NEW YORK STATE OF OPPORTUNITY. Department of Health

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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

The 2025-2030 Prevention Agenda: Community Health Improvement Planning Guidance For Local Health Departments and Hospitals in New York State

What is the Prevention Agenda?

The Prevention Agenda, also known as the New York State Health Improvement Plan (SHIP), is a strategic tool to enhance state and local efforts in improving health, well-being, and equity across New York State. It sets data-driven objectives to address the challenges identified in the 2024 State Health Assessment. Given the complexity of these challenges, the Prevention Agenda calls for cross-sector partnerships and alignment on measurable goals.

How Will the Prevention Agenda Be Implemented?

The Prevention Agenda is designed to be implemented by a wide range of public and private partners. The list of priorities, objectives, and evidence-based interventions in the Prevention Agenda provides flexible options for all communities, as well as approaches to improve outcomes for New Yorkers of all ages.

Role of Local Health Departments and Hospitals

Local Health Departments (LHDs) and hospitals are leaders in local community health improvement planning. These entities are required to conduct community assessments and develop improvement plans. See Table 1 and Table 2 for more information about the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Community Service Plan (CSP) requirements and submission timeline.

Table 1. Requirements for Local Health Departments and Hospitals

	National Requirements	New York State Requirements
Local Health Departments (LHDs)	As a prerequisite of accreditation by the Public Health Accreditation Board (PHAB), LHDs must conduct a community health assessment (CHA) and develop a community health improvement plan (CHIP) at least every five years.	**Six-year cycle**: Beginning January 1, 2025, LHDs must complete assessments and plans on an aligned six-year cycle, with a mid-cycle assessment update. **Reporting**: By December 31, 2025, LHDs must submit CHAs to NYSDOH for 2025-2030. CHIPs can be submitted in one of two ways: **Option 1:** Submit the CHIP together with the CHA by December 31, 2025.

		<u>Option 2:</u> If not submitted with the CHA, the CHIP must be submitted by June 30, 2026. If utilizing Option 2: Please note that the Cover Page and Table of Contents will need to be updated with CHIP submission in June, along with the addition of the Executive Summary.
Hospitals (Tax-exempt 501(c)(3) charitable hospitals)	The Internal Revenue Service (IRS) requires tax-exempt hospitals to conduct a community health needs assessment (CHNA) and adopt an implementation strategy to address the identified needs every three years[1].	**Three-year cycle:** Hospitals will continue to complete assessments and plans on an aligned 3-year cycle (2025-2027; 2028-2030) **Reporting**: By December 31, 2025, hospitals must submit assessments and plans to NYSDOH for 2025-2027. **Community benefit expenditures**: Hospitals are encouraged to submit Schedule H of IRS Form 990 to NYSDOH annually, including any attachments.

Table 2. Timeline for CHAs/CHIPs/CSPs Submission for the 2025-2030 Prevention Agenda.

Year #	Time	LHDs	Hospitals
Y1	**Dec 2025-June 2026**	• **Submit the CHA by December 2025.** • **Submit the CHIP either:** o **At the same time as the CHA by December 2025; OR** o **Following the CHA submission, no later than June 2026.**	• **Submit the 2025-2027 CHA/CSP by December 2025.**
Y2	**Dec 2026**	• **Submit CHIP progress report by December 2026.**	• **Submit CSP progress report by December 2026.**

[1] Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3) | Internal Revenue Service (irs.gov)

Y3	**Dec 2027**	• **Submit CHIP progress report by December 2027.**	• **Submit CSP progress report by December 2027.**
Y4	**Dec 2028**	• **Submit the mid-cycle CHA update to assist hospitals with their IRS-required CSP, if applicable** • **Submit CHIP progress report by December 2028.**	• **Submit the 2028-2030 CHA/CSP by December 2028**
Y5	**Dec 2029**	• **Submit CHIP progress report by December 2029.**	• **Submit CSP progress report by December 2029.**
Y6	**Dec 2030 End of Cycle**	• **Submit CHIP progress report by December 2030.**	• **Submit CSP progress report by December 2030.**

Local Collaboration

LHDs and hospitals are encouraged to collaborate on their CHAs/CHIPs/CSPs, involving community partners throughout assessment, priority selection, planning, implementation, and evaluation. The extent of collaboration may vary depending on the number of LHDs and hospitals in the community, their service areas or jurisdictions, and other factors. The New York State Department of Health also strongly encourages LHDs and hospitals to work together with other regional partners to develop one joint assessment and plan. This collaborative approach aims to leverage combined efforts and shared resources, improve effectiveness, and reduce duplication in assessment and planning efforts.

Joint vs. individual plans

- **A joint plan:** LHDs and hospitals within the same county or community collaborate with other partners to develop a single assessment and plan. This results in one assessment document and one plan document for the community, with all the LHDs and all participating hospitals named as leading entities.
- **An individual plan:** 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 LHD in its service area, and discussions should take place to ensure collaboration.

Organization-specific community health assessments and improvement plans will be accepted if the organizations can demonstrate collaboration in the identification of local priorities and selection of interventions to address those priorities. Collaboration should occur at the county level. If a hospital's service area covers multiple counties, or if contiguous county health departments have a history of resource sharing, a multi-county or regional planning process can be beneficial. Regardless of the partnership configuration, a collaborative planning process and

shared community health goals and strategies that align with the Prevention Agenda are essential.

As in previous years, hospitals are asked to reflect their Prevention Agenda efforts in their community benefit programs when completing the form. We expect hospitals to increase their investments in the Community Benefit categories of Community Health Improvement and Community Building, which include activities needed to improve community health. Our goal is for each hospital to align and increase its investments in evidence-based interventions related to the Prevention Agenda.

The 2025-2030 Prevention Agenda:

Requirements for the Community Health Assessment, Community Health Improvement Plan, and Community Service Plan

What to Submit?

1) The CHA/CHIP/CSP
2) The Prevention Agenda Workplan in Excel format (Please use the provided Template)
3) The Prevention Agenda Checklist (Appendix A)

Where to Submit?

Submit required documents to prevention@health.ny.gov with the subject line "*CHA/CHIP/CSP. County Name. LHDName/HospitalName*."

When to Submit?

Submissions are due electronically on or before December 31, 2025. Any requests for extensions must be received at least one week prior to the due date.

What to Expect After Submission?

- Your submission will be acknowledged within one week. If you do not receive an acknowledgment within one week, please contact the Prevention Agenda team at prevention@health.ny.gov
- NYSDOH staff will review submissions and provide feedback via email to organization liaisons identified in the workplan template by July 2026.

Required Components

A. Cover Page

The cover page should include:

- County/counties or service area covered in the assessment and plan.
- Indication if it is an individual or joint plan.
- Organization(s) name(s) and contact information.
    - List of participating Local Health Department(s), and CHA/CHIP Liaison name(s) and email(s).
    - List of participating hospital/hospital system(s), and CSP liaison name(s) and email(s).
    - Name and email of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals.

B. Table of Contents

C. Executive Summary

The Executive Summary outlines the work described in the CHIP/CSP narratives and should include the following elements:

- **Prevention Agenda Priorities**: Identify the priorities and disparities to be addressed in your county/community for the 2025-2030 period.
- **Data Review:** Summarize the data sources used to identify and confirm existing priorities or select new ones.
- **Partners and Roles:** Identify which partners you are working with and what their roles are in the assessment and implementation processes. Also, explain how you are engaging the broad community in these efforts.
- **Interventions and Strategies:** Explain what specific evidence-based interventions, strategies, or activities are being implemented to address the specific priorities and associated health disparities. Provide a justification for how these interventions were selected.
- **Progress and Evaluation:** Explain the process measures being used and how progress and improvement are being tracked to evaluate impact.

D. Community Health Assessment (CHA)

1. **Community Description**: Provide a description of the community being assessed.

    - **Service Area**: Provide a description of service area location. This could be one county, several counties, or parts of several counties in a regional assessment. For regional assessments, the health needs of each individual county must be identified.
    - **Demographics:** Provide an analysis of the population's characteristics to identify health needs and disparities. This includes socioeconomic, educational, and environmental factors that affect health such as race/ethnicity; age; gender ratio; sexual orientation; languages spoken within the jurisdiction; income; disabilities; mobility; educational attainment; housing stability and affordability; home ownership; employment status; health insurance status; access to regular care; and immigrant/migrant status.

2. **Health Status Description:** Provide an overview of the population's health and identify factors that contribute to health status and health challenges.

- **Data Sources:** Explain the data collection process, data type, and sources. Assemble and analyze secondary data from other sources to gain insights into the community's health status. Collect and analyze primary data whenever possible[2].
    - *Primary data* is collected firsthand for a specific purpose, while *secondary data* is existing information collected by others.
- **Data Collection Methods:** Outline the scientific methods used for collecting and analyzing data, including the timeframe.
- **Community Engagement:** Identify any parties with whom the health department or hospital collaborated or contracted for assistance in planning and conducting the assessment. Provide a description of how preliminary findings were shared with the community and how community input was sought and incorporated.
- **Relevant Health Indicators:** Compile and analyze trend data to describe changes in community health status and influencing factors. Present key health metrics with charts and graphs to illustrate trends over time. Compare data by race/ethnicity, age, gender, and other demographic factors to identify and address disparities. Additionally, compare local data with state or other local data to provide context and benchmarks.
- **Health Challenges and Associated Risk Factors**: Identify leading community health problems.
    - **Contributing Causes of Health Challenges:** Provide a summary of the contributing causes of health challenges in your community, including behavioral risk factors, environmental factors (including the built environment), socioeconomic factors, policies (e.g., smoke-free parks, menu labeling, zoning for walkable communities, taxation, education, transportation, insurance status), injury, maternal and child health issues, infectious and chronic diseases, and unique state characteristics impacting health status.
    - **Health Disparities:** Identify issues related to health disparities, high-risk populations, and high-need neighborhoods within the service area. Factors that contribute to higher health risks and poorer health outcomes in specific populations must be considered.

3. **Community Assets and Resources**: Identify existing and needed community assets or resources to address health challenges. These may include target populations and services provided by local health departments, hospitals, healthcare providers, community-based organizations, businesses, academia, media, and other government sectors. Examples include local parks or recreation centers, farmers' markets, public facilities at schools, and mutual aid groups or support circles.

E. Community Health Improvement Plan/Community Service Plan (CHIP/CSP)

1. **Major Community Health Needs:** Identify major health needs with partners based on the findings of the community health assessment.

[2] Authors are responsible for appropriately referencing and citing sources for data, pictures, diagrams, etc. presented in the community health assessment.

2. **Prioritization Methods:**
    a. **Description of Prioritization Process:** Provide a description of the process and criteria that were used to identify priorities.
    b. **Community Engagement**: Provide a description of the community engagement process that was used to select the new priorities.
    c. **Justification for Unaddressed Health Needs:** Identify the health needs you do not intend to address and explain why.
3. **Developing Objectives, Interventions, and an Action Plan:**
    a. **Alignment with Prevention Agenda:** LHDs and hospitals should align their CHIPs/CSPs with each of the following components of the 2025-2030 Prevention Agenda:

	Prevention Agenda	CHIP/CSP
Priorities	The Prevention Agenda has 24 priorities that include social determinants of health, health behaviors, access to care, and health outcomes.	Select at least ***three*** priorities from the Prevention Agenda list. Selection of at least ***one*** of the following social determinants of health is strongly encouraged: • Poverty • Unemployment • Nutrition Security • Housing Stability and Affordability • Health and Wellness Promoting Schools • Opportunities for Continued Education Priorities should be informed by the CHA.
Tracking progress with SMART(IE) objectives	Objectives are statements describing a specific outcome to be achieved. • SMART) objectives are specific, measurable, achievable, realistic, and time-bound. • SMARTIE objectives are specific, measurable, achievable, realistic, time-bound, inclusive, and equitable. • All objectives must include an indicator — a specific metric or measure used to quantify an	• For each selected priority, choose ***one or more*** SMART(IE) objectives, and for each objective, select at least ***one*** indicator to track progress. • At least ***two*** of the selected objectives must be SMARTIE, specifically addressing populations experiencing disparities (Subpopulation of Focus).

	outcome, typically expressed as a number, percent, or rate.	
Interventions	The Prevention Agenda includes a list of evidence-based interventions or promising practices for each priority area[3].	Select evidence-based or promising practice interventions for each identified priority. If the selected intervention is not yet described in the literature, the LHD or hospital should provide evidence demonstrating its impact.
Equity	Health equity is a key principle of the Prevention Agenda[4]. Achieving measurable improvements requires a multi-sector, community-engaged approach focused on priority populations, setting universal targets, selecting effective strategies, and ensuring proper implementation.	For each selected priority, select interventions and strategies likely to reduce disparities and inequities, and allocate and tailor resources to communities where the need is greatest.

b. **Action Plan:** For each chosen health priority, include a summary of the following information**:**
   i. **Actions and Impact:** Describe the hospital and LHD actions to address the health issue and their anticipated impact.
   ii. **Geographic Focus:** whenever possible, specify the geographic location for the intervention.
   iii. **Resource Commitment:** Identify the resources the LHD and hospital will commit, including relevant Prevention Agenda activities to address social determinants of health and other priorities, as well as spending reported to the IRS for community health improvement.
   iv. **Participant Roles:** Describe the roles and resources of other participants, stakeholders, and community-based organizations.
   v. **Health Equity:** State whether the actions will address health disparities and explain how.

4. **Partner Engagement**: Briefly describe the process that will be used to monitor CHIP/CSP progress with community partners during this Prevention Agenda cycle and the process that will be used to make mid-course corrections.

[3] 'Evidence-based' or 'best-practice' interventions are those supported by evidence demonstrating their effectiveness.

[4] Health equity allows individuals to reach their full health potential despite historical and contemporary injustices. It is achieved when everyone in a community has access to affordable, inclusive, and quality infrastructure and services.

5. **Sharing Findings with Community**: Briefly describe plans for disseminating the Executive Summary to the public and how the plan will be made widely available, including the website where it can be found.

F. 2025-2030 Prevention Agenda Workplan

Please use the template posted on the Prevention Agenda website to submit your Workplan in Excel format. The template includes six tabs: one for organizational information, and five that correspond to a Social Health Determinants Domain of the 2025-2030 Prevention Agenda.

Community Health Assessment and Improvement Planning Resources

CHA/CHIP Resources

- National Association of County and City Health Officials (NACCHO) Resource Center
- The Centers for Disease Control and Prevention (CDC) CHA/CHIP Resources
- The Public Health Accreditation Board (PHAB): The 2022 Standards and Measures
- Community Tool Box
- The Association for Community Health Improvement (ACHI) CHA Toolkit
- Community Commons

Data Resources

- The Prevention Agenda Dashboard
- The New York State Community Health Indicator Reports (CHIRS)
- County Health Indicators by Race and Ethnicity (CHIRE)
- NYSDOH dashboards
- The New York State 2023 Health Equity Report
- New York's Open Data
- The U.S. Census Bureau
- The American Community Survey (ACS)
- County Health Rankings
- America's Health Rankings
- Office of Mental Health (OMH) Statistics and Reports
- Office of Addiction Services and Supports (OASAS) Addiction Data Bulletins
- The Small Area Health Insurance Estimates (SAHIE) program

Evidence-Based Resources

- The Prevention Agenda
- Healthy People 2030
- County Health Rankings – What Works for Health
- The Community Guide
- Substance Abuse and Mental Health Services Administration National Registry of Evidence-Based Programs and Practices
- The National Institutes of Health
- The Cochrane Library
- Robert Wood Johnson Foundation (RWJF) - Evidence for Action
- Evidence-Based Toolkits for Rural Community Health

Appendix A: CHA/CHIP/CSP Self-Assessment Checklist

Local Health Department/Hospital Name:
Service County:
Date of Submission:

Required Components	Met √	Not Met X	Page #
Cover page that includes a list of participating organizations, service area, type of plan (joint vs. individual), and contact details			
Table of Contents reflecting all sections and subsections			
Executive Summary as outlined in the guidance			
Community Health Assessment (CHA)			
Describe service area and reflect the demographic profile of population			
Describe socioeconomic, educational, and environmental factors that affect health			
Provide an overview of the population's health and identify factors that contribute to health status and health challenges			
Assemble and analyze secondary data and whenever possible primary data to describe the health status of the community			
Compile and analyze trend data to describe changes in community health status and in factors affecting health			
Use scientific methods for collecting and analyzing data			
Compare selected local data with data from other jurisdictions (e.g., local to state, local to local)			
Provide evidence of community collaboration in planning and conducting the assessment			

Identify leading community health problems			
Identify population groups at risk for health problems			
Identify existing and needed health assets and resources			
Community Health Improvement Plan (CHIP)/ Community Service Plan (CSP)			
Workplan Template:			
Utilize CHA findings to identify priorities			
Follow template instructions to select priorities, objectives, interventions, and measures			
Submit Workplan in Excel format			
Narrative:			
Describe the process and criteria used to identify priorities based on the findings of the community health assessment			
Describe the community engagement process that was used to select the new priorities			
Justify unaddressed health needs			
Select at least three priorities from the Prevention Agenda list. At least one priority should include social determinants of health factors such as Poverty, Unemployment, Nutrition Security, Housing Stability and Affordability, etc.			
Develop objectives, interventions, and an action plan			
Describe the process for monitoring plan progress with community partners and making mid-course corrections			
Briefly describe plans for disseminating CHA/CHIP/CSP reports to the public			
Submission: Send the documents to prevention@health.ny.gov on or before December 31, 2025.			
Additional Comments:			

OPHP USE ONLY:

Date received:
Date of initial review:
Reviewer(s):
Date of emailing feedback: