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IMPLEMENTING THE 2025-2030 NYS PREVENTION AGENDA

OFFICE OF LOCAL HEALTH SERVICES
AND
OFFICE OF SCIENCE

FALL 2025

AGENDA

- Prevention Agenda Background
- Shifting Focus from Downstream to Upstream
- Prevention Agenda Components
- Action Plans & Example
- Next Steps and Implementation for Local Health Departments / Hospitals
- Monitoring and Evaluation

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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 PHAB accreditation must publish a SHIP.
- **Who?**
  - Created by NYSDOH with partners
  - Implemented by Local Health Departments, hospitals, and other organizations
- **When?**
  - A new Prevention Agenda is published every 6 years.

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Shifting Focus:
Downstream → Upstream

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PEI Chief Public Health Office. (2023). When We Think & Act Upstream: We Create a Healthier, Safe World. https://www.livewellpei.ca/sites/www.livewellpei.ca/files/2024-02/Upstream%20Downstream-%20Expanded.jpg

PREVIOUS VS NEW PREVENTION AGENDA

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-Being and Prevent Mental and Substance Use Disorders
5. Prevent Communicable Diseases

2019-2024 Prevention Agenda

1. Economic Stability
2. Social and Community Context
3. Neighborhood and Built Environment
4. Health Care Access and Quality
5. Education Access and Quality

2025-2030 Prevention Agenda

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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**

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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**

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Action Plan Overview

2025-2030 Prevention Agenda

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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

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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

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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

Specific numbers that quantify desired outcome

The selected metric to track progress

Source of data

Priority Populations

Most recent data

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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] 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.

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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

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Implementation

How Will the 2025 -2030 Prevention Agenda Be Implemented?

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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

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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

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JOINT VS. INDIVIDUAL PLANS

Joint

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

Individual

This includes other forms of collaboration within the same community or county, such as a joint assessment with separate plans, or separate assessments and separate plans. If a hospital chooses an individual plan, the priorities, goals, and interventions should align with the local health departments in its service area, and discussions should take place to ensure collaboration.

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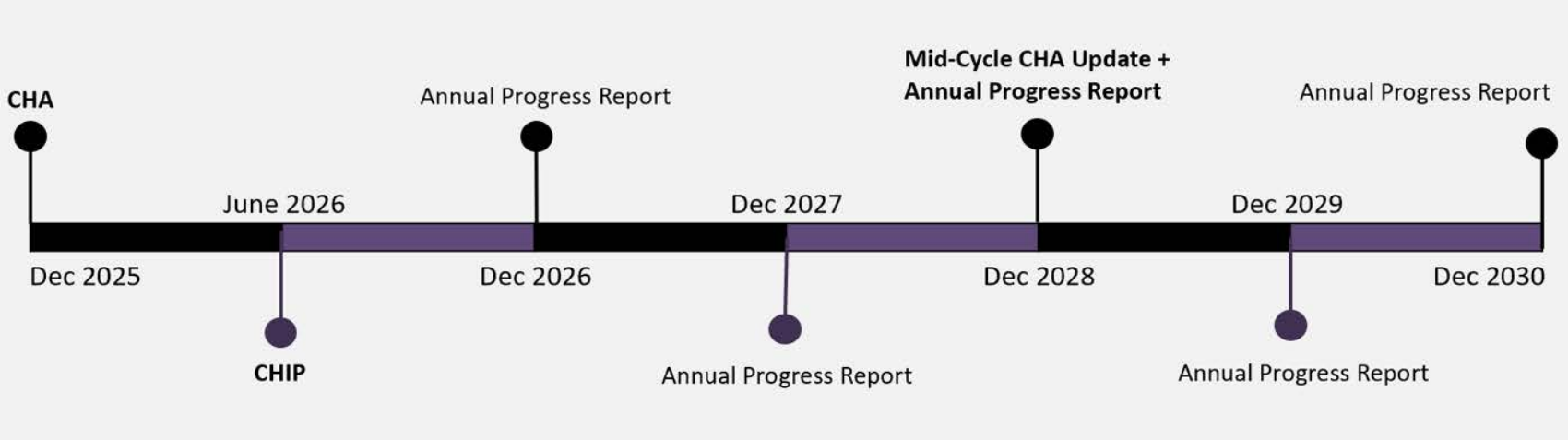
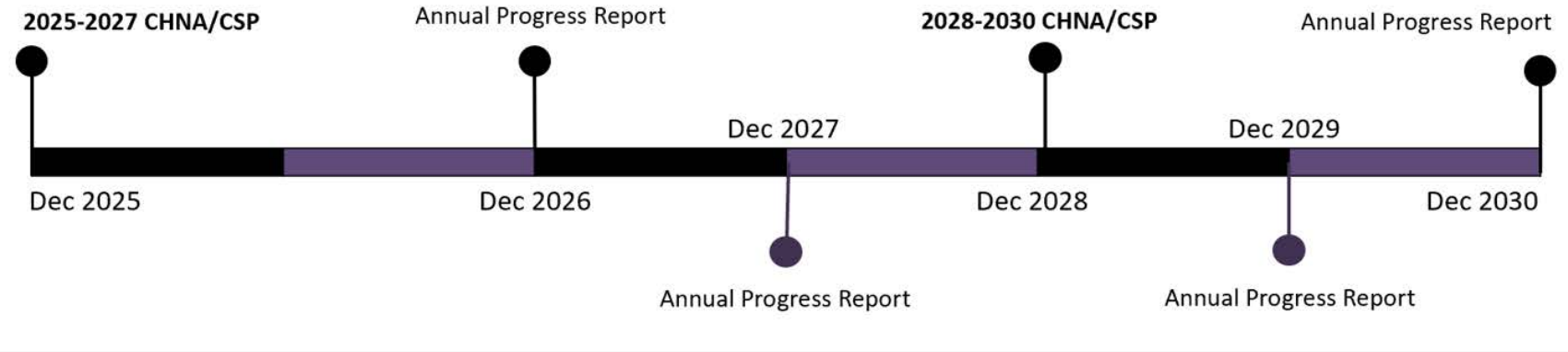
CHIP/CSP SUBMISSION TIMELINES

COMMUNITY HEALTH IMPROVEMENT PLAN/ COMMUNITY HEALTH ASSESSMENT



Local Health Departments



Hospitals

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CHIP/CSP ALIGNMENT WITH THE PREVENTION AGENDA

1. Select at least **3 priorities** from the Prevention Agenda list.
   - At least **1 of the selected priorities should represent a Social Determinant of Health**.

2. For each priority, **choose 1 or more objectives, and for each objective, select at least 1 indicator** to track progress.

3. **At least *2 of the total number of* selected objectives must specifically address populations experiencing disparities** (SMARTIE).

4. Select evidence-based interventions for each identified priority.

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EXAMPLE SELECTION - PRIORITIES

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

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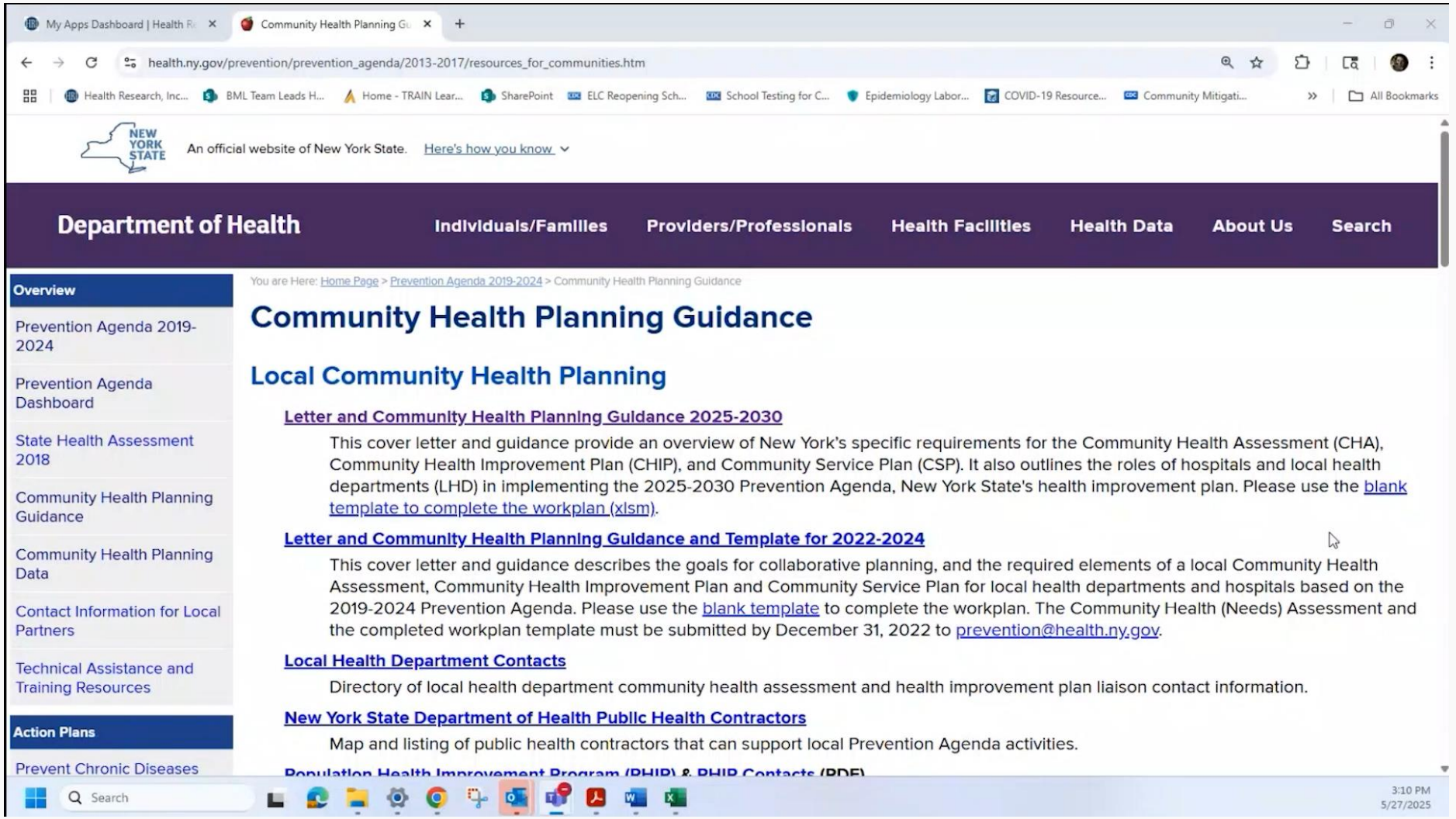
FILLING OUT THE WORKPLAN TEMPLATE



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CHIP/CSP GUIDANCE AND REQUIREMENTS

Required Submission Components:

- Cover Page
- Table of Contents
- Executive Summary
- Community Health Assessment (CHA)
- Community Health Improvement Plan (CHIP)/Community Service Plans (CSP)
- Completed Workplan Template
- Self-Assessment Checklist

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CHIP/CSP GUIDANCE AND REQUIREMENTS

Submission Guidance:

- **What to submit?** Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) / Community Service Plan (CSP), Workplan Template, and Self-Assessment Checklist
- **Where to submit?** prevention@health.ny.gov with the subject line "CHA/CHIP/CSP.County Name. LHDName/HospitalName."
- **When to submit?** On or before December 31, 2025*
- **What to expect after submission?** Submission will be acknowledged within one week. Feedback will be provided to organization liaisons by December 2026.

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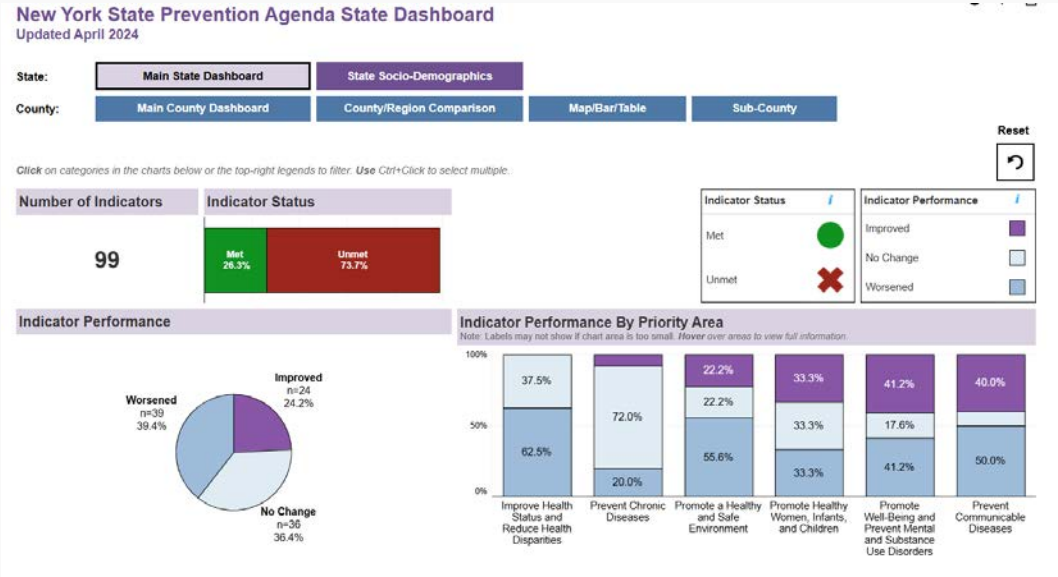
MONITORING AND EVALUATION – STATE LEVEL

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.



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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

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Office of Science
Dashboards and County-Level Data for Prevention Agenda Indicators

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COMMUNITY HEALTH DASHBOARDS

Current Prevention Agenda Dashboard

- 99 indicators at the state level, 47 indicators by major socio-demographics
- 70 Indicators at the county level, 6 at sub-county (both not stratified by socio-demographics)

Leading Causes of Death Dashboard

- Top 7 causes of death by year, with death counts and rates
- At the state level, can filter by region, sex, age group and race and ethnicity
- At county level, top 7 causes with counts and rates, can filter by sex

Community Health Indicators Reports

- 350+ indicators at the state and county level
- 44 socio-demographic indicators

County Health Indicators by Race and Ethnicity

- 60 indicators presented at county level by major race and ethnicity categories

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TOPIC-SPECIFIC DASHBOARDS

Asthma Surveillance Dashboard
- 44 indicators at the state level
- 23 include drill down data by major socio-demographic data
- 29 indicators available at the county level

Opioid Dashboard
- 97 indicators at the state level
- 72 by major socio-demographics
- 76 indicators at the county level

Maternal and Child Health Dashboard
- 52 indicators at the state level
- 34 by major socio-demographics
- 18 indicators at the county level

Pregnancy Risk Assessment Monitoring System Dashboard
- 76 indicators presented by socio-demographics
- Statewide; Rest of State and New York City comparisons

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WHERE TO FIND COUNTY-LEVEL DATA FOR THE 2025-2030 PA

Indicator Title	Where can this data currently be viewed?
Percentage of deaths that are premature (before age 65 years)	Current Prevention Agenda Dashboard 2019-2024
Premature deaths (before age 65 years), difference in percentages between Black non-Hispanics and White non-Hispanics	Current Prevention Agenda Dashboard 2019-2024
Premature deaths (before age 65 years), difference in percentages between Hispanics and White non-Hispanics	Current Prevention Agenda Dashboard 2019-2024
Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000	Current Prevention Agenda Dashboard 2019-2024
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black non-Hispanics and White non-Hispanics	Current Prevention Agenda Dashboard 2019-2024
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics	Current Prevention Agenda Dashboard 2019-2024
Percentage of adults with health insurance, aged 18-64 years	Current Prevention Agenda Dashboard 2019-2024
Adults 18 years of age and older who have a regular health care provider, age-adjusted percentage	Current Prevention Agenda Dashboard 2019-2024
Percentage of people living in poverty	CHIRS, CHIRE, also can be viewed on federal ACS data website
Percentage of people, aged 65+, living in poverty	CHIRE, also can be viewed on federal ACS data website
Percentage unemployed	CHIRS, CHIRE, also can be viewed on federal ACS data website
Percentage unemployed, Black residents, aged 16+	CHIRE, also can be viewed on federal ACS data website
Number of people living in HUD-subsidized housing in the past 12 months	https://www.huduser.gov/portal/datasets/assthsg.html#data_2009-2024
Percentage of adults 18 years and older experiencing frequent mental distress during the past month, age-adjusted percentage	Current Prevention Agenda Dashboard 2019-2024
Suicide mortality, age-adjusted rate per 100,000 population	Current Prevention Agenda Dashboard 2019-2024, CHIRE

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WHERE TO FIND COUNTY-LEVEL DATA FOR THE 2025-2030 PA

Indicator Title	Where can this data currently be viewed?
Opioid analgesic prescription rate per 1,000 population	Opioid Dashboard
Opioid analgesic prescription rate per 1,000 population for patients who were opioid naïve and received an opioid prescription of more than 7 days	NYS Opioid Annual Report (not county level though)
Unique individuals enrolled in OASAS treatment programs - rate per 100,000 population - who reported any opioid as the primary substance	Opioid Dashboard, NYS Opioid Annual Report 2024
Patients who received at least one buprenorphine prescription for opioid use disorder - rate per 100,000 population	Opioid Dashboard
Overdose deaths involving drugs- rate per 100,000 population	Opioid Dashboard
Prevalence of cigarette smoking among adults 18 years of age and older	Current Prevention Agenda Dashboard 2019-2024
Prevalence of any tobacco use among high school students	NYS Commercial Tobacco and E-cigarettes Reports
Indicated reports of abuse/maltreatment, rate per 1,000 children, aged 0-17 years.	Current Prevention Agenda Dashboard 2019-2024
Percentage of infants who are exclusively breastfed in the hospital among all infants	Current Prevention Agenda Dashboard 2019-2024
Percentage of infants who are exclusively breastfed in the hospital among Black non-Hispanic infants	Current Prevention Agenda Dashboard 2019-2024
Count of Climate Smart Community Actions related to community resilience	https://www.health.ny.gov/environmental/weather/cooling/
Count of cooling centers on Cooling Center Finder New Yorkers in high heat vulnerable areas and disadvantaged communities	https://climatesmart.ny.gov/actions-certification/participating-communities/
Percentage of births with early (1st trimester) prenatal care	MCH Dashboard
Percentage of births with early (1st trimester) prenatal care, striated by insurance status, uninsured	MCH Dashboard
Infant mortality rate per 1,000 live births	MCH Dashboard, Current Prevention Agenda Dashboard 2019-2024, CHIRE
Maternal mortality rate per 100,000 live births	MCH Dashboard, Current Prevention Agenda Dashboard 2019-2024
Maternal mortality rate per 100,000 live births, among Black non-Hispanics	MCH Dashboard

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WHERE TO FIND COUNTY-LEVEL DATA FOR THE 2025-2030 PA

Indicator Title	Where can this data currently be viewed?
Percentage of birthing persons who report depression during pregnancy	PRAMS
Percentage of birthing persons who report depression during pregnancy, aged 20-24	PRAMS
Percentage of birthing persons who report depressive symptoms after giving birth	PRAMS
Percentage of birthing persons who report depressive symptoms after giving birth, aged 20-24	PRAMS
Asthma emergency department visit rate per 10,000, aged 0-17	Asthma Dashboard
Asthma emergency department visit rate per 10,000, for Black, non-Hispanic children and youth aged 0-17 years	Asthma Dashboard
Hypertension management (percentage of adults 18 years of age and older reporting medication use to manage their hypertension)	Current Prevention Agenda Dashboard 2019-2024
Percentage of 24–35-month old children with the 4:3:1:3:3:1:4 combination series by their 2nd birthday	Current Prevention Agenda Dashboard 2019-2024
Percentage of 13-year-old adolescents with a complete HPV vaccine series	Current Prevention Agenda Dashboard 2019-2024
Percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age	Childhood Lead Exposure - NYSDOH Environmental Health Tracker https://apps.health.ny.gov/statistics/environmental/public_health_tracking/tracker/index.html#/childhoodEBLLevels
Percentage of children reported as flourishing in the NSCH survey	Datasets for download at https://www.census.gov/programs-surveys/nsch/data/datasets.html
Percentage of children, in a household living between 0-99% of the poverty level, reported as flourishing in the NSCH survey	Datasets for download at https://www.census.gov/programs-surveys/nsch/data/datasets.html
Percentage of public-school students in grades K-8 with >10% absenteeism (chronic absenteeism)	Data can be download at https://data.nysed.gov/downloads.php
Percentage of economically disadvantaged public-school students in grades K-8 with >10% absenteeism (chronic absenteeism)	Data can be download at https://data.nysed.gov/downloads.php
Percentage of high school seniors that attend a 2 or 4 year college within 5 years	Data can be download at https://data.nysed.gov/downloads.php
Percentage of economically disadvantaged high school seniors that attend a 2 or 4 year college within 5 years	Data can be download at https://data.nysed.gov/downloads.php

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SUPPRESSION CRITERIA LIMITATIONS

Data Source	Suppression Criteria
Death data	Denominator population (<30)
Birth data	Denominator total births (<30)
Hospitalization data	Numerator 1-5 cases
Cancer data	Total cases across all cancer types (<16)
HIV/AIDS data	Numerator 1-5 cases
Sexually Transmitted Diseases data	Numerator 1-5 cases

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SUBCOUNTY DATA

When we do have subcounty data available, we present in aggregate at zip code, town, or city level.

Some subcounty data is available on the Prevention Agenda dashboard, the asthma dashboard, and opioid dashboard.

New York State 2021 Health Equity Reports show sociodemographic and health outcome data at the town and city level.

- Note that the 2025 reports are currently under executive review and should be released later in 2025.

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EXTRA DATA RESOURCES

American Community Survey

American Housing Survey

Small Area Health Insurance Estimates

CDC Wonder

Open Health Data NY

Open Data NY

County Health Rankings

America's Health Rankings

Behavioral Risk Factor Surveillance System

Youth Risk Behavior Surveillance System

National Survey on Drug Use and Health

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Questions?

Please contact us at prevention@health.ny.gov

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