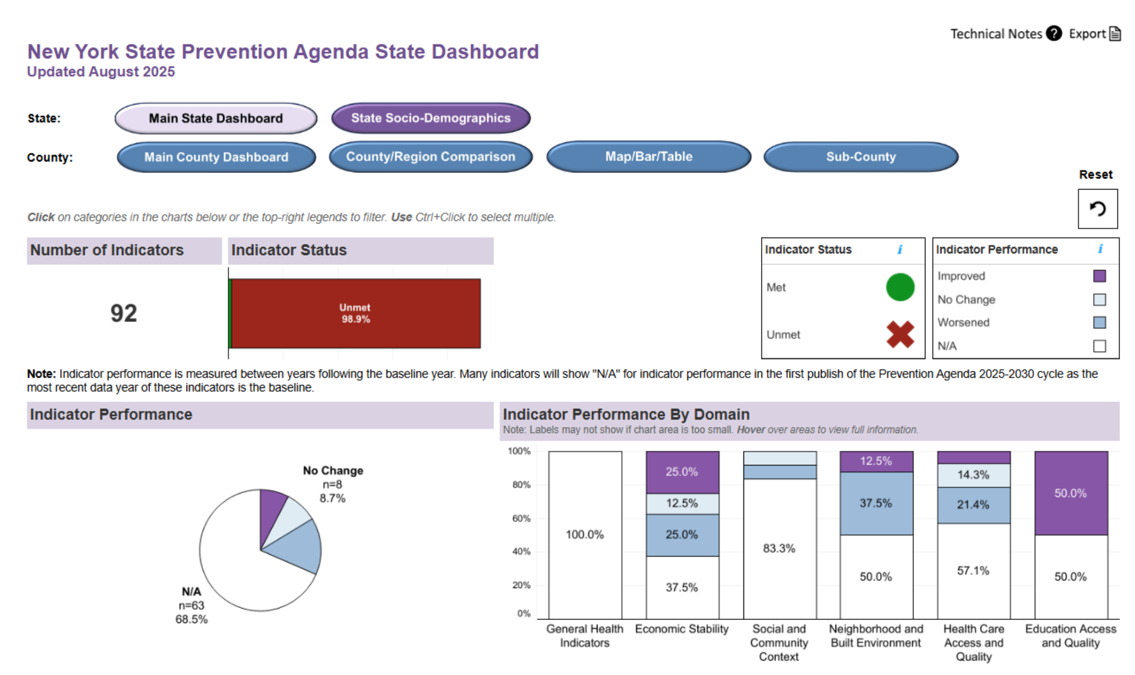
Axis (final_sasoutput.sas7b...)	Axis2 (Calculation)	Characteristics (final_sasoutput.sas7bdat)
Percent	Percent	Female
Percent	Percent	Male
Percent	Percent	Low-income ZIP Code
Percent	Percent	Non-low-income ZIP Code
Percent	Percent	2024 Objective
Percent	Percent	Asian/PI NH
Percent	Percent	Black NH
Percent	Percent	Hispanic
Percent	Percent	White NH
Percent	Percent	NYC



DASHBOARD REVIEW & APPROVAL TIMELINE

Step 4: New dashboard review, approval, and launch (October 2025 – Spring 2026)

- New dashboard is under DOH and partners' review and approval process
- Target date for launching the new dashboard for public access: early Spring 2026



Questions?

Please contact us at prevention@health.ny.gov

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