

Priority: Poverty

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. NYS's poverty rate remains around 14%, slightly above the national average of 11.1%.^{21,22} Alternative poverty metrics, such as ALICE (Asset Limited, Income Constrained, Employed), reveal a significant portion of NYS households struggle to cover basic necessities like housing, childcare, food, and health care 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 NYS 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 to lift them out of these conditions.



NYS maintains a commitment to reducing socioeconomic disparities for those living in the state. Reducing poverty does not necessarily require reinventing the wheel since many programs already exist embedded in communities. Additionally, the focus on novel measures of poverty seeks to broaden the perspective of local health departments, hospitals, and community-based organizations as they shape their policies and programs to reach and support families and individuals living in poverty. By focusing on existing public health infrastructure and improving networking and public awareness of existing programs, NYS can address the negative health impacts associated with poverty.







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 years and older 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% (2018-2022)	12.5% (2030)
			Subpopulation of Focus	Baseline	Target
			Adults aged 65 years and older	12.2% (2018-2022)	11% (2030)





Interventions	Population of Focus	Age Range	Intermediate Measures
 <p>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).²³</p> <p>LHD H O</p>	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
 <p>Featured Intervention: Partner with organizations that provide services for older adults in rural areas (e.g., Office for Aging, faith-based organizations, centers serving older adults, libraries, and community-based organizations (CBOs)) to reduce food insecurity for those living in poverty. These services may include:</p> <ul style="list-style-type: none"> • Development of mobile food banks • Delivery of programs on eating nutritious food • Resources on food access • Provision of information designed for older adults on programs such as Prescription Produce and farmers markets 	Older adults	Ages 65+	Number of people receiving services

Interventions	Population of Focus	Age Range	Intermediate Measures
<ul style="list-style-type: none"> Identifying transportation resources for older adults not living in senior housing to take trips to farmers' markets or grocery stores that may be further away²⁴⁻²⁶ 			
 <p>Incorporate educational programs that enhance recruitment for needed positions while mitigating disparities in recruitment efforts in the community.²⁷</p> 	Adults enrolled in public benefits, high school-age youth	Ages 16+	Employment rate by age group and industry
 <p>Promote recruitment and selection of underrepresented groups, particularly in science, technology, engineering, and mathematics (STEM) by creating and sustaining programs for public school middle and high school students. Activities may include:</p> <ul style="list-style-type: none"> Creating educational programs that directly interact with public school children Creating promotional materials to be shared with school guidance counselors Having NYS employees in STEM representation at career fairs in lower income areas <p>An example of a program is the Academic Partnerships Program established by the Association of Public Health Laboratories.²⁸⁻³¹</p> 	Underrepresented populations	Ages 16+	Employment rate by demographic group and type of job
 <p>Partner with, promote, and refer to supplemental nutrition programs including Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) and the NYS Agency Nutrition programs such as:</p> <ul style="list-style-type: none"> School Lunch School Breakfast 	Low-income individuals and families	N/A	Number of families and individuals receiving benefits.

Interventions	Population of Focus	Age Range	Intermediate Measures
<ul style="list-style-type: none"> • Summer Electronic Benefits Transfer (EBT) • Child and Adult Care Food Program (CACFP) • WIC Farmers Market • Fresh Connects • Double Bucks³² 			
 <p>Collaborate with local departments of social services to provide information on child-care subsidy programs by developing guidelines and training on the referral process. Examples include:</p> <ul style="list-style-type: none"> • Establishing a joint needs assessment, creating formal referral pathways • Co-hosting community outreach • Cross-training staff on services offered • Developing shared data systems • Fostering leadership support from both agencies³³⁻³⁵ 	Low-income individuals and families	N/A	Number of families and children receiving childcare assistance.
 <p>Improve data collection for SDOH to identify current programs in areas that have low poverty to compare their effectiveness. Implement or improve upon the programs for counties with higher rates of poverty.³⁶</p> 	Low-income individuals and families	N/A	Participation among organizations responsible for data reporting and collection, progress on size of data set
 <p>Promote and/or facilitate opportunities to receive education on personal finance for those who receive public assistance or who are enrolled in Medicaid.³⁷⁻³⁹</p> 	Children and families in poverty	Ages 16-64	Number of individuals receiving information on personal finance
 <p>Provide education and conduct standardized screening for hospitals, providers, and clinics through the</p>	Underserved, low-income communities	N/A	Healthcare Effectiveness Data and Information Set (HEDIS) measure: Social Need Screening and Intervention (SNS-E) - DOH has this measure

Interventions	Population of Focus	Age Range	Intermediate Measures
utilization of the Health-Related Social Needs Screening Tool (HRSN). ⁴⁰ 			
 Create medical and legal partnerships to assist with screening, referral services, legal guidance, and/or case management. ⁴¹ 	Low-income individuals and families	Ages 18+	Number of medical/legal partnerships established; number of patients participating in a medical/legal partnership; number of patients referred to services via a medical/legal partnership
 Conduct regular screening of patients at the hospital for SDOH factors like income and unemployment. ^{23,42-44} 	Hospital patients	Ages 18+	Number of patients screened for SDOH at the hospital; number of hospitals implementing SDOH screening
Promote programs that optimize compensation for caregivers, including those who provide care to children, older individuals, and people with disabilities. ⁴⁵ 	People working in care-giving positions	Ages 16-64	Average wage of these groups of workers
Explore the use of novel socioeconomic intervention strategies in programming. Examples include conditional cash transfer programming, basic income, and reverse co-pays. ⁴⁶ 	Adults enrolled in Medicaid (or receiving SNAP/TANF)	Ages 18-64	Number of organizations using novel methods, number of people receiving intervention
 Develop two-generation approaches to strengthen TANF (Temporary Assistance for Needy Families) by: <ul style="list-style-type: none"> Supporting linkages between high-quality educational services for children and workforce development services for their parents Supporting programmatic efforts to help parents gain the skills, knowledge, and resources to support their child's development⁴⁷ 	Underserved/Low-income communities	N/A	Government Performance and Results Act (GPRA) Indicators, number of children connected to educational services, Number of adults connected to workforce development services

Interventions	Population of Focus	Age Range	Intermediate Measures
 <p>Increase awareness of financial assistance programs available to employees that earn up to 200% of the Federal Poverty Line (FPL) (e.g., program eligibility, policies and procedures, documents to be submitted, timeliness, etc.) through outreach applying the public health detailing approach.⁴⁸⁻⁵⁰</p> <p>LHD H O</p>	<p>Underserved/Low-income communities Employers that pay salaries under 200% FPL Employees earning under 200% FPL</p>	<p>Ages 16-64</p>	<p>Financial assistance program uptake at local community level (participation rate)</p>
 <p>Promote and partner with early education programs like Head Start and Early Head Start to increase enrollment.^{51,52}</p> <p>O</p>	<p>Families with school-age children who qualify</p>	<p>School-age children</p>	<p>HeadStart/early HeadStart participation rates</p>
 <p>Promote and partner with family-based prevention programs (e.g., Nurse Family Partnership) and Healthy Families Home Visiting Programs (OCFS).⁵³⁻⁵⁶</p> <p>LHD O</p>	<p>Population eligible for NFP and Healthy Families HV programs</p>	<p>Qualifying ages</p>	<p>Number of families and individuals served by intervention</p>
 <p>Develop a resource guide that can be posted on websites and distributed at clinics, hospitals, libraries, and pharmacies to include information on community resources. Examples include:</p> <ul style="list-style-type: none"> • Food banks and pantries • Summer food programs for children • Farmers markets • Locations that participate in produce double bucks program • Low-income housing resources • Homelessness intervention programs • County Department of Social Services (DSS) • Support programs for completing Medicaid/SNAP applications • Community outreach /human services programs⁵⁷ <p>LHD O</p>	<p>Underserved/Low-income communities</p>	<p>N/A</p>	<p>Service uptake, data on distribution (how many website visits, how many flyers distributed, etc.)</p>

Interventions	Population of Focus	Age Range	Intermediate Measures
 <p>Partner with hospital systems to provide education and tools for developing an intake process that screens patients for social needs such as housing and food insecurity, employment, and childcare needs. Encourage follow-up with emergency department patients from the hospital social worker to increase awareness of local resources.⁵⁸</p> <p>LHD H</p>	<p>Children and adults experiencing food insecurity</p>	<p>N/A</p>	<p>Number of hospitals performing screenings, number of successful follow-ups with hospital social workers, number of successful referrals made to social support services</p>
 <p>Promote two-generation, community-level financial literacy interventions (e.g., school banking, budgeting).⁵⁹</p> <p>LHD O</p>	<p>Everyone</p>	<p>School-age and up</p>	<p>Participation rate among schools, banks, CBOs, number of people receiving intervention</p>
 <p>Conduct referrals of nutrition- insecure adults to community-based organizations.⁶⁰</p> <p>LHD H O</p>	<p>Food insecure adults</p>	<p>Ages 18+</p>	<p>Number of successful referrals made</p>
 <p>Create healthy food pantries in hospitals to ensure food security and access to healthy food.^{61,62}</p> <p>H O</p>	<p>Food insecure adults</p>	<p>Ages 18+</p>	<p>Hospital participation rate, number of referrals made, number of people served by pantries</p>

Lead Partner Agencies and Organizations

[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](#)

One Stop Career Centers

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 Head Start programs

Soup kitchens, food pantries, regional food banks

Implementation Resources

[Promise Neighborhoods](#)

[United Way](#)

[NYS OSC Poverty Trends data](#)

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