New York State
Prevention Agenda

This plan outlines priorities for state and local action to achieve the vision that every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan.

NEW YORK STATE | Department of Health

Developed by the NYS Public Health and Health Planning Council and the NYS Department of Health

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Glossary

Key Terms

Term	Meaning
Accessibility	The ability to access facilities, programs, and services; and receive clear and effective communication. Accessibility is a term often used when referring to people with disabilities. It is about making environments, programs, systems, and information usable by as many people as possible regardless of ability.[1]
Baseline	Data value for the current or most-recently-available year. Baseline data provides a comparison to measure against in the future.
Best practices	Intervention that has been shown to be effective in achieving positive health outcomes and can be implemented in various settings to address specific health issues.[2]
Contributors	Individuals and groups, including New York State Department of Health staff and external participants, who actively engaged in and contributed to the development of the Prevention Agenda through their expertise, lived experience, leadership governance, or other valuable input.
Domain	The 2025-2030 Prevention Agenda groups priorities into 5 major social determinants of health (in prior cycles, domains were called priorities). The current cycle of the Prevention Agenda bases its 5 domains on the 5 domains of social determinants of health defined by Healthy People 2030.
Ethnicity	A grouping of people based on having a shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry (usually from the same geographic area) and shared history. [3]
Evidence-based Interventions	Interventions that have been proven effective within certain circumstances, environments, and cultures. The effects are clearly linked to the activities themselves, not to outside unrelated events. Evidence of effectiveness is demonstrated by: (1) inclusion in federal registries of data-driven interventions; (2) reports in peer-reviewed journals; or (3) documentation in other reputable sources of information.
Equity	Policies and practices that lead to equitable outcomes, meaning everyone gets what they need to be successful. Equity ensures that identity is not predictive of opportunities or outcomes.[4]

Goal	A general statement about desired result. For all priorities, the universal goal is to reduce disparities and inequities within the next 6 years.
Health	A state of optimal physical, mental, and social well-being.[5]
Health care access	The "timely use of personal health services to achieve the best possible health outcomes." [5]
Health disparities	Measurable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health between population groups. [6] Health disparities may lead to differences in health outcomes that are avoidable, unfair, and unjust
Health equity	Everyone has a fair and just opportunity to be healthy, where no one is limited in achieving optimal health because of who they are or where they live. This means that to work towards health equity, everyone must be able to access and experience the conditions in life that contribute to optimal health: safe and secure housing, steady and livable income, quality education, social support networks, quality health care, nutritious food, safe transportation, green spaces, clean air and water, and freedom from discrimination based on race, gender, sexual orientation, disability status, or any other part of one's identity. In a world where health equity is the norm, everyone has fair and just access to these conditions, and therefore, has a fair and just opportunity to achieve optimal health.[7]
Health inequity	Differences in health that are unnecessary, unfair, unjust, and avoidable which inherently make individuals more underserved. Health inequities are rooted in different levels of access to the social determinants of health, and social injustices. [7]
Health outcomes	A change in the health status of an individual, group or population that is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.[8]
Inclusion	A mindset where all individuals are valued, welcomed, and able to participate fully as members of community. Systems and policies are designed to meet diverse needs across ability, religion, race, ethnicity, gender identity, and more at every level of the agency.[7,9] An individual has a sense of belonging, such as security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group. [7,9]
Indicator	A specific metric or measure used to evaluate progress of a given initiative by quantifying intermediate outcomes, typically expressed as a number, percent, or rate.
Intermediate measure	An intermediate measure evaluates changes following an initial activity. This offers insight into whether an intervention is progressing as expected before long-term outcomes are achieved. It assesses changes in behavior, skills, or other impacts that manifest weeks or months after the intervention is implemented.
Interventions	Policies, programs, or other actions intended to address the objectives.
SMART(IE)	SMART and SMARTIE are frameworks for development of goals and objectives often used in public health initiatives. In the SMART(IE) framework, an objective should have the following qualities: **S**pecific: the objective should focus on a component of a greater goal of a program.

	Measurable: the objective should include a measurement strategy and benchmark for monitoring progress. **A**chievable: the objective should be attainable but challenging. **R**ealistic: the objective should be relevant to the program and feasible. **T**ime-bound: the objective should have a clear timeline and deadline for achievement. **I**nclusive: the objective should "bring traditionally excluded individuals and groups into processes, activities, decisions and policy making in a way that shares power." **E**quitable: the objective should include address a systemic injustice or inequity. [10]
Objective	A statement describing a specific outcome to be achieved within a timeframe, using the SMARTIE Framework. [10]
Population of Focus	A specific group of individuals identified as having particular needs with respect to health care, social support services, or other interventions. Such populations are generally identified as experiencing certain health disparities through review of health-related data. Populations of focus outlined in the Prevention Agenda Action Plan have been identified by applying the SMART and SMARTIE frameworks to a review of publicly available data.[10] The term 'population' refers to groups of patients linked by defined similarities, such as their health diagnoses, geographic location, or health care provider.[11]
Priorities	The Prevention Agenda identified 24 priorities that affect the overall health and well-being of children, families and adults of all ages in New York State; in prior cycles, priorities were called focus areas.
Promising Practice	Interventions that have at least preliminary evidence of effectiveness in small-scale settings or with potential for generating data that will be useful for making decisions about generalizing the results to diverse populations and settings.[12]
Race	Today, the term "race" is usually used to refer to a group of people descended from common ancestors (often from the same geographic area). However, it's important to note that racial categories and labels are considered social constructs that are not based in biology. [13] The labels of race have historically been used to create advantages and disadvantages between these categories of people. [14]
Social determinants of health	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality-of-life outcomes and risks. As defined by Healthy People 2030, SDOH can be grouped into 5 domains: (1) Economic Stability (2) Social and Community Context (3) Neighborhood and Built Environment (4) Health Care Access and Quality (5) Education Access and Quality The 5 domains of the 2025-2030 Prevention Agenda align with this structure.[15]

Systemic or structural racism	Racial discrimination that is built into policies, social structures, history, and culture. Examples of this might include racial discrimination that is built into education, health care, criminal justice, and other institutions. Structural racism occurs when racist policies and practices create advantages for White people and oppression and disadvantages for people of color. These advantages and disadvantages are interconnected and reinforce each other, which worsens racial inequities across the social determinants of health. Policies and practices don't have to directly mention race in order for them to treat people differently based on race.[7,14] For example, even 100 years after slavery ended, Jim Crow laws, lack of equitable investment in education, redlining, and exclusion from public insurance programs are just some of the policies and practices that worked to prevent people of color from building wealth and health. The consequences of the barriers to wealth and health created by structural racism persist to this day.
Target	A specific number that quantifies the desired outcome.

Acronyms Used in This Report

Acronym	Meaning
ACS	American Community Survey (U.S. Census Bureau)
AHR	America's Health Rankings
BRFSS	Behavioral Risk Factor Surveillance System
CBOs	Community-Based Organizations
CDC	U.S. Centers for Disease Control and Prevention
CHA	Community Health Assessment. The CHA is developed by local health departments and hospitals and includes an analysis of county-level secondary data and, where available, primary data on health status, demographics, and community resources. Based on this assessment, local health departments and hospitals identify key community health priorities and develop a plan to address them, ensuring a strategic approach to improving public health outcomes.
CHIP	Community Health Improvement Plan. The CHIP is developed by local health departments and must align with Prevention Agenda priorities and objectives and incorporate evidence-based interventions to address selected priorities. CHIPs are updated annually, with the Office of Local Health Services assisting local health departments in monitoring performance.
CSP	Community Service Plan. Hospitals typically refer to the Community Health Assessment (CHA) as the Community Health Needs Assessment (CHNA) and the Community Health Improvement Plan (CHIP) as the Community Service Plan (CSP), though the content is similar.
HRSA	Health Resources and Services Administration
IRS	Internal Revenue Service

LHDs	Local Health Departments
NYSED	New York State Education Department
OASAS	New York State Office of Addiction Services and Supports
OMH	New York State Office of Mental Health
OPH	New York State Department of Health, Office of Public Health
PHAB	Public Health Accreditation Board
PHHPC	The Public Health and Health Planning Council
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SHA	State Health Assessment
SHIP	State Health Improvement Plan
USPSTF	United States Preventive Services Task Force
VS	Vital Statistics
YRBS	Youth Risk Behavior Survey

Acknowledgments

The 2025-2030 Prevention Agenda was approved by the New York State Public Health and Health Planning Council (PHHPC) in September 2024. This plan outlines priorities for state and local action to achieve the vision that every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan. The Council agreed to the new focus of the plan, including an emphasis on social determinants of health, and committed itself to a regular review of progress during the 2025-2030 cycle to support successful implementation.

The Ad Hoc Committee to Lead the State Health Improvement Plan (SHIP) played an essential role in the development of the new 2025-2030 Prevention Agenda. The domain workgroup members were comprised of experts in Social Determinants of Health, health equity, health disparities, and community members. Together, members formulated the goals, objectives, and interventions. Additionally, many New York State Department of Health staff provided subject matter expertise, supported action plan development, and contributed baseline data.

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Lead Entities

Prevention Agenda Leads	Titles	Credentials
Zahra S. Alaali	Research Scientist III, Office of Local Health Services	MPH
Elizabeth Whalen	Medical Director, Office of Public Health	MD, MPH, DipABLM
Office of Public Health	**Titles**	**Credentials**
Laura Trolio	Deputy Director & Acting Deputy Commissioner	
Division of Public Health Infrastructure	**Titles**	**Credentials**
Keshana Owens-Cody	Director, Division of Public Health Infrastructure	MSHRM
Office of Local Health Services	**Titles**	**Credentials**
Alexander Morrison	New York State Public Health Corps Fellow III	MPH
Bella S. Mazzetti	Health Education Program Coordinator I	MPH
Gina M. Gillooley	Program Manager I	

Planning Participants

New York State Department of Health

Office of Science and Technology	Titles	Credentials
Alizah Tariq	New York State Public Health Corps Fellow III	MPH
Brooke Turcotte	Population Health Data Manager	MPH
Cheryl Simmons	Community Development Coordinator I	
Christopher F. Davis	Manager, Population Health Data-Community Health Assessment Unit Lead	PhD, MPH
Christopher Joseph	Evaluation Specialist III	MPH
Douglas Done	Research Scientist	PhD, MPH
Margaret Ryan	Research Scientist	MPH
Naila Kabiraj	Program Research Specialist III	MPH
Natarsha Waklatsi	Director-Health, Wealth & Wellbeing	MPH
Samira Skochko	Asthma Surveillance and Evaluation Manager	MS
Stephanie Mack	Assistant Director, Division of Science	
Tabetha Wilson	Community Development Coordinator I	
Trang Nguyen	Acting Director, Division of Science	MD, DrPH, MPH
Wahida Ferdousi	Research Scientist	PhD, MSS
Wei Zhang	Research Scientist	MS

PHHPC, Public Health Committee

Name	Titles	Credentials
Anderson Torres	Vice Chair	PhD
Denise Soffel	Member	PhD
Jo Ivey Boufford	Chair	MD
Kevin Watkins	Member	MD
Lawrence E. Eisenstein	Member	MD, MPH
Lindsay C. Farrell	Member	MBA
Mario Ortiz	Member	PhD
Nilda I. Soto	Member	MSEd
Patsy Yang	Member	DrPH
Sabina Lim	Member	MD, MPH
Stanfort J. Perry	Member	
Wendy C. Wilcox	Member	MD, MPH, MBA

Ad Hoc Committee Members

Organization Name	Name	Credentials
AARP New York	Beth Finkel	
American Cancer Society (ACS)	Michael D. Seserman	MPH
Association of Perinatal Networks of New York, Inc	Tina M. Cobb	
Center for Independence of the Disabled, NY (CIDNY)	Sharon McLennon Wier	PhD, MSEd, LMHC
Children's Defense Fund - New York (CDF-NY)	Melissa Genadri	MPH
Community Health Care Association of NYS (CHCANYS)	Diane Ferran	MD, MPH
	James B. Welsh	
	Mercy Mbogori	MPA
Equality New York (EQNY)	Amanda Babine	MSW
Greater New York Hospital Association (GNYHA)	Lloyd Bishop	
Greater Rochester Health Foundation (GHHF)	Matthew Kuhlenbeck	PhD
Health Foundation of Western and Central New York (HFWCNY)	Diane Oyler	PhD
	Nora O'Brien-Suric	PhD
Healthcare Association of New York State (HANYS)	Kristen Phillips	MPA
	Lauren May Ashley	MBA, MS
Healthy Capital District (HCD)	Kevin Jobin-Davis	
Housing Works (HW)	Anthony Feliciano	
Hunger Solutions (HS)	Linda Bopp	
	Sherry Tomasky	MA
Inclusive Alliance IPA Inc. (IAIPA)	Lauren Wetterhahn	DrPH, MPH
John A. Hartford Foundation (JAHF)	Terry Fulmer	PhD
Let's Get Immunized New York (LGI NY)	Sandra Ribeiro	
	Vito F. Grasso	
Long Island Health Collaborative (LIHC)	Janine Logan	MS
Medical Society of the State of New York (MSSNY)	Geoffrey Moore	MD
	Patricia Clancy	
Mental Health Association in New York State (MHANYS)	Glenn Liebman	
New York City Department of Health and Mental Hygiene (NYC DOHMH)	Amy Shah	MPH
New York Health Foundation (NYHealth)	Ali Foti	MPH
	Avital Havusha	MPH
	Bronwyn Starr	MPH
New York Health Plan Association (HPA)	Kathleen Preston	MPA
NYS Academy of Family Practice (NYSAFP)	Vito F. Grasso	
NYS Academy of Pediatrics (NYSAP)	Elizabeth Murray	DO, MBA
	Lucia Castillejo	

New York State Association of County Health Officials (NYSACHO)	Patricia Ruppert	DO, MPH, DABFM
	Jennifer Rodriguez	MS, MSW
	Sarah Ravenhall	MHA
NYS Business Council (BCNYS)	Chelsea Lemon	
NYS Conference of Local Mental Hygiene Directors (CLMHD)	Lynda M. Battaglia	LCSW
	Courtney David	
NYS Dental Association (NYSDA)	Betsy Bray	
NYS Podiatric Medical Association (NYSPMA)	Dan Kline	MSPH, MBA
Northeast Business Group on Health (NEBGH)	Jeanette Fuente	
NYS Department of Agriculture and Markets (NYSDAM)	Damali Wynter	MPA
NYS Department of State (NYSDOS)	Paul Beyer	JD
NYS Office for the Aging (NYSOFA)	Charles Williams	JD
	Greg Olsen	
NYS Office of Addiction Services and Supports (OASAS)	Barbara Bennet	MPH
	Chinazo Cunningham	MD
	Patricia Zuber-Wilson	
NYS Office of Mental Health (OMH)	Ann Sullivan	MD
	Audrey Erazo-Trivino	PsyD
	Jeremy Darman	MSW
	Loretta (Lora) Santilli	MPH
	Merrill Rotter	MD
	Patricia Bowes	MSW
	Thomas Smith	MD
NYU School of Global Public Health (NYU GPH)	Cheryl Healton	DrPH
Primary Care Development Corporation (PCDC)	Jordan Goldberg	JD
REACH CNY, Inc.	Elizabeth G. Crockett	PhD, MS
S2AY Rural Health Network (S2AY RHN)	Derrik Chrisler	MBA
Schuyler Center for Analysis and Advocacy Inc. (SCAA)	Bridget Walsh	MPH
	Kate Breslin	MS
Spanish American Medical Dental Society of New York, Inc. (SAMDSNY)	Samuel Arce	MD
SUNY Albany College of Integrated Health Sciences (CIHS) (formerly School of Public Health (SPH))	Mary P. Gallant	PhD, MPH
The New York Academy of Medicine (NYAM)	Ann Kurth	PhD, MPH
	Linda Weiss	PhD
United Hospital Fund (UHF)	Joan Guzik	MBA
	Oxiris Barbot	MD
New York State Department of Health (NYSDOH)		
AIDS Institute	Joe Kerwin	MA, MDiv
Capital District Regional Office	Rob Swider	
Center for Community Health (CCH)	Travis O'Donnell	
Center for Environmental Health (CEH)	Daniel Lang	MS
	Gary Ginsberg	PhD

	Kathleen Bush	PhD
Central New York Regional Office	Cheryal Geiler	
	Kelly Firenza	
Division of Chronic Disease Prevention	Barbara Wallace	MD, MSPH
Division of Epidemiology	Emily Lutterloh	MD, MPH
Division of Family Health	Kirsten Siegenthaler	PhD, MSPH
	Marilyn A. Kacica	MD, MPH
Division of Nutrition	Jill Dunkel	MS, MPA
Division of Public Health Infrastructure (PHI)	Keshana Owens-Cody	MSHRM
Metropolitan Area Regional Office		
	Gianne Gerena	MPH
	Ivette Santiago	MS
Office of Aging and Long-term Care (OALTC)	Andrew Lebwohl	JD, MBA, LLM
	Val Deetz	
Office of Gun Violence Prevention (OGVP)	Calliana Thomas	
Office of Health Equity and Human Rights (OHEHR)	Tina Kim	MSPH
Office of Health Insurance Programs (OHIP)	Emily W. Engel	MBA
	Myla Harrison	MD, MPH
Office of Local Health Services (LHS)	Alexander Morrison	MPH
	Bella Mazzetti	MPH
	Gina Gillooley	
	Shane Roberts	DrPH, MPH
	Zahra Alaali	MPH
Office of Minority Health and Health Disparities Prevention (OMH-HDP)	Wilma Alvarado-Little	MA, MSW
Office of Primary Care and Health Systems Management (OPCHSM)	Doug G. Fish	MD
Office of Public Health (OPH)	Elizabeth Whalen	MD, MPH, DipABLM
	Laura J. Trolio	
Office of Science and Technology (OST)	Eli Rosenberg	PhD
Office of the Commissioner	Johanne Morne	MS
	Maclain Berhaupt	
Public Health Information Group (PHIG)	Changing Xu	MPH
	Christopher F. Davis	PhD, MPH
	Naila Kabiraj	MPH
	Spencer Cavallaro	MPH
	Stephanie Mack	
	Trang Nguyen	MD, DrPH, MPH
Western Regional Office	AmyLyn Clarke	MPA
	Jill Kaczoe	MSEd

Domain Workgroup Members

Domain 1: Economic Stability

Domain Leads:	Credentials:
Keshana Owens-Cody, New York State Department of Health	MSHRM
Wilma Alvarado-Little, New York State Department of Health	MA, MSW

Workgroup 1: Poverty, Unemployment

Workgroup Leads		Credentials
New York State Department of Health	Brooke Costello	MPH
	Tristan Sharratt	MS, MPH

Workgroup Members		Credentials
New York State Department of Health	Brooke Clemons	MS
	Cheryl Simmons	
	Christopher F. Davis	PhD, MPH,
	Dennison Moore	
	Jeremy Stipano	MFA
	Natarsha Waklatsi	MPH
	Shirley Madewell	MPH
	Wei Zhang	MS
New York State Office of Temporary and Disability Assistance (OTDA)	Elida Esposito	
	Isaac McGinn	
	Stacey Nodelman	
	Stephanie Boshart	
	Susan Zimet	
	Tracy Barnes	
	Valerie Figueroa	MPA
	Wendy DeMarco	
Mount Sinai Health System	Alexis Zebrowski	PhD, MPH
Essex County Health Department	Andrea Whitmarsh	MPH
Healthcare Association of New York State (HANYS)	Colleen E. McVeigh	
Champlain Valley Family Center	Dana Isabella	
New York State Community Action Association	Jacqueline Orr	
Westchester County Department of Health	Kevin Morrison	MSc
Broadview Federal Credit Union	Sarah Trela	MBA
Human Services Coalition of Tompkins County	Simone Gatson	

Westchester Medical Center Health Network (WMCHealth)	Thomas Scaglione	
New York State Academy of Family Physicians	Vito F. Grasso	

Workgroup 2: Nutrition Security, Housing Stability & Affordability

Workgroup Leads		Credentials
New York State Department of Health	Olutomisin Akanbi Rachel Cicigline	MS

Workgroup Members		Credentials
New York State Department of Health	Andrew Lebwohl Brooke Turcotte Delia E Easton James Coffin Jillian Annunziata Debold Karalii Rabii Leonard Peruski Lewis Clarke Patrick Javarone Shana Horn Tabetha Wilson	JD, MBA, LLM MPH PhD MPH MS PhD MPH
AARP (The American Association of Retired Persons)	Beth Finkel Kristen McManus	
YWCA (Young Women's Christian Academy) of Queens	Eun-Kyung Kim	
Huddle Health Independent Practice Association	Jacob Michael Reider	
Health Research, Inc. (HRI)	Jacquelyn C. Mallett	
University at Albany College of Integrated Health Sciences (formerly the School of Public Health)	Janine M. Jurkowski	PhD, MPH
Hunger Solutions New York	Jennifer Matrazzo	MA
NY Health Plan Association	Kathleen Preston	MPA
Greater New York Hospital Association	Kiley Atkins	
Inclusive Alliance	Lauren Wetterhahn	DrPH, MPH
Westchester Medical Center Health Network (WMCHealth)	Megan Baldwin	MBA

Erie County Department of Health Office of Health Equity	Michael Wiese	MPH
New York State Office of Temporary and Disability Assistance (OTDA)	Tracy Barnes	
Food Pantries for the Capital District	Natasha Pernicka	MPA

Domain 2: Social and Community Context

Domain Leads: N/A

Workgroup 1: Anxiety & Stress, Depression, Suicide

Workgroup Leads		Credentials
New York State Office of Mental Health	Tricia Hartnett	MSW
Workgroup Members		**Credentials**
New York State Department of Health	Christopher Bramfeld Priscilla Paiva Wahida Ferdousi	MBA MD, MPH PhD, MSS
New York State Office of Mental Health	Audrey Erazo-Trivino Loretta (Lora) Santilli Maxine Smalling Merrill Rotter	PsyD MPH MD
St. Peter's Health Partners	Chloe Blaise	MPH
New York State Conference of Local Mental Hygiene Directors	Courtney David	
Flushing Hospital Medical Center & Jamaica Hospital Medical Center	Daniel Chen	MD
Institute for Parenting, Adelphi University	Joaniko Kohchi	MPhil,
Greater New York Hospital Association	Kiley Atkins	MPH
Healthcare Association of New York State (HANYS)	Kristen Phillips Victoria Aufiero	MPA JD, MS
Genesee County Health Department	Lynda Battaglia Sherri Bensley	LCSW
Onondaga County Health Department	Mariah Senecal-Reilly	MPA
Westchester County Department of Health	Nidhi Patel	MPH

Mount Sinai Health System/ Public Health and Health Planning Council (PHHPC)	Sabina Lim	MD, MPH
Upstate University Hospital	Erin Shortslef Sarah Vienne	MSN LMSW
Orange County Department of Mental Health	Tammy L. Rhein	

Workgroup 2: Substance Misuse, Alcohol and Tobacco Use

Workgroup Leads		Credentials
New York State Office of Addiction Services and Supports (OASAS)	Barbara Bennet Pat Zuber-Wilson	MPH
New York State Department of Health	Gina O'Sullivan Haven Battles	MPH PhD
Workgroup Members		**Credentials**
New York State Department of Health	Allan Clear Aubrey Copperwheat Christina Peluso Elizabeth Anker Holly Marie Proper-Plaat John Heaphy John Morley Kathleen Bush Kelly Sullivan Kimberly Leonard Laura Ordway Lucila Zamboni Mary Sutphen Naila Kabiraj Narelle Ellendon Richard Pachucki Sharon Stancliff Stephanie Mack Tracy Berger Trang Nguyen	 PharmD MPH MD PhD PharmD PharmD PhD, MPP MPH PharmD MD MD, DrPH, MPH
North Country Healthy Heart Network	Ann Morgan	MS
Housing Works	Anthony Feliciano	
Greater New York Hospital Association	Benjamin Gonzalez	
Human Services Coalition	Cindy Wilcox	MPA

St. Joseph's Health	Danielle O'Brien	MS
BRiDGES, Madison County Council on Alcoholism and Substance Abuse, Inc.	Heather Bernet	
Otsego County Health Department	Heidi Bond	
Genesee and Orleans County Health Departments	Kaitlin Pettine	MPH
Tioga County Public Health	Kristin Russell	
Healthcare Association of New York State (HANYS)	Lauren May Ashley	MBA, MS
Medical Society of the State of New York	Melissa Hoffman Pat Clancy	MPP

Workgroup 3: Adverse Childhood Experiences (ACEs)

Workgroup Leads		Credentials
New York State Department of Health	Amber Whiteside Shaka McCoy	
Workgroup Members		**Credentials**
New York State Department of Health	Cheryl Geiler Eric Jeffrey Erika Baker Gena Gallinger Margaret Ryan Myla Harrison Shaunna L. Escobar Tabetha Wilson Wolfgang Zasada	 MS MPH MD, MPH MD, MPH
Carecentrix	Angela Schonberg	
New York State Office of Mental Health	Bonnie Catlin	
Upstate University Hospital Community Campus	Cathy Narcavage-Bradley	DNP, MS
Community Health Care Association of New York State (CHCANYS)	Diane Ferran	MD, MPH
Livingston County Health Department	Jennifer Rodriguez	MS, MSW
Partnership for the Public Good	Regine Ndanga	LMSW
North Country Prenatal Perinatal Council, Inc.	Tina Cobb	

New York State Office of Children and Family Services	Candi Griffin-Jenkins Shayla Owens	LMSW, MA

Workgroup 4: Healthy Eating

Workgroup Leads		Credentials
New York State Department of Health	Jessica N Peck Katie Potestio	MS MPH

Workgroup Members		Credentials
New York State Department of Health	Amy Gildemeister Elizabeth Whalen Ishani Choksi Lucinda Caruso Marci McCall Margaret Ryan Pretima Sharma	PhD MD, MPH, DipABLM MD MPH MPH
Mount Sinai Health System	Ashley Fitch	MS, MA
Medical Society of the State of New York (MSSNY)	Geoffrey Moore	MD
New York Health Foundation	Julia McCarthy	JD, MPH
Cornell Cooperative Extension of Albany County	Kathleen McAllister	MS
Institute for Family Health /Bronx Health REACH	Kelly Moltzen	MPH
George Mason University	MB (Marybeth) Mitcham	PhD, MPH
Common Ground Health	Mike Bulger	MA
Adirondack Health Institute	Sara Deukmejian	MBA, MS
University of Rochester Medical Center	Sarah Merritt	MS
Tioga County Public Health	Susan Medina	MPH
Nassau County Department of Health	Tavora Buchman	PhD
Northwell Health	Theodore Strange	MD
University of Rochester	Selena Davis	

Domain 3: Neighborhood and Built Environment

Domain Leads:
Michael Bauer, New York State Department of Health
Paul Beyer, New York State Department of State

Credentials:
MS
JD

Workgroup 1: Opportunities for Active Transportation and Physical Activity, Access to Community Services and Support, Injuries and Violence

Workgroup Leads		Credentials
New York State Department of Health	Michael Bauer	MS
New York State Department of State	Paul Beyer	JD
Workgroup Members		**Credentials**
New York State Department of Health	Ann Lowenfels	MPH
	Brooke Turcotte	MPH
	Dan French	MS
	Douglas Done	PhD, MPH
	Emily D'Angelo	MPH
	Gena I. Gallinger	MS
	Jessica Sunshine	MPH, MSW
	Kristen Vacca	MPH
	Margaret Ryan	MPH
	Tomica M. Collado-Robinson	
	Wilma Alvarado-Little	MA, MSW
Rain Total Care, Inc.	Anderson Torres	PhD,
Westchester County Department of Health	Bryan Schaub	MPH
Albany County Department of Health	Charles Welge	
Broome County Health Department	Devin Link	MPH, MA
Oswego County Health Department	Diane E. Oldenburg	
CDPHP	Erin Vickers	
	Kathy Leyden	MSW
Cattaraugus County Health Department	James E. Lawrence	MPH
The John A. Hartford Foundation	Catelyn Edwards	
	Jane Carmody	DNP, MBA
	Terry Fulmer	PhD

Suburban Hospital Alliance/Long Island Health Collaborative	Janine Logan	MS
St. Lawrence Health Initiative	Karen Bage	
Bertrand Chaffee Hospital	Kathleen Hebdon	MSN
Allegany County Health Department	Robert Matasich	MBA, MSL
Binghamton Metropolitan Transportation Study	Scott Reigle	MA
Blueprint 15 INC	Tara Harris	

Domain 4: Health Care Access & Quality

Domain Leads:
Heather Dacus, New York State Department of Health
Kirsten Siegenthaler, New York State Department of Health

Credentials:
DO, MPH
PhD, MSPH

Workgroup 1: Access to and Use of Prenatal Care, Prevention Infant and Maternal Mortality

Workgroup Leads		Credentials
New York State Department of Health	Kirsten Siegenthaler	PhD, MSPH
Westchester Medical Center Health Network (WMCHealth)	Thao M. Doan	DrPH, MPH

Workgroup Members		Credentials
New York State Department of Health	Christopher Joseph	MPH
	Jeannine Giroux-Holland	
	Lara A. Madison	MPH
	Lindsey A. Jones	MSN
	Lois Sexton	MSN
	Lolisa McLaughlin	MPH
	Natalie Wedge	
	Sally Holt	DrPH, MS
	Shani Fields	
	Stephanie Shulman	
SBH Health System	Alvin Lin	MBA
Greater New York Hospital Association	Benjamin Gonzalez	
Health Foundation for Western and Central New York	Diane Oyler	PhD
Healthcare Association of New York State (HANYS)	Erin Gretzinger	
Franklin County Public Health	Hannah Busman	MPH

Jamaica Hospital Medical Center	Janice Krystal Ascencio	MD, MBA
Westchester County Department of Health	Jiali Li	PhD
Primary Care Development Corporation	Louise Cohen	MPH
New York Health Foundation	Mary Ford	MS
Community Health Care Association of New York State	Mercy Mbogori	MPA
University of Rochester Medical Center - Center for a Tobacco-Free Finger Lakes	Ryan Mulhern	
Nathan Kline Institute	Sebrena Tate	
Syracuse Healthy Start: Onondaga County Health Department	Sunny Jones	

Workgroup 2: Preventive Services for Chronic Disease Prevention and Control, Oral Health Care, Preventive Services

Workgroup Leads		Credentials
New York State Department of Health	Emily Martin Heather Dacus Janet Campanella	 DO, MPH

Workgroup Members		Credentials
New York State Department of Health	Barbara Wallace	MD, MSPH
	Elizabeth Whalen	MD, MPH, DipABLM
	Haley Cowlin	MPH
	Jessica Kumar	MPH, DO
	Kate Bliss	MSW, MPH
	Lauren Miller	PhD, MS
	Lauren Stairs	MPH
	Linda Janenka	
	Michele Griguts	DDS
	Rachael Austin	MPH
	Sabryna Strack	
	Samira Skonchko	MS
	Sasha Latvala	MS
	Victoria Wagner	PhD, MSS
	Wahida Ferdousi	

The Heart Network	Amy Kohanski Ann Morgan Arriana Patraw	 MS
New York City Department of Health and Mental Hygiene	Achala Talati	
Saratoga Hospital	Ann Hutchison	MBA
Sullivan County Department of Public Health	Audrey Myers	
Greater New York Hospital Association	Benjamin Gonzalez	
Catholic Health	Chris Hendriks	MA
New York State Podiatric Medical Association	Dan Kline	MSPH, MBA
Jamaica Hospital Medical Center	Deborah Gazzillo	DDS
Northeast Business Group on Health	Jeanette Fuente	
United Hospital Fund	Joan Guzik	MBA
Primary Care Development Corporation	Jordan Goldberg	JD
Finger Lakes Health	Kimberly Ilacqua	MS
American Cancer Society	Michael D. Seserman	MPH

Workgroup 3: Early Intervention and Childhood Behavioral Health

Workgroup Leads		Credentials
New York State Department of Health	Jessica Simmons	
Workgroup Members		**Credentials**
New York State Department of Health	Alizah Tariq	MPH
	Betsy Foust	MPH
	Brenda J. Jackson	MSN
	Christopher Foote	PhD, MS
	Claire Fan	PhD
	James Chithalen	MS
	Junsheng Yuan	MFA
	Karen C. Bovell	MS
	Karen Dwyer	MD, MPH
	Mary Amendola	MPH
	Nathan Graber	MS
	Paloma Luisi	PhD
	Shirleen McClarren	
	Shu-Kuang Tai	

University at Albany College of Integrated Health Sciences (formerly the School of Public Health)	Christine T. Bozlak	PhD, MPH
Oneida County Health Department	Dan Gilmore	PhD, MPH
Sullivan County Department of Public Health	Josie Waldo	
Episcopal Health Services	Preet Kukreja	MBA, MHA
Liftoff Western New York	Rachel Bonsignore	
Blueprint 15, Inc	Raquan Pride-Green	
InUnity Alliance	Sarah DuVall	MPH
New York State Office of Mental Health	Sarah Kuriakose	PhD

Domain 5: Education Access and Quality

Domain Lead:
Cord Stone, New York State Department of Health

Credentials:
EdD, MPH

Workgroup 1: Health and Wellness Promoting Schools & Opportunities for Continued Education

Workgroup Leads		Credentials
New York State Department of Health	April Davis	PhD, MS, DVM
	Rebecca Hoen	MS, DrPH
Workgroup Members		**Credentials**
New York State Department of Health	Barbara Raymond	
	Cali Riese Messner	
	Erin Van Denburgh	MS
	Jillian Bumpus	MBA, PsyD
	Kelly Barrett	MPH
	Lauren Van Buren	
	Leonard Peruski	PhD
	Melissa Lurie	MPH
	Molly Kuenzel	MS
	Sherrie Strain	MPH
	Stephanie Mack	
New York State Office of Mental Health	Allison Trujillo	
Broome County Health Department	Brooke Traver	MPH

Rockland County Department of Health	Carrie Steindorff	MA
Niagara County Department of Health-Nursing	Cathy Hoy-Patterson	MS
Suffolk County Department of Health Services	Danielle Craigg	MD
Glens Falls Hospital	Elizabeth Hoffman	MEd
New York State Education Department	Gemma Rinefierd Maribeth Barney	
Erie 1 BOCES Creating Healthy Schools & Communities	Kate Huber	MS
Blueprint 15	Marquita Hetherington	
Westchester Medical Center Health Network (WMCHealth)	Matilde Roman	JD
Adirondack Health Institute/Adirondack Rural Health Network	Sara Deukmejian	MBA, MS
Westchester County Department of Health	Xingwei Cui	MA, MPH

Letter from the Commissioner

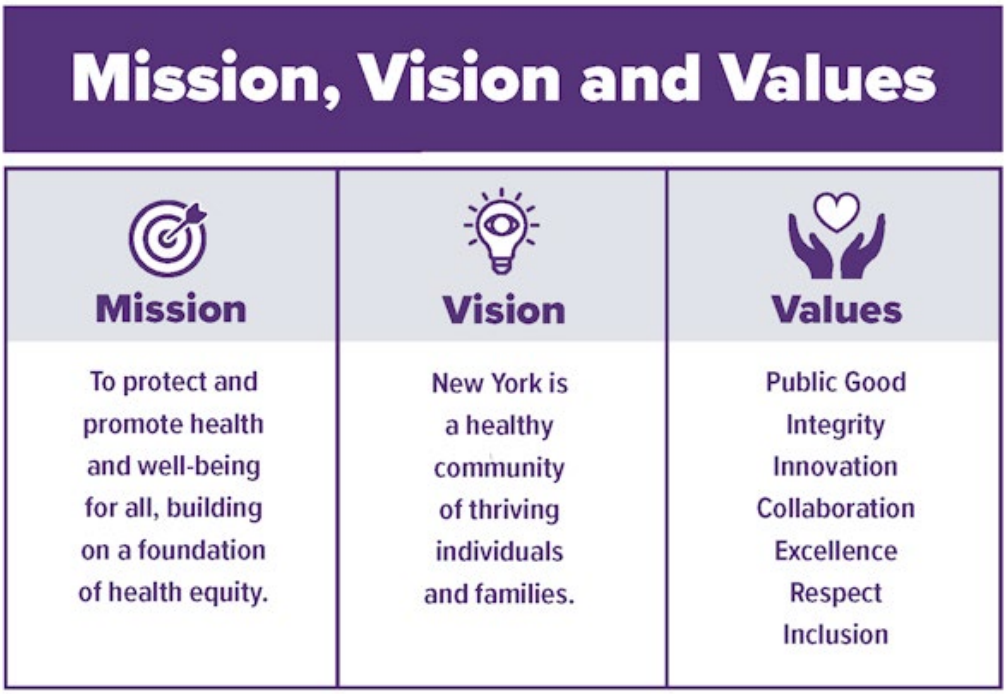
James V. McDonald, MD, MPH

The 2025-2030 New York State's Prevention Agenda is the State Health Improvement Plan (SHIP), a six-year initiative aimed at improving health and reducing health disparities through a strong emphasis on prevention. This iteration of the Prevention Agenda has a strong focus on primary health drivers known as the Social Determinants of Health, which include conditions in which people are born, grow, work, live and age. We know that these non-medical factors strongly influence health outcomes and confer advantages or disadvantages. Optimizing individuals social determinants of health aligns with our mission to protect and promote health and well-being for all, building on a foundation of health equity.

The New York State Department of Health is excited to share the 2025-2030 New York State Health Improvement Plan. This plan is a roadmap to support healthier people and healthier communities across New York State.

Our State Health Improvement Plan is the culmination of a data driven, deliberative process. We have engaged hundreds of stakeholders including public, private, and community partners throughout the entire state who worked together identifying evidence-based practices to improve health outcomes. We are grateful for the partnership and look forward to collaborative efforts to bring this plan to fruition in the coming years.

We invite you to visit the New York State Department of Health Website at https://www.health.ny.gov/



Executive Summary

What is the Prevention Agenda?

The Prevention Agenda is New York's State Health Improvement Plan (SHIP), a six-year initiative aimed at improving health and reducing health disparities through a strong emphasis on prevention. It serves as a blueprint for coordinated state and local action to improve the health and well-being of all individuals in New York.

The vision of the Prevention Agenda 2025-2030 is that *every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan.*

The objectives outlined in the Prevention Agenda serve as aspirational benchmarks for public health progress. These objectives are designed to inform strategic planning and implementation efforts driven by health departments, hospital systems, and local organizations.

In addition, the Prevention Agenda identifies hundreds of evidence-based interventions that organizations may consider leveraging to further the Agenda's objectives. These interventions are proposed as optional strategies and are not to be construed as mandates. Their inclusion is intended to offer flexibility, enabling communities to tailor approaches that align with their particular circumstances, resources, and public health priorities.

Collectively, the objectives and interventions outlined in the Prevention Agenda are illustrative and non-exhaustive. They represent examples of the type of measures that can be leveraged in pursuit of reducing health disparities in New York State.

The main components of the 2025-2030 Prevention Agenda are:

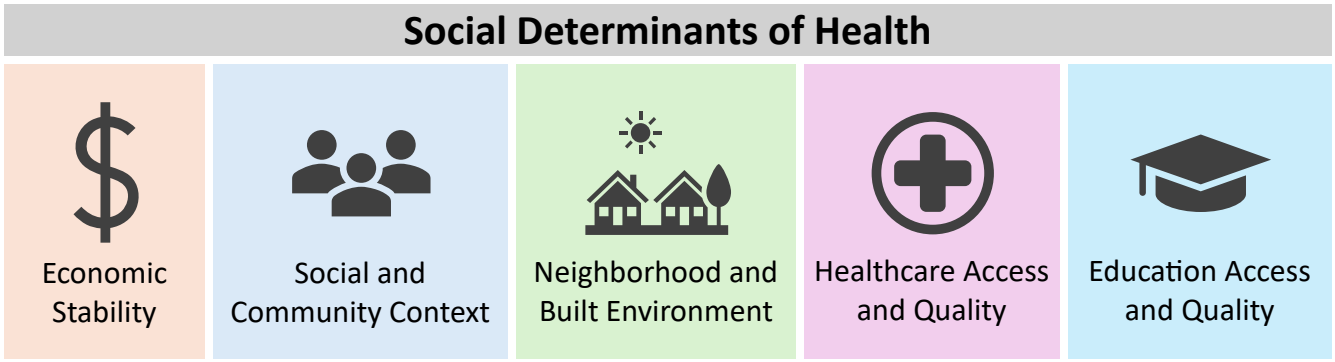
- **Domains and Priorities:** The Prevention Agenda includes 5 domains that focus on Social Determinants of Health (SDOH) and align with Healthy People 2030. The domains encompass 24 statewide priorities that were identified by the State Health Assessment (SHA). These priorities address contributing factors to health outcomes and quality of life (See Figure 1).
- **State Level Goals:** Across all domains and priorities, the universal goal is to reduce disparities and inequities within the next 6 years. Each domain has an overarching state-level goal as well as a state-level goal for each priority. These state-level goals inform each priority's objectives, interventions, and tracking indicators.
- **Objectives:** Prevention Agenda has a total of 84 measurable and equitable objectives to be achieved within the 6-year timeframe. Each 2025-2030 Prevention Agenda priority has at least one objective that benefits the greater good and one objective that specifically address populations experiencing health disparities.
- **Interventions:** Prevention Agenda interventions are public health policies, programs, strategies, supporting activities, or other actions intended to address each priority's objectives. For each priority, the 2025-2030 Prevention Agenda includes evidence-informed interventions for local health departments, hospitals, community organizations, and other entities.

- **Tracking Indicators:** Prevention Agenda tracking indicators provide a specific metric or measure used to evaluate progress on a given objective by quantifying intermediate outcomes, typically expressed as a number, percent, or rate. The 2025-2030 Prevention Agenda incorporates at least one tracking indicator for each objective, including baselines, targets, and sources. Across all Domains, there are a total of 84 tracking indicators.

Why is the Prevention Agenda Important?

New York's 2024 State Health Assessment (SHA) highlights significant health disparities across racial, ethnic, and socioeconomic groups. The Prevention Agenda addresses these challenges by setting data-driven objectives that emphasize measurable goals and cross-sector partnerships. Through a collaborative process, the Prevention Agenda aligns priorities, advances initiatives, removes state-level barriers, eliminates redundancies, and coordinates efforts to maximize impact, ultimately driving progress toward health equity.

Figure 1: Social Determinants of Health



How was the Prevention Agenda Developed?

The process of setting the 2025–2030 Prevention Agenda priorities was a collaborative effort that emphasized contributor 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 to prioritize social drivers of health and related health indicators.

How will the Prevention Agenda be Implemented?

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. The success of these interventions depends on cross-sector collaboration between organizations, as well as innovative and thoughtful use of available resources.

Purpose and Overview

What is the Prevention Agenda?

The Prevention Agenda is New York's SHIP, a comprehensive blueprint for local and state action to improve health and well-being throughout New York, with a particular focus on prevention and reducing health disparities. The Prevention Agenda initiative began in 2008 and is updated every 6 years by the New York State Public Health and Health Planning Council (PHHPC) at the request of the New York State Department of Health (the Department). Development and implementation of a SHIP is required for accreditation through the Public Health Accreditation Board (PHAB). For more details on the PHAB accreditation process, please see the information under the PHAB Accreditation heading in the next section.

The Prevention Agenda is a tool to enhance state and local efforts in improving health, well-being, and equity across New York State. It can be used by local public health agencies, hospitals, government agencies, community-based organizations, health care providers, advocates, educators, policymakers, and other key partners to promote action, maximize resources, and prioritize interventions and supporting activities that advance health.

Prevention Agenda History and Evolution

2008-2012 Prevention Agenda

The Prevention Agenda Towards the Healthiest State began in 2008 as a call to action to improve the health of individuals living in New York by preventing population-level health problems from occurring and mitigating negative health outcomes. The first cycle of the Prevention Agenda identified ten priorities:

- Access to Quality Health Care
- Chronic Disease
- Community Preparedness
- Healthy Environment
- Healthy Mothers, Healthy Babies, Healthy Children
- Infectious Disease
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

In 2009, local health departments (LHDs) and hospital systems from across the state joined the initiative to conduct the necessary community health planning to develop New York's first Prevention Agenda.[16]

2013-2018 Prevention Agenda

The 2013-2018 Prevention Agenda cycle had 5 prevention-centered priorities.

- Prevent Chronic Disease
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

This cycle also introduced the "Health Across All Policies" approach, which calls on all state agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health.[17]

2019-2024 Prevention Agenda

The 2019-2024 Prevention Agenda focused on the same priorities as the previous cycle, consistent with a Health Across All Policies approach. It also added the cross-cutting principle of supporting healthy aging and making New York the First Age-Friendly State. It utilized a collaborative, holistic approach to address public health problems, with more direct emphasis on social determinants of health. The progress of the 2019-2024 Prevention Agenda was undoubtedly affected by the COVID-19 pandemic, which put significant strain on health care systems and required a mass refocusing of effort to manage.

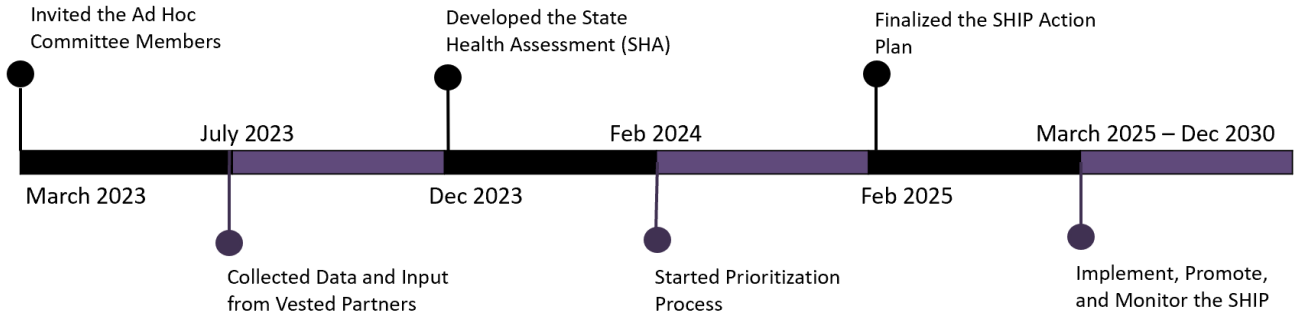
2025-2030 Prevention Agenda

The 2025-2030 Prevention Agenda was informed and developed using the 2024 SHA. The SHA provides an overview of what we know about the health of people who are born, live, learn, work, play, and age in New York State. The SHA was developed by a cross-disciplinary team of New York State Department of Health staff and external partners. The SHA team collected and analyzed data from New York State data profiles, local health departments, and hospitals to identify key health issues and areas for state and local action. For more details about the findings of the SHA, visit the New York State Health Assessment 2024.

Building upon the work of the SHA, the Ad Hoc Committee was established by the PHHPC and charged with developing the framework and specifics of the Prevention Agenda. In recognition of significant disparities in socioeconomic opportunity and its effects on health, the Prevention Agenda framework was revised to align with the 5 social determinants of health addressed in Healthy People 2030. The new framework incorporates each social determinant of health as a separate domain, similar to the priorities identified in previous Prevention Agenda cycles. Each domain is further categorized into priorities, similar to focus areas from previous cycles.

The Ad Hoc Committee met quarterly between March 2023 and July 2024 to support the identification of the 24 priorities and foundational principles that guide the work of the Prevention Agenda 2025-2030 (See Figure 2). For more details about the methodology and findings of the Ad Hoc Committee, please see the 2024 State Health Assessment.

Figure 2: Prevention Agenda Timeline



PHAB Accreditation

The New York State Department of Health was first accredited through the Public Health Accreditation Board (PHAB) in 2014 and has maintained accreditation since. The Department was one of the first large state health departments to receive such accreditation. Pursuit of this accreditation assisted the Department in implementing a thoughtful, deliberate approach to quality improvement and assurance and led to more meaningful collaboration with local health departments.

The 2025-2030 Prevention Agenda was developed through a collaborative process that meets all PHAB standards, including:

- **MEASURE 5.2.1 A: Develop a SHIP**[12]
  - Identify participating partners involved in the SHIP process;
  - Review information from SHA and the causes of disproportionate health risks or health outcomes of specific populations, and
  - Utilize a deliberative process to select priorities.
- **MEASURE 5.2.2 A: Adopt a SHIP as a result of the health improvement planning process**[12]
  - Establish priorities and measurable objectives;
  - Identify evidence-informed interventions for each priority, including policy changes;
  - Assess available assets and resources, and
  - Establish a process to track progress on SHIP objectives.
- **MEASURE 5.2.3 A: Implement, monitor, and revise the SHIP in collaboration with partners**[12]
  - Provide specific examples of SHIP implementation activities;
  - Review annual progress of all SHIP interventions, and
  - Revise SHIP based on progress reviews.

New York State conducts its SHA every 6 years, in alignment with the cycles of the Prevention Agenda initiative. The findings of the SHA are used to develop the priorities, goals, equitable objectives, and vision of each cycle of the Prevention Agenda to ensure that New York State is addressing population health needs in line with PHAB standards. The Prevention Agenda further provides a menu of evidence-informed interventions with strong potential to address social determinants of health and alleviate the causes of health inequity identified in the SHA. Throughout the next 6 years, the Prevention Agenda will be implemented, tracked, and reported at both a state and local level. Per PHAB standards, the Prevention Agenda will be a dynamic document that has the flexibility to accommodate changes and revise interventions and supporting activities as needed to address complex population health issues.

2025-2030 Prevention Agenda Framework

Figure 3: Prevention Agenda Framework

Vision and Foundations

The 2019-2024 Prevention Agenda's vision aimed to make New York the healthiest state in the nation. While health rankings provide useful benchmarks, they primarily reflect relative progress, meaning a state's higher ranking may result from another state's decline rather than absolute improvement. Therefore, the 2025–2030 Prevention Agenda's vision shifts its focus toward reducing health disparities and advancing health equity, ensuring that progress is measured by meaningful improvements in health outcomes rather than comparative rankings. This vision also aligns with the New York State Department of Health's commitment to ensure that every individual can attain their highest level of health across the lifespan.

The 2025-2030 Prevention Agenda was built around 4 foundations:

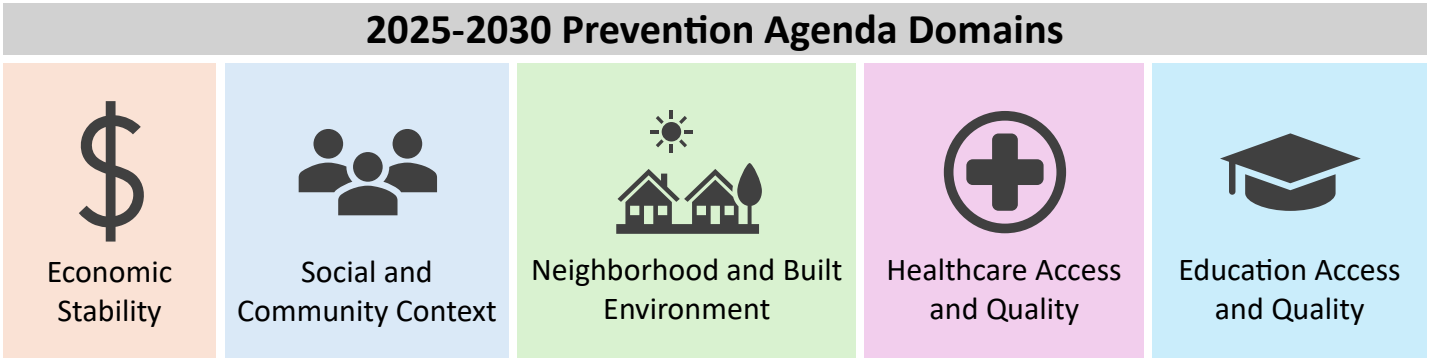
1. **Health Across All Policies -** Promote an interdisciplinary, multi-sector collaboration.
    a. The Health Across All Policies approach was first incorporated in the 2013-2018 Prevention Agenda and continues to be a foundational element in the current cycle. This approach emphasizes interdisciplinary, multi-sector collaboration to address social and community factors of health and well-being. For more information, see Health Across All Policies in New York State.
2. **Health Equity -** Focus on addressing structural racism and implicit bias as social drivers of health.
    a. In July 2024, the New York State Department of Health released its Health Equity Plan, a guide for all staff to ensure that health equity is a primary consideration in decisions made throughout the Department. Though it predates the Health Equity Plan, the Prevention Agenda is in alignment with the Plan's goal: to eliminate health inequities that are avoidable and unjust through proactive and inclusive processes. For more information, see the New York State Department of Health Equity Plan.

3. **Prevention Across the Lifespan -** Promote health and prevent disease through evidence-based interventions, addressing social determinants and health inequities at every stage of life.
    a. The 2025-2030 Prevention Agenda framework incorporates primary and secondary interventions and supporting activities as well as initiatives that promote access to care for people of all ages. Progress on the Prevention Agenda's objectives is tracked through the Prevention Agenda Dashboard and can be utilized to examine trends across demographic factors, including age groups. For more information, see the Prevention Agenda Dashboard.
4. **Local Collaborative Effort -** Work collaboratively with partners and community members to achieve Prevention Agenda goals.
    a. NYS Public Health Law (NYS PHL) requires both local health departments and hospitals to work collaboratively with community partners when conducting Community Health Assessments (CHAs), Community Health Improvement Plans (CHIPs), and Community Service Plans (CSPs). For more information about these mandates, see NYS PHL Section 40-2.40 and Section 2803-I. For information about CHA, CHIP, and CSP requirements, see the Community Health Improvement Planning Guidance For Local Health Departments and Hospitals in New York State.

Domains and Priorities

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. It aligns with Healthy People 2030 by adopting the 5 social determinants of health domains:

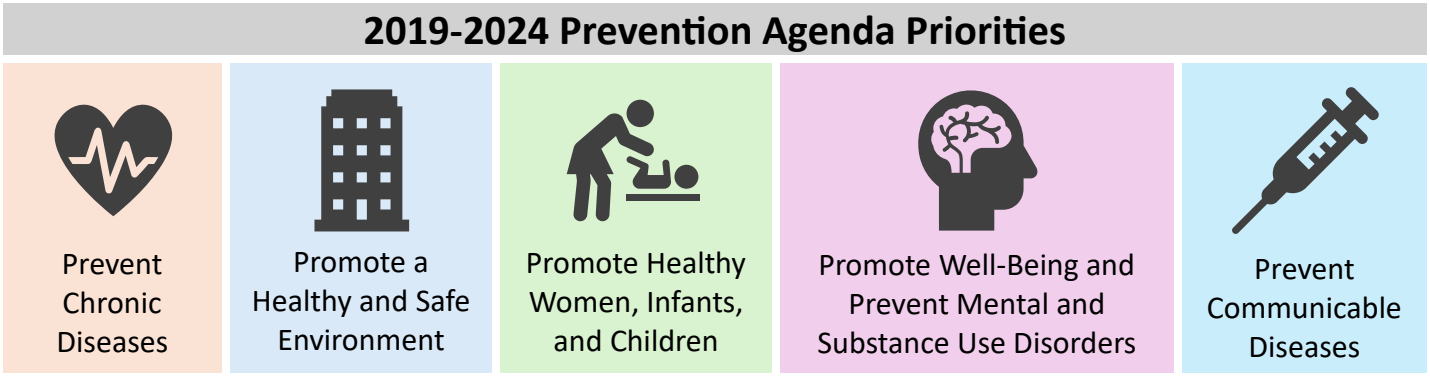
Figure 4: 2025-2030 Prevention Agenda Domains



These 5 domains encompass 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality health care. Addressing these issues is crucial for reducing health disparities.

The 2019-2024 Prevention Agenda named 5 domains, previously referred to as priorities, focused on overall health outcomes. The 5 priorities included:

Figure 5: 2019-2024 Prevention Agenda Priorities



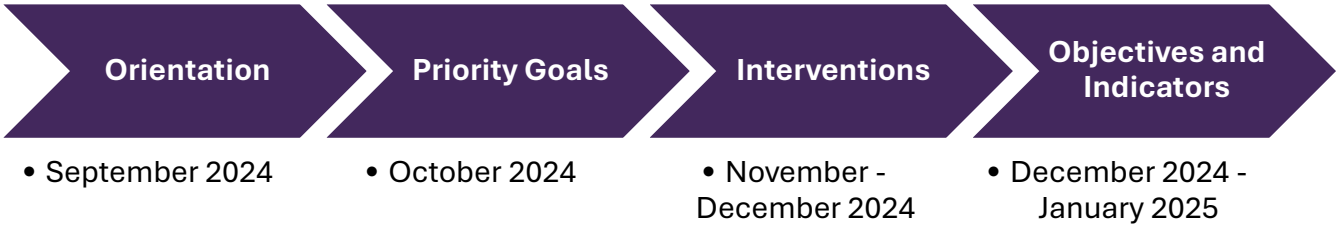
Action Plan Development

Subject matter experts were organized into workgroups to create 5 domain-specific action plans. Using a template provided by the New York State Department of Health, each workgroup developed a final set of goals, equitable and inclusive objectives, indicators to track progress, and organizational-level, evidence-informed interventions to achieve these goals.

To identify workgroup members for the 5 domains of the 2025-2030 Prevention Agenda, a survey was distributed in August 2024. This survey was shared using the snowball recruitment method, a research technique that utilizes word of mouth and referrals to find participants. A total of 290 individuals expressed interest in participating. Members were grouped into 11 workgroups based on their interests and expertise. Each workgroup was tasked with addressing one to three priorities. See Appendix IV for more detailed information on workgroup structure and members.

Members convened at weekly virtual meetings from September 2024 to January 2025 to develop action plans. They began with identifying the overarching goals for each priority. Once goals were clearly articulated, members identified evidence-informed interventions. Interventions were selected prior to objectives to ensure that they would drive change. This approach aligns objectives with realistic expectations and effective actions, making them feasible and directly linked to measurable outcomes. It increases the chances of success and strengthens the overall impact of the plan. See Figure 6 for a process timeline.

Figure 6: Workgroups' Process Timeline



Action Plan Components

Domains and Priorities

The 2025-2030 Prevention Agenda framework is divided into 5 domains, mirroring the 5 social determinants of health included in Healthy People 2030.[15] These 5 domains include Economic Stability, Social and Community Context, Neighborhood and Built Environment, Health Care Access and Quality, and Education Access and Quality. Each of the 5 domains in the 2025-2030 Prevention Agenda has an overarching visionary goal that guides efforts within its perspective

area. The 5 domains encompass 24 priorities, each with their own unique goal, working toward reducing disparities and inequities throughout the six-year cycle.

Economic Stability focuses on the financial resources that individuals and families need to maintain good health and well-being. It emphasizes the importance of factors such as employment, income, expenses, and financial security, as these directly impact people's ability to access necessary health care, live in safe environments, and afford healthy food and other resources that promote health. This domain recognizes that economic conditions are a foundation for improving health outcomes across populations.

Social and Community Context focuses on how social relationships, community support, and civic engagement influence health outcomes. It emphasizes the importance of strong social networks, supportive communities, and fair treatment for promoting mental and physical well-being. This domain highlights that social factors—such as community support, fairness, and work conditions—are vital to improving health and reducing disparities.

Neighborhood and Built Environment focuses on how physical environments—such as housing, transportation, and access to safe public spaces—affect health. This domain aims to improve living environments that support physical, mental, and social well-being, helping to reduce health disparities.

Health Care Access and Quality focuses on improving access to high-quality health care services and ensuring that all individuals can receive timely, effective, and equitable care. The goal of this domain is to reduce barriers to health care, improve the quality of services, and ensure that health care is equitable, especially for underserved and marginalized populations.

Education Access and Quality focuses on how access to quality education affects health outcomes. It recognizes that higher levels of education are linked to better health, healthier behaviors, and improved access to resources. This domain emphasizes the importance of education at all levels in promoting health, reducing health disparities, and improving life outcomes.

Objectives and SMART(IE) Framework

The 2025-2030 Prevention Agenda includes 84 objectives:

- 42 SMART objectives that addresses a general population.
- 42 SMARTIE objectives that specifically address populations experiencing health disparities.

To ensure objectives are clear, measurable, and equity-driven, the 2025-2030 Prevention Agenda adopts the SMART(IE) framework:

- **S**pecific: The objective should clearly define what is to be achieved.
- **M**easurable: The progress or success should be quantifiable, allowing for tracking.
- **A**chievable: The objective should be realistic and attainable given the resources and constraints.
- **R**elevant: The objective should align with broader goals and have a meaningful impact.
- **T**ime-bound: The objective should include a clear timeline or deadline.
- **I**nclusive: The objective should address equity, ensuring that it benefits all groups and accounts for disparities.
- **E**quitable: It should aim to reduce or eliminate disparities and promote fairness across populations.

Indicators

There are 84 indicators included in the 2025-2030 Prevention Agenda to track progress toward identified objectives. An indicator is a specific metric or measure used to evaluate progress of a given initiative by quantifying intermediate outcomes, typically expressed as a number, percent, or rate. Each Prevention Agenda indicator has a baseline and target.

- The baseline represents the most recent data available for each indicator.
- The target is a data point representing what the Prevention Agenda aims to achieve at the end of the 6-year cycle.

Indicators were chosen based on relevance, measurability and consistency, ongoing availability and geographic availability. Other considerations included actionability, timeliness, disparity measurement, alignment with Healthy People 2030, public understanding, and inclusivity. For more information about indicator selection criteria, please see Appendix III.

Figure 7: Example - Objective and Indicator – 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

Interventions are policies, programs, or other actions intended to address objectives. Each priority in the 2025-2030 Prevention Agenda includes several interventions that can be implemented in a variety of settings. These interventions are evidence-informed, meaning that there is either rigorous research evidence showing that the intervention has achieved positive outcomes relevant to the priorities, or there is information provided by subject matter experts that the approach is promising. If well implemented, these interventions are likely to improve the health of people living in New York. See Appendix III for the intervention prioritization criteria and evidence resources.

There are 3 types of interventions in the 2025-2030 Prevention Agenda, including:

1. **Evidence-Based**: interventions that have been proven effective within certain circumstances, environments, and cultures. The effects are clearly linked to the activities themselves, not to outside unrelated events.
2. **Best Practice**: interventions that have been shown to be effective in achieving positive health outcomes and can be implemented in various settings to address specific health issues.
3. **Promising Practice**: interventions that have at least preliminary evidence of effectiveness in small-scale settings or with potential for generating data that will be useful for making decisions about generalizing the results to diverse populations and settings.[18]

Prevention Agenda interventions will be implemented through community health improvement efforts led by local health departments, hospitals, and other state and community-based partners. Therefore, the interventions in the Prevention Agenda focus on:

- **Primary prevention**, including upstream activities that address community conditions
- **Secondary prevention**, including screening and early intervention
- **Access to care**, including innovative settings or methods (such as school-based health care or telehealth).

A key focus of the Prevention Agenda is reducing health disparities. To achieve this, the Prevention Agenda prioritizes evidence-informed interventions that address disparities and inequities across racial/ethnic, socioeconomic, geographic, and other characteristics. While the evidence base for reducing disparities continues to evolve, interventions can still be effective, especially when they are culturally adapted and tailored to meet the needs of the priority population. For effective implementation, the interventions are grouped by organizational level, including local health departments, hospitals, and other agencies.

Figure 8: Example - Interventions - Poverty

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).[23] 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

Advancing Health Equity through the Prevention Agenda

Since the establishment of the New York State Prevention Agenda in 2008, the state has strengthened its focus on health equity by prioritizing the elimination of health disparities.

What is Health Equity?

"Health equity means everyone has a fair and just opportunity to be healthy."

- *New York State Department of Health*

Definitions from Healthy People 2030:

Health Equity: "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[19]

Health Disparities: "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion."[19]

Figure 9: Health Equity

The state's vision of health equity is that every individual in New York, regardless of who they are or where they live, will have the opportunity to achieve optimal health.[7] To achieve this, all individuals in New York must have access to safe and secure housing, quality health care services, affordable and nutritious food, accessible transportation, social support networks, and protection against discrimination based on race, gender, sexual orientation, disability status, or any other part of one's identity.[20]

Why is Health Equity Important?

Health inequities lead to worse health outcomes, shorter life expectancy, and otherwise avoidable chronic stress. Communities that have suffered systemic discrimination are impacted by health inequities the most. The COVID-19 pandemic worsened existing health inequities – a result of structural racism and the unequal distribution of resources across communities in New York State. This highlighted the need for a health equity foundation across all programming and policymaking. The following statistics from New York's SHA show just a few examples of health disparities in the state.

Figure 10: Example - Health Disparities in New York

Severe Maternal Morbidity is highest among Black non-Hispanic mothers, with rates of nearly 200 deaths per 10,000 deliveries, compared to fewer than 80 deaths per 10,000 among White non-Hispanic mothers.

Economic Disparities

18% of children in New York live below the poverty line, with Black and Hispanic children experiencing the highest poverty rates, at 28% and 26%, respectively. 48.1% of adults earning less than $25,000 experience food insecurity, and many individuals avoid health care due to cost, particularly among lower-income and minority groups.

Disparities in Maternal and Child Health

The rate of low-birth-weight births for Black non-Hispanics is nearly twice that of White non-Hispanics. Black non-Hispanic mothers also have higher rates of premature births, and less prenatal care – 65.8% receive early prenatal care, compared to over 80% of White non-Hispanics.

See the NYSDOH Health Equity Plan for more information.

Health Equity in the 2025-2030 Prevention Agenda

The 2025-2030 Prevention Agenda prioritizes health equity by:

Figure 11: Social Determinants of Health

Addressing the root causes of disparities by adopting the Healthy People 2030 SDOH framework.

Defining SMART(IE) objectives that are equitable and inclusive for individuals and groups at higher risk. All objectives set higher long-term targets for groups that experience disparities/ and inequity.

Prioritizing evidence-informed interventions that consider potential impacts on disparities and inequities by racial/ethnic, socioeconomic, geographic, and other characteristics. While the evidence base on what works to decrease disparities is limited and evolving, the selected interventions may still be effective, especially if culturally adapted and tailored to meet the needs of priority populations.

Collaborating across sectors during the planning, implementation, and evaluation stages of the Prevention Agenda. This improves the overall process and outcomes by obtaining contributor feedback and identifying interventions through multidisciplinary workgroups.

Alignment of local health improvement plans also presents an opportunity to strengthen efforts in overlapping communities. Additionally, an Interagency Task Force on Health Equity and Diversity, Equity, and Inclusion has been implemented at the State level to aid LHDs, hospitals, and community organizations during the implementation phase.

2025

Action Plans

Reader's Guide

The Prevention Agenda provides a long-term vision through a comprehensive framework and a concise set of priorities. The following Action Plans provide foundational tools for implementation, including measurable objectives and evidence-informed interventions. It is a roadmap, rather than a step-by-step implementation guide.

The action plan begins with the priority's goal, followed by an explanation of what the priority is and why it is important. Figure 12 illustrates the objectives, tracking indicators, and relevant information for monitoring progress and impact.

All objectives should be met by December 31, 2030.

Figure 12: Example - SMART and SMARTIE Objective Format and Content

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)

Figure 13 illustrates the formatting for priority interventions. Each intervention has an associated population of focus, potential age range of focus, and intermediate measures that explain how progress and success should be evaluated.

Figure 13: Example - Featured Intervention Format and Content

Intervention *(A description of a policy, program, or other action intended to address the priority objectives)*	**Population of Focus** *(The specific group that this intervention will support)*	**Age Range** *(The specific age range of focus for this intervention)*	**Intermediate Measures** *(Specific measure that evaluates whether the intervention is progressing as expected before long-term outcomes are available)*
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] 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

The legend below provides visual references to guide readers through each priority's list of interventions. If a Social Driver icon is displayed, that indicates that the intervention is crosscutting between 2 domains. For the intervention in Figure 13, its cross-cutting domain is Health Care Access & Quality in addition to the Economic Stability domain it is housed in.

The color-coded boxes below each intervention indicate the organizational levels in which the intervention can be applied. Interventions are grouped into 3 organizational levels: local health departments, hospitals, and other agencies (e.g., community-based organizations, state agencies, and educational institutions). The intervention in Figure 13 can be applied across all 3 levels.

Featured Interventions, as illustrated in Figure 13, are those that have a high evidence rating indicating credible evidence of effectiveness and direct outcomes that can be observed and evaluated using the tracking indicator for that priority.

Table 1: Legend of Icons and Symbols

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)

For each priority, a list of Lead Partner Agencies and Organizations and Implementation Resources follows the selected interventions. Lead Partner Agencies and Organizations can provide support and collaborate on implementation of selected interventions. Implementation Resources are current resources available to support implementation of selected interventions, including existing programs and funding opportunities.

Domain 1:
Economic Stability

Priorities:

- Poverty
- Nutrition Security
- Unemployment
- Housing Stability and Affordability

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)

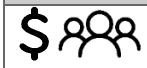
Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Implement a comprehensive measure of poverty for county health needs assessments following the guidance of metrics similar to ALICE (Asset Limited Income Constrained Employed).[23] LHD H O	Population living under 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 (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: • 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
• Identifying transportation resources for older adults not living in senior housing to take trips to farmers' markets or grocery stores that may be further away[24-26] LHD O			
 Incorporate educational programs that enhance recruitment for needed positions while mitigating disparities in recruitment efforts in the community.[27] LHD H O	Adults enrolled in public benefits, high school-age youth	Ages 16+	Employment rate by age group and industry
 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: • 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 An example of a program is the Academic Partnerships Program established by the Association of Public Health Laboratories.[28-31] LHD O	Underrepresented populations	Ages 16+	Employment rate by demographic group and type of job
 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: • 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
• Summer Electronic Benefits Transfer (EBT) • Child and Adult Care Food Program (CACFP) • WIC Farmers Market • Fresh Connects • Double Bucks[32] LHD H O			
 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: • 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 agencies[33-35] LHD O	Low-income individuals and families	N/A	Number of families and children receiving childcare assistance.
 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] LHD O	Low-income individuals and families	N/A	Participation among organizations responsible for data reporting and collection, progress on size of data set
 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] LHD	Children and families in poverty	Ages 16-64	Number of individuals receiving information on personal finance
 Provide education and conduct standardized screening for hospitals, providers, and clinics through the	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] LHD H O			
 Create medical and legal partnerships to assist with screening, referral services, legal guidance, and/or case management.[41] H O	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] H	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] LHD H O	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] LHD O	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: • 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 development[47] LHD O	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
 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] LHD H O	Underserved/Low-income communities Employers that pay salaries under 200% FPL Employees earning under 200% FPL	Ages 16-64	Financial assistance program uptake at local community level (participation rate)
 Promote and partner with early education programs like Head Start and Early Head Start to increase enrollment.[51,52] O	Families with school-age children who qualify	School-age children	HeadStart/early HeadStart participation rates
 Promote and partner with family-based prevention programs (e.g., Nurse Family Partnership) and Healthy Families Home Visiting Programs (OCFS).[53-56] LHD O	Population eligible for NFP and Healthy Families HV programs	Qualifying ages	Number of families and individuals served by intervention
 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: • 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 programs[57] LHD O	Underserved/Low-income communities	N/A	Service uptake, data on distribution (how many website visits, how many flyers distributed, etc.)

Interventions	Population of Focus	Age Range	Intermediate Measures
 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] LHD H	Children and adults experiencing food insecurity	N/A	Number of hospitals performing screenings, number of successful follow-ups with hospital social workers, number of successful referrals made to social support services
 Promote two-generation, community-level financial literacy interventions (e.g., school banking, budgeting).[59] LHD O	Everyone	School-age and up	Participation rate among schools, banks, CBOs, number of people receiving intervention
 Conduct referrals of nutrition- insecure adults to community-based organizations.[60] LHD H O	Food insecure adults	Ages 18+	Number of successful referrals made
 Create healthy food pantries in hospitals to ensure food security and access to healthy food.[61,62] H O	Food insecure adults	Ages 18+	Hospital participation rate, number of referrals made, number of people served by pantries

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

Priority: Unemployment

Goal: Promote equitable approaches to optimize employment.

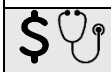
What is Unemployment and Why is it Important?

Unemployment and underemployment are significant public health challenges in NYS, contributing to critical issues within our communities. Employment status is a complex public health issue related to multiple SDOH that play a crucial role in perpetuating health inequities. Individuals who are unemployed or unable to work encounter greater obstacles in achieving favorable health outcomes and accessing health care. Unemployment is associated with reduced access to health care services, and as the duration of unemployment increases, health behaviors and outcomes tend to worsen. Adverse health outcomes increase with the duration of unemployment, with the most severe effects observed among individuals unable to work. The unemployment rate is particularly elevated among Black individuals (9.4%) and those with a disability (14.1%), who are more likely to be unemployed or unable to work.[63,64]

Unemployment is a multifaceted issue influenced by various factors, including the evolving nature of work, a fluctuating labor market, insufficient enforcement of labor protection standards, a decline in unionization, and wage stagnation. These factors interact with several SDOH, further complicating the situation. The consequences of unemployment extend beyond financial strain, adversely affecting health and overall well-being. Collaborating with multidisciplinary partners will emphasize the significance of employment status and quality in addressing health disparities. Additionally, integrating workforce health and well-being into health, labor and economic development strategies across the state, local health departments, hospitals, and other organizations is crucial for promoting healthier communities. By focusing on equitable approaches to increase employment, NYS can promote sustainable economic growth, full and productive employment, and workforce health and well-being.

<table>
<tr><th colspan="6">SMART(IE) Objective:</th></tr>
<tr><td colspan="6">2.0 Reduce unemployment among individuals aged 16 years and older from 6.2% to 5.5%.
2.1 Reduce unemployment among <u>Black residents</u> from 9.3% to 7.9%.</td></tr>
<tr><th>Desired Outcome</th><th>Indicator</th><th>Data Source</th><th>Population</th><th>Baseline</th><th>Target</th></tr>
<tr><td rowspan="3">Decrease the percentage of people unemployed</td><td rowspan="3">Percentage unemployed</td><td rowspan="3">ACS</td><td>Everyone aged 16 years and older</td><td>6.2% (2018-2022)</td><td>5.5% (2030)</td></tr>
<tr><td>Subpopulation of Focus</td><td>Baseline</td><td>Target</td></tr>
<tr><td>Black residents (Aged 16 years and older)</td><td>9.3% (2018-2022)</td><td>7.9% (2030)</td></tr>
</table>

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** Engage in multi-sector collaborations that highlight the health burden of unemployment and underemployment and leverage these collaborations to create local pathways to meaningful employment. Strategies include identifying the partners and resources to develop job training programs and job opportunities that align with local labor market demands.[65-67] LHD H O	Everyone aged 16 or older	Ages 16+	Employment rate by age group and industry
 **Featured Intervention:** Collaborate on developing training and outreach programs with health care professionals, hospitals, and educational organizations to recruit and train health educators, patient advocates, community health workers, care coordinators, health coaches, and health promotion coordinators. Examples include: • Partner engagement, communication, and employer partnerships to evaluate the community health care needs and health care workforce • Include direct connections to local departments of social services to engage individuals on public assistance and Supplemental Nutrition Assistance Program (SNAP) in these career pathways opportunities[68,69] LHD H O	Everyone aged 16 or older	Ages 16+	Participation rate among organizations of focus, number of outreach events, number of individuals reached, number of individuals recruited (striated by occupation)
 Revise hiring requirements for positions to move away from unnecessary and costly degree inflation and align workers with employer needs and job opportunities. Examples include: • Limit artificial degree requirements • Promote skills-based hiring • Allow employers to ask more open questions not inhibited by Equal Employment Opportunity Commission (EEOC)[70,71] • H O	Employers and potential health care workers	N/A	Participation rate among organizations of focus, employee recruitment metrics among organizations of focus, local employment rates

Interventions	Population of Focus	Age Range	Intermediate Measures
 Provide training on inclusive employment practices to employers and co-workers to ensure that people with intellectual and developmental disabilities experience a supportive working environment.[72] LHD H O	Employers	N/A	Number of employers offering training on working with Intellectual and Developmental Disabilities (IDD) individuals, number of new trainings created to fulfill this need
 Promote and/or participate with the NYS Youth Jobs Program to increase opportunities for young people entering the workforce and to offer guidance and resources on how to apply.[73] LHD H O	Unemployed or underemployed 16- to 24-year-olds	Ages 16-24	Number of businesses signing up for the NYS Youth Jobs Program, number of youth referrals made to the Program at hospitals, number of youth applying for the Program
 Provide comprehensive employer benefits navigation (e.g., insurance selection, flexible spending, health savings accounts, paid time off request, etc.) to employees earning wages up to 200% of the Federal Poverty Line.[49,74,75] LHD H O	Workforce earning under 200% FPL; Employers	Ages 16-64	Number of individuals enrolled in social services programs, number of individuals enrolled in Flexible Spending and Health Savings Accounts, number of individuals with employer-sponsored health insurance
 Provide digital literacy training and community outreach to address the adoption barrier of internet utilization among the aging population and low-income households.[76] LHD O	Rural and urban low-income communities and aging population with new broadband connections	All ages	Number of literacy programs, number of trainings administered, number of students served
 Strengthen partnerships among health care employers, Boards of Cooperative Educational Services (BOCES) programs, high schools, and community colleges to expand training, apprenticeships and employment opportunities for entry-level careers. Examples include: • Home health aide • Community Health Worker (CHW) • Licensed practical nurse (LPN) • Dental assistants/hygienist • Direct support staff	Everyone aged 16 or older	Ages 16+	Participation rate among organizations of focus, number of graduates from health training/schools, number of new hires, interns, and apprenticeships for entry-level health positions

Interventions	Population of Focus	Age Range	Intermediate Measures
Strategies would include establishing provisional certifications in the health care field, curriculum design, and collaboration on community outreach and communication.[68,69, 77] LHD H O			
 Collaborate with local schools and nonprofit organizations to promote high school completion programs that offer mentoring, counseling, vocational training, and supplemental academic services.[78-81] LHD O	At-risk youth; new Americans	High school age	Participation rate among organizations of focus, number of students receiving high school diplomas or High School Equivalency diplomas
 Develop an internship pilot program for disabled adults aged 18 to 35 who have transitioned into adulthood. Examples include: • Life-skills training (e.g., Living Well in the Community) • Navigation to support services (e.g., Medicaid, Social Security disability insurance (SSDI), SNAP) • Employment skills and how to engage/behave in the work and navigating transportation[82, 83] LHD O	Young people with learning disabilities	Ages 16+	Number of people served by pilot program, number of intern and/or employment placements among participants
 Develop a community investment strategy to improve health and health disparities by leveraging economic and social capital to generate living wage jobs in the community by partnering with medical centers, university hospitals, and centers for excellence. Strategies include: • Build employment opportunities and economic stability by hiring local candidates at a living wage • Invest financially in job training and workforce development • Utilize business operations to improve community health by supporting the local economies These anchor strategies include efforts such as: hiring locally, building and contracting with local businesses, and local investing.[84-87] LHD H	N/A	N/A	Participation rate among organizations of focus, number of new jobs generated, unemployment rate, poverty indicators for the community (Behavioral Risk Factor Surveillance System (BRFSS), US Census).

Lead Partner Agencies and Organizations

NYS Department of Labor
NYS Office of Temporary and Disability Assistance
NYS Department of Health (Office of Health Insurance Programs, Office of Public Health)
NYS Department of Taxation and Finance
NYS Education Department
Secondary and postsecondary schools
Health care providers, health plans, insurance brokers
Trade unions, local businesses
Local libraries, NorthStar Digital Literacy Program, NYPL TechConnect, Education Trust-New York, Alianza Dropout Prevention - Catholic Charities Community Services
Center for Community Investment, Philanthropic foundations

Implementation Resources

New York Youths Job Program

Work for Success (WFS) Program

Worker Adjustment and Retraining Notification (WARN)

State Education Department: Adult Career and Continuing Education Services (ACCES-VR)

ConnectALL

Promise Neighborhoods

Center for Community Investment Philanthropic foundations

Priority: Nutrition Security

Goal: Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.

What is Nutrition Security and Why is it Important?

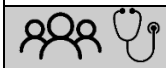
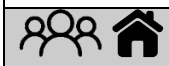
Consistent access to affordable, healthy food is an important factor in reducing hunger and preventing chronic disease, especially for vulnerable populations at high risk for nutrition-related health disparities. Nutritious food promotes healthy child development and aging and improves health outcomes across the lifespan. Geographic location, cost, time, and transportation all play a role in food accessibility and can contribute to households experiencing temporary or long-term periods of food insecurity. In 2021, approximately 3 in 4 (75.1%) of NYS adults rarely or never worried about accessing adequate food and 1 in 4 (24.9%) adults indicated that they were always, usually, or sometimes worried or stressed about having enough money to buy nutritious meals.[88] The United States Department of Agriculture (USDA) defines food security as having access, at all times, to enough food for an active, healthy life, while food insecurity is characterized by limited or uncertain access to adequate food due to limited economic resources.[89] The definition for nutrition security goes a step further, ensuring that all people have consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being.[90]

Food insecurity disproportionately impacts certain populations. Based on a 2021 NYS survey, the prevalence of reported food insecurity was higher among Hispanic adults (44.0%), Black, non-Hispanic adults (33.1%), women (26.7%), adults with a household income less than $25,000 (51.9%), those with less than a high school degree (49.7%), and those who were unemployed (46.5%).[88] Disparities are also seen in many low-income neighborhoods, rural and remote areas, and urban communities, often due to a lack of full-service supermarkets and a pervasiveness of corner shops and convenience stores that offer higher prices and less variety, as well as fast food or fast casual eateries that sell food high in calories, fat, and sodium.[91] Strategies to address food insecurity include expanding food access points, increasing child and adult enrollment in government nutrition programs, implementing strong nutrition standards in different settings (e.g., schools, emergency food programs, worksites, etc.), and championing innovative practices, such as produce prescription programs. By leveraging these strategies to address systems, policies, and structural barriers, NYS can reduce food insecurity and support individuals in achieving and maintaining a healthy lifestyle.

SMART(IE) Objective:					
3.0 Increase consistent household food security from 71.1% to 75.9%. **3.1 Increase food security in households with an annual total income of less than $25,000 from 42% to 51.1%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase household food security	Percentage of adults that were food secure in the past 12 months, aged 18 years and older	BRFSS	Households experiencing food insecurity	71.1% (2023)	75.9% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Households with an annual income of less than $25,000	42% (2023)	51.1% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs. Examples include: • Emergency food programs/food pantries • Supplemental Nutrition Assistance Program (SNAP) • Women, Infants, and Children (WIC) • National School Lunch Program • School Breakfast Program • Summer Food Service Program • Meals on Wheels • Medically Tailored Meals • Food Prescription Programs[92] LHD H O	Everyone	All ages	Number of health practices and facilities that screen for food insecurity and facilitate referrals to supportive services, percent of eligible individuals in New York participating in SNAP, percent of eligible individuals in New York participating in WIC USDA Program Data Site: SNAP, WIC, School Lunch NYS OTDA Monthly Caseload Statistics Food and Nutrition Service Data Visualization

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** Expand or create access points to get affordable, high quality, nutritious food. Examples include: • Emergency food programs/food pantries • Farmers' markets • Colleges/schools • Community-based organizations • Mobile fruit and vegetable markets • Online grocery purchasing pilots/programs for SNAP and WIC • Community gardens • Food hubs • Community supported agriculture • Hospitals • Healthy corner/convenience stores[93-96] LHD H O	Adults	Ages 18+	Number of supermarkets, corner stores, and retail food stores in underserved communities/regions, number of farm stands and farmers' markets, number of emergency food programs, number of food cooperatives and community gardens Food Access Research Atlas Retail Food Stores - data.ny.gov
 Promote student participation in the National School Lunch Program (NSLP) and School Breakfast Program (SBP) through innovative strategies, such as Healthy School Meals for All, Community Eligibility, Provision 2, alternative breakfast models, and restricting sales of competitive foods.[97-103] O	Children, adolescents	Ages 5-18	Average daily student participation in the NSLP, average daily student participation in the SBP Food and Nutrition Service Data Visualization NYSED Child Nutrition Management System
 Implement values-based food procurement practices, such as increasing food purchases from NYS farms and from minority and women-owned businesses, to create a more equitable, accountable, and transparent food system.[104,105] LHD H O	Adults	Ages 18+	Amount of money spent on food from minority and women-owned business enterprises (M/WBE), amount of money spent on food items that were either grown, processed, manufactured, or distributed by business enterprises located within New York State NYC Food Policy Purchasing
 Implement nutrition standards and food service guidelines for meals and snacks served in facilities, worksites, and institutions (e.g., vending machine options, meals served in cafeterias, etc.).[106-108] LHD H O	Adults	Ages 18+	Number of hospitals that implement nutrition standards for meals and snacks served

Interventions	Population of Focus	Age Range	Intermediate Measures
 Promote and support enrollment in nutrition programs that improve the quality of meals and snacks served in early learning and childcare settings (e.g., Child and Adult Care Food Program, Eat Well Play Hard in Child Care Settings, Farm to Early Care and Education).[109] O	Children	Ages 0-4	Number of early care and education sites that implement nutrition policies and practices Child and Adult Care Food Program Participation The Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC)
 Expand Food as Medicine approaches across the lifespan, especially for populations at a higher risk of nutrition-related health disparities (e.g., medically tailored meals and groceries, produce prescription programs, etc.).[110] H O	Individuals with complex, nutrition-sensitive chronic diseases and high health care utilization	All ages	Number of health care facilities and health insurance plans that self-report implementing a Food as Medicine initiative/program
 Promote and expand the availability of fruit and vegetable incentive programs.[111-115] LHD H O	Everyone	Ages 18+	Number of programs that adopt policies and practices to increase consumption of fruits and vegetables How to Run a Nutrition Incentive Network- PAGE 34, 47, APPENDICES
 Implement healthy food and nutrition guidelines (e.g., Healthy Eating Research (HER) Guidelines, Hunger Prevention and Nutrition Assistance Program (HPNAP) nutrition standards) to improve the quality of foods offered within the charitable food system (e.g., food banks, food pantries, community kitchens, emergency shelters, etc.).[116-117] LHD O	People who access emergency food relief organizations (EFROs)	Ages 18+	Number of HPNAP sites Health Data NY: HPNAP Sites
 Implement periodic community needs assessments to prioritize the development of nutrition programs in high-risk areas.[118-120] O	Everyone	All ages	Track data collected and collection methods for need assessments

Interventions	Population of Focus	Age Range	Intermediate Measures
 Promote Farm to School networks and edible school gardens to increase access to fruits and vegetables in schools.[121] O	Children, adolescents	Ages 5-18	Number of schools that have edible school gardens, number of schools that received food from NYS farms

Lead Partner Agencies and Organizations

NYS Department of Health
- Division of Nutrition
- Hunger Prevention Nutrition Assistance Program (HPNAP)
- Women, Infants, and Children (WIC)
- Child and Adult Care Food Program (CACFP)
- Eat Well Play Hard (EWPH)
- State Physical Activity and Nutrition Programs

NYS Education Department
- Division of Child Nutrition
- National School Lunch Program
- School Breakfast Program
- Summer Food Service Program
- Afterschool Snack Program
- Farm to School
- Special Milk Program
- Fresh Fruit and Vegetable Program

NYS Office of Temporary and Disability Assistance
- Supplemental Nutrition Assistance Program (SNAP)
- Summer EBT
- SNAP-Ed
- Restaurant Meals Program
- Double Up Food Bucks
- NY Fresh Connect Checks

NYS Office for the Aging
- Community Dining
- Home-delivered meals
- Senior Farmers' Market Nutrition Program
- Local offices for the aging

NYS Department of Agriculture and Markets
- Council on Hunger and Food Policy NYC Department of Health and Mental Hygiene
- NYC Health and Hospitals Corporation
- GrowNYC
- The Alliance for a Hunger Free New York
- Cornell Cooperative Extension

Implementation Resources

Patrick Leahy Farm to School Grant Program

NYS Department of Agriculture and Markets Farm-to-School

Cornell Cooperative Extension

The Alliance for a Hunger Free New York

Priority: Housing Stability and Affordability

Goal: Foster reliable and equitable access to safe, affordable, and secure housing options.

What is Housing Stability and Affordability and Why is it Important?

Housing insecurity is defined as unstable housing conditions due to factors such as affordability, safety, or reliable occupancy. These conditions can arise from environmental issues like lead piping or asbestos-containing materials in the home, career and life changes, and unstable housing due to overcrowding or risk of eviction. The risks of unstable housing can interfere with an individual's ability to choose appropriate health care and other basic needs because they need to prioritize housing costs. Addressing housing security and affordability in NYS is essential to decreasing homelessness, decreasing physically inadequate housing, and decreasing illness and injury caused by unsafe living spaces and the inability to afford proper medical treatment.

According to the United Way's United for ALICE (Asset Limited, Income Constrained, Employed) Research Center in 2022, 15% of the households in NYS earned an income below the Federal Poverty Level (FPL).[122] The ALICE threshold is defined as "earning more than the FPL, but not enough to afford the basics where they live," and 31% of NYS households were considered ALICE. Considering the cost of housing has risen 50% - 80% since 2015,[123] and out of 3 million people, these increased housing costs require more than 30% of their household income,[124] this poses a significant housing burden on residents.

Low-income families, racial and ethnic minorities, and other vulnerable populations such as older adults, often experience a disproportionate housing burden. According to the Healthcare Value Hub, Black and Hispanic populations who live in low-income areas are also more likely to experience higher levels of stress and illness than Caucasian populations,[125] which indicates that social disparities continue to deepen health inequities. By focusing on public health interventions that address unmet housing needs, NYS can improve health outcomes for the populations most in need.

SMART(IE) Objective:					
4.0 Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000. **4.1 Increase the percentage of adults, with an annual income of less than $25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the proportion of people who receive housing assistance.	Number of people living in HUD-subsidized housing in the past 12 months.	U.S. Department of Housing and Urban Development (HUD)	All low-income households	987,957 (2023)	1,092,000 (2030)
	Subpopulation Indicator	**Data Source**	**Subpopulation of Focus**	**Baseline**	**Target**
	Percentage of adults who were able to pay their mortgage, rent, or utility bills in the past 12 months, aged 18 years and older.	BRFSS	Adults with an annual total income of less than $25,000	85.1% (2022)	89.4% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Provide standardized screening for unmet Housing Security and Affordability needs to improve overall access.[40,92,126] H O	Medicaid members	All ages	Number of households and individuals screened, number of successful referrals made
Featured Intervention: Refer housing insecure individuals to state, local, and federal benefit programs and community-based health-related social needs providers to address unmet needs (e.g., Temporary Assistance for Needy Families (TANF), Home Energy Assistance Program (HEAP), Medical Respite programs, Home Modification services, etc.).[92] O	Medicaid members	All ages	Number of households and individuals screened, number of successful referrals made
Improve access to housing discrimination complaint forms by promoting the online	Adults in underserved populations	Ages 18+	Participation rate among community businesses and health care organizations, number of website visits

Interventions	Population of Focus	Age Range	Intermediate Measures
platform using quick-response (QR) codes in physical documentation and increasing the community businesses and medical facilities that keep the physical forms onsite.[127,128] H O	(Black, Indigenous, and People of Color (BIPOC), Low-income, disabled)		from QR codes, utilization rate of complaint forms
Distribute "Healthy Home Kits" and provide education on the items contained in them. Examples include: • Radon detectors • Mold test kits • Carbon monoxide detectors • Nontoxic cleaning supplies • Guidance materials on reducing indoor pollutants, private well water contaminants, and state programs that assist with environmental testing[129-131] LHD O	Adults in underserved populations (BIPOC, Low-income, disabled)	Ages 18+	Number of kits distributed, number of test results submitted, number of follow-up communications, number of referrals made to further testing and remediation services
Promote and provide incentives to increase the mandatory testing for contaminants in rental properties before leasing.[131-133] LHD O	Everyone	All ages	Number of tests performed, number/amount of incentives distributed
Improve knowledge of and access to community land trusts in rural populations that decrease mortgage payments and cost burdens to low- and middle-income families.[134,135] O	Adults in rural, low-income neighborhoods	Ages 18+	Number of families and individuals from focus population served, value of cost burdens alleviated
Support the rehabilitation and preservation of United States Department of Agriculture (USDA) Section 515 properties across the state.[136,137] O	Underserved populations (BIPOC, Low-income, disabled)	All ages	Number of applications submitted, number of applications approved, number of habitable housing units made available, number of people housed

Interventions	Population of Focus	Age Range	Intermediate Measures
 Enhance and grow existing New York State initiatives like the Empire State Poverty Reduction Initiative to improve access to the amount of home rehabilitation loans for low-income families to help ease the burden of home repairs that go beyond just lead rehabilitation.[131] LHD O	Low-income families	All ages	Number of applications submitted, number of applications approved, number of homes rehabilitated, value of cost burden alleviated
 Conduct a community assessment regarding awareness of programs available that assist with rental and home rehabilitation costs (and provide navigation supports).[138,139] LHD H O	Everyone	All ages	Track data collected and collection methods for assessments, periodic measures re: utilization rates of available programs
 Advance fair and equitable emergency/disaster recovery efforts by providing improved access to the National Low Income Housing Coalition (NLIHC)'s Disaster Housing Recovery Coalition and its resources and adding more NYS representation within the Coalition.[139] LHD O	Low-income families	All ages	Number of communities and/or local organizations participating in Coalition, number of households and individuals represented in Coalition
 Identify funding for community providers to decrease staffing shortages to improve the quality of services offered and decrease housing waitlists.[77, 140-142] O	Everyone	All ages	Amount of funding procured, staffing rate trends, housing waitlist length trends
 Improve potable drinking water systems by continuing to upgrade the physical structures, facilities, and networks to meet Safe Drinking Water Act regulations.[143] LHD O	Everyone	All ages	Proportion of local structures, facilities, and networks that meet regulations, number of structures upgraded

Interventions	Population of Focus	Age Range	Intermediate Measures
Increase collaboration with local health departments (LHDs) to provide resources and education materials that increase the amount of compliant commercial cooling towers in areas with priority and vulnerable populations. LHDs are already responsible for managing the cooling tower program within their counties, though they have limited funding.[144] LHD O	All communities	All ages	Number of cooling towers available to priorities and populations, number of new cooling towers installed
Collaborate with new and current partners to increase access to safe and affordable housing. These partnerships would: • Provide access to funding that helps rural, low-income families improve their water quality through purchasing filtration systems • Bring awareness to veterans about the NYS housing grants that exist for emergency rent, mortgage payments, and back taxes • Establish a connection with the Division of Housing and Community Renewal • Provide access to legal services in hospitals if patients are facing eviction or landlords • Improve access to housing security and affordability services[14, 127,128] O	Everyone	All ages	Amount of funding procured, participation rate among hospitals and other organizations in providing access to housing support services, number of people referred to needed services, utilization rate of affordable housing services (can track data separately for utilization of NYS housing grants for veterans, legal services, remediation services, housing security assistance services, etc.)

Lead Partner Agencies and Organizations

U.S. Environmental Protection Agency (EPA)
- Renovation, Repair, and Painting Rule (RRP)
- Lead-Based Paint Activities (Abatement) programs
- EPA Environmental Justice Thriving Grantmaking Program
- National Healthy Housing Standard

NYS Office of the Attorney General
NYS Division of Human Rights
NYS Department of Veterans' Services
NYS Office of Temporary and Disability Assistance
- Emergency Rental Assistance Program
- Landlord Rental Assistance Program
- Housing and Support Services

NYS Housing Authority
- Section 8

NYS Department of Environmental Conservation
NYS Homes and Community Renewal
NYC Housing Authority
Local Departments of Social Services
Fair Housing Justice Center
Housing Opportunities Made Equal
Housing Justice for All
Housing Conference
Coalition for the Homeless
NYS Tenants and Neighbors
Association for Neighborhood and Housing Development
NY Rural Area Water Association
Cornell Cooperative Extension
New York State CLT Network
New Economy Project
Enterprise Community Partners
Urban Homesteading Assistance Board (UHAB)
Community Development Block Grants

Implementation Resources

DSRIP 1115 Waiver Concept Paper

U.S. Department of Housing and Urban Development (HUD) Fair Housing and Equal Opportunity

HUD - Housing Discrimination Under the Fair Housing Act

HUD Language Access Plan

Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities Social Care Needs Screening Tool

American Lung Association Radon Action Plan

Urban Institute - Leveraging the Built Environment for Health Equity

County Health Rankings and Roadmaps - Healthy Home Environment Assessments

County Health Rankings and Roadmaps - Community Land Trusts

National Center for Healthy Housing - National Healthy Housing Standard

Regional Plan Association - Rural New Yorkers at Risk

National Association of Realtors - The Importance of Community Engagement in Zoning Reform

Robert Wood Johnson Foundation - How Home Affects Health

National Low Income Housing Coalition - The Solution

NYS OTDA - Emergency Rental Assistance Program (ERAP)

The Legal Aid Society - Housing, Foreclosure & Homelessness

NYS Homes and Community Renewal - Division of Housing and Community Renewal

University of Notre Dame Lab for Economic Opportunities - Lessons Learned: HUD-VASH

Homelessness Research Institute - Working in Homeless Services: A Survey in the Field

Healthy People 2030 - Safe Drinking Water Information System (SDWIS)

World Health Organization (WHO) - Drinking Water

NYS Homes and Community Renewal - Residential Emergency Services to Offer (Home) Repairs to the Elderly (RESTORE) Program

NYS Homes and Community Renewal - Access to Home Program

AARP Livability Index

Domain 2:
Social and Community Context

Priorities:

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

Priority: Anxiety and Stress

Goal: Increase the proportion of people living in New York who show resilience to challenges and stress.

What is Anxiety and Stress and Why is it Important?

Mental health refers to the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.[145] Stressful circumstances can make people feel worried, anxious, and unable to cope.[146] Chronic stress leads to overactivation of the "fight or flight" response and can have negative effects on organ systems in the body. Stress can also contribute to mental and behavioral health challenges, including depression, anxiety, suicidal ideation, and substance misuse.[147] Anxiety is anticipation of a future threat and can be associated with muscle tension and vigilance in preparation for future behavior and cautious or avoidant behaviors.[148]

Persistent anxiety and stress can increase the chances of poor mental health and lead to premature death.[146] NYS has seen an increasing trend of frequent mental distress since 2016, reaching a rate of 15.9% in 2022. In 2021, frequent mental distress affected a notably higher percentage of adults with a household income of less than $25,000 (21.0%) and an even higher percentage of adults with a disability (30.5%).[149] By promoting opportunities for increased focus on anxiety and stress, NYS can address overall mental health and well-being in populations most at need.

SMART(IE) Objective:

5.0 Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0%.
5.1 Decrease the percentage of adults in households with an annual income of less than $25,000 who experience frequent mental distress from 21.0% to 18.9%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce the prevalence of anxiety and stress	Percentage of adults experiencing frequent mental distress during the past month, age-adjusted, aged 18 years and older	BRFSS	Adults	13.4% (2021)	12.0% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Adults with household income less than $25,000	21.0% (2021)	18.9% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Promote and increase awareness of evidence-based mindfulness resources to reduce the negative impact of stress and trauma.[150-152] LHD H O	Everyone	All ages	Manner of outreach and data re: reach of intervention (e.g., number of outreach events, number of flyers distributed, number of website visits)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Implement and promote Mental Health First Aid course training.[153,154] LHD H O	Everyone	All ages	Number of trainings delivered; number of people trained
Promote awareness and use of screening through social care networks (SCNs).[155] LHD O	Everyone	All ages	Participation rate among SCNs, number of families and individuals screened, number of successful referrals made as a result of screening
Promote and implement models that screen people for stress, anxiety, and their social needs. Two models that may be used are Community Mental Health Promotion and Support (COMHPS) and ENGAGE.[156,157] LHD O	Everyone	All ages	Participation rate among organizations of focus, number of people screened, number of successful referrals made to needed services as a result of screening
Promote resilience-building strategies for people living with chronic illness by enhancing protective factors, such as: • Independence • Social support • Positive explanatory styles • Self-care • Self-esteem • Reduced anxiety[158] LHD H O	People living with chronic illness	All ages	Manner of outreach and data re: reach of intervention (e.g., number of outreach events and attendees, number of flyers distributed, number of website visits, number of people trained)
Promote and expand school-based social-emotional learning (SEL) to teach youth skills needed to handle stress, resolve conflicts, and manage emotions and behaviors. Programs include: • Positive Action • Second Step • The Good Behavior Game • Promoting Alternative Thinking Strategies (PATHS)[159-163] O	School-age youth	School-age youth	Participation rate among schools, number of students receiving SEL education

Lead Partner Agencies and Organizations

NYS Department of Health
NYS Office of Mental Health
NYS Office of Addiction Services and Supports (OASAS)
NYS Education Department
New York State Trauma Informed Network and Resource Center
Mental Health Association of New York State (MHANYS)

Implementation Resources

NYS Office for Mental Health (OMH)

NYS OMH - Mental Health First Aid

Community Mental Health Promotion and Support (COMPHS)

Columbia University Department of Psychiatry - ENGAGE

NYS Trauma Informed Network (TIN) and Resource Center

NYS TIN and Resource Center - Breath-Body-Mind

Mental Health Association of New York State (MHANYS)

NYS Office of Addiction Services and Supports (OASAS)

NYS Education Department (NYSED)

Priority: Suicide

Goal: Prevent suicides.

What is Suicide and Why is it Important?

Suicide is death caused by injuring oneself with the intent to die. It was the 11th leading cause of death overall in the US in 2022, and the second among individuals aged 10-34. Approximately 16 million Americans seriously considered suicide in 2023.[164]

One of the highest priorities in NYS is to save lives and reduce the devastating impact of suicide on individuals, families, and communities. In 2022, there were 9.0 suicides per every 100,000 individuals in NYS, leaving the state with the third lowest suicide rate in the nation. Suicide was the third leading cause of death among 15- to 24-year-olds in NYS.[165] In 2023, 18.5% of high schoolers in NYS reported seriously considering suicide during the previous 12 months and 10.9% reported attempting suicide.[166] But the tragedy of suicide goes well beyond the statistics, because each death is someone's parent, child, family member, friend, or colleague, casting a long shadow.

By promoting opportunities for public health, health care systems, and community organizations to work together, NYS can support collaborative efforts to prevent suicide, provide support for those at risk, and follow a framework for long-term solutions.

SMART(IE) Objective:

6.0 Reduce the suicide mortality rate from 7.9% to 6.7%.
6.1 Reduce adolescent suicide attempts from 13.6% to 12.2% (New York City).
6.2 Reduce adolescent suicide attempts from 9.4% to 8.5% (New York State outside New York City).

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Reduce suicide deaths	Suicide mortality, age-adjusted rate per 100,000 population	NYS Vital Records	Everyone	7.9% (2021)	6.7% (2030)
	Subpopulation Indicator #1	**Data Source**	**Subpopulation of Focus**	**Baseline**	**Target**
	Percentage of high school students who attempted suicide one or more times during the past year (New York City)	YRBSS (Youth Behavioral Risk Surveillance System)	High school students (New York City)	13.6% (2023)	12.2% (2030)
	Subpopulation Indicator #2	**Data Source**	**Subpopulation of Focus**	**Baseline**	**Target**
	Percentage of high school students who attempted suicide one or more times during the past year (New York State outside New York City)	YRBSS	High school students (New York State outside New York City)	9.4% (2023)	8.5% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Promote evidence-based, connection-building programs across the lifespan such as: • NY CARES UP, an initiative focused on improving the mental health and wellness of uniformed personnel and Veterans • Hope Squad, a school-based, peer-to-peer, suicide prevention program • Life is Precious, a "home away from home" for Latina teens. • Sources of Strength, a peer-to-peer suicide prevention program[167-171] O	Everyone	All ages	Participation rate in promoted programs among host organizations, manner of promotion and data re: reach (number of flyers distributed, number of website visits), Number of people provided with education
 **Featured Interventions:** Implement suicide safer care services and protocols (Zero Suicide) in health care settings to effectively identify, engage, treat, and follow up with individuals at elevated suicide risk.[172] H	Everyone	All ages	Participation rate among health care organizations, number of trainings delivered to health care staff, capacity of health care staff to follow protocols
 Provide training on suicide prevention for community members, organizations, and other groups to identify and respond to people who may be at risk of suicide.[173-175] LHD H O	Adults	Ages 18+	Number of trainings provided, number of people trained
 Promote the use and implementation of Social-Emotional Learning (SEL) programs in elementary and early education settings for resilience and emotional regulation, particularly in schools serving high-needs students.[176] LHD O	School-age youth	School-age youth	Participation rate among early and elementary education settings, number of students receiving SEL education

Interventions	Population of Focus	Age Range	Intermediate Measures
 Improve availability and access to culturally relevant information on suicide prevention and community resources, especially in underserved and historically marginalized communities.[177-178] LHD H O	Everyone	Ages 16+	Participation among CBOs in promotion activities, manner of promotion activities and data on reach (number of outreach events, number of attendees, number of flyers distributed, number of website clicks, etc.)
 Promote calling or texting 988 through social media, digital marketing campaigns, and other utilized marketing strategies.[179-181] LHD H O	Everyone	All ages	Data on reach of promotion strategy (e.g., number of views, number of website visits, source of website visits, etc.)
 Review, revise, and disseminate policies, programs, and best practices that put time and space between a person at risk and a lethal means of suicide.[182-187] LHD H O	Everyone	All ages	Participation among local organizations, capacity of organizations to implement necessary policies, programs, and best practices
 Promote and conduct comprehensive suicide prevention training for staff.[172] H O	Health care staff	N/A	Participation among health care organizations, number of trainings delivered, number of staff trained capacity of staff to implement skills gained from training

Lead Partner Agencies and Organizations

NYS Department of Health
NYS Office of Mental Health
NYS Education Department
NYS Office for Addiction Services and Supports
NYS Department of Transportation

Implementation Resources

New York State Education Department - Social Emotional Learning

Suicide Prevention Center of NY - A Guide for Suicide Prevention In New York Schools

Comunilife - Life Is Precious, A Latina Suicide Prevention Program

Sources of Strength

NY CARES UP

Hope Squad Peer-to-Peer Suicide Prevention

Priority: Depression

Goal: Increase screening and treatment for depression in order to decrease prevalence.

What is Depression and Why is it Important?

Depression (also known as depressive disorder) is a common mental disorder that involves a depressed mood or loss of pleasure or interest in activities for long periods of time. it is a significant mental health issue in NYS, affecting a substantial portion of the population and leading to considerable personal and economic challenges. According to the New York State Department of Health, mental disorders are both common and disabling, with more than one in 5 individuals in NYS experiencing symptoms of a mental disorder annually. Notably, one in ten adults and children face mental health challenges severe enough to impair their daily functioning in work, family, and school settings.[188]

The prevalence of depression varies across different groups. For individuals in Black, Indigenous, and People of Color (BIPOC) communities, there is an increased risk of Post Traumatic Stress Disorder (PTSD), depression, and substance use due to chronic experiences of stress, threats, and violent events that occur in direct relation to race and aspects of identity.[189] NYS' maternal mental health crisis is also driving an alarming racial disparity in maternal mortality that disproportionately affects Black individuals in NYS.[190] Black communities are at greater risk for poor maternal mental health outcomes due to the concept of "weathering" or the deterioration of wellness from chronic exposure to stress.[191] For example, Black birthing persons experienced higher rates of COVID-related anxiety and depression and reported more concerns about childbirth and childcare.[192]

Despite the availability of effective treatments, barriers such as stigma, discrimination, and limited access to care prevent many individuals from seeking help. By promoting opportunities to increase awareness, reduce stigma, and improve access to mental health services, particularly for populations disproportionately affected, NYS can provide an effective, comprehensive approach to addressing poor health outcomes associated with depression.

SMART(IE) Objective:					
7.0 Reduce the percentage of adults with a major depressive episode during the past year from 6.7% to 5.7%. **7.1 Increase the percentage of postpartum birthing persons who seek counseling after being told they have depression from 53.1% to 62.0%.** **7.2 Increase the percentage of postpartum birthing persons who receive a medication prescription after being told they have depression from 61.7% to 70.0%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Reduce the percentage of adults with major depressive episodes	Percentage of adults with major depressive episodes during the past year, aged 18 years and older	National Survey on Drug Use and Health (NSDUH)	Adults	6.7% (2021-2022)	5.7% (2030)
	Subpopulation Indicators	**Data Source**	**Subpopulation of Focus**	**Baseline**	**Target**
	Percentage of birthing persons who were identified as having depression after birth who received counseling for depression	Pregnancy Risk Assessment Monitoring System (PRAMS)	Postpartum birthing persons	53.1% (2022)	62.0% (2030)
	Percentage of birthing persons who were identified as having depression after birth who took a prescription medicine			61.7% (2022)	70.0% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Implement and promote Mental Health First Aid (MHFA) training in communities and health care settings.[153] LHD H O	Everyone	All ages	Number of organizations that implement MHFA in the next 2 years
Featured Intervention: Implement a collaborative care model to ensure that individuals with depression receive treatment.[193-194]	Everyone	All ages	Participation among health care organizations, number of people receiving care through collaborative care model

Interventions	Population of Focus	Age Range	Intermediate Measures
LHD H			
 Promote the implementation of Social-Emotional Learning (SEL) programs in elementary and early education settings for resilience and emotional regulation, particularly in schools serving high-needs students. This can be achieved by using evidence-based curriculum and staff professional development.[159,163] O	School-age children	Ages 4-18	Academic performance (grades, test scores, attendance, and homework completion), SEL skills, Attitudes, Positive social behavior, Conduct problems (Child Behavior Checklist), Emotional distress (Children's Manifest Anxiety Scale)
 Integrate behavioral health into primary care by: • Promoting the use of standardized screening tools • Marketing the availability of enhanced reimbursement rates • Expanding thresholds available to primary care providers who provide behavioral health services[195-196] LHD H O	Everyone	All ages	Number of primary care settings implementing new behavioral health screenings or treatments

Lead Partner Agencies and Organizations

NYS Education Department
NYS Department of Health
NYS Office of Mental Health
Greater New York Hospital Association (GNYHA)
Mental Health Association of New York State (MHANYS)

Implementation Resources

NYS Office of Mental Health - Mental Health First Aid

The Academy for Integrating Behavioral Health and Primary Care | Agency for Healthcare Research and Quality

Substance Abuse and Mental Health Services Administration (SAMHSA)

Primary Care Team LEAP - Improving Primary Care Team Guide

PRAMS Data | PRAMS | CDC

Priority: Primary Prevention, Substance Misuse, and Overdose Prevention

Goal: Reduce substance use, misuse, overdose and/or associated harms.

What is Primary Prevention, Substance Misuse, and Overdose Prevention and Why is it Important?

Substance use, misuse, and overdose mortality are persistent public health challenges in NYS and have lasting negative social, medical, and economic outcomes across the life span.

Early initiation of alcohol use, social access and availability of substances including alcohol, prescription medications, and cannabis are recognized as contributing factors for youth substance use and misuse and the development of substance use disorder later in life.[197] Mediating these factors at the individual, family, and community-levels can greatly reduce the development of problematic substance use and its associated harms.[198] Well-supported scientific evidence demonstrates that factors influencing substance use and misuse can be positively moderated through the multi-pronged delivery of evidence-based primary, secondary and tertiary prevention practices.

Reducing access and availability of alcohol, cannabis, prescription drugs and other substances including opioids and stimulants through community-level policies and practices can effectively reduce substance use and decrease social norms favorable towards substance use.[199] Evidence-based environmental strategies such as reducing outlet density, monitoring prescriptions, providing lock boxes and drug destruction kits for cannabis and prescription medications provide opportunities to promote evidence-based community and individual level prevention strategies.

Additionally, it is critical to expand interventions and increase access to lifesaving treatments for youth, families and adults. Evidence-based programs such as Screening Brief Intervention and Referral to Treatment (SBIRT), Brief Screening and Intervention for College Students (BASICS) and Teen Intervene reduce the negative impact of alcohol and substance use and misuse across the life span.

The opioid epidemic continues to devastate communities nationwide, and in NYS disparities continue with increases in drug overdose deaths for Black non-Hispanic and Native Hawaiian or other Pacific Islanders non-Hispanic people between 2022 and 2023.[200] Using the data to focus on the most vulnerable populations will address disparities and help dismantle the inequities, stigma and disparities which contribute to this vulnerability.

Statewide naloxone availability is paramount for reversing the effects of opioids, like heroin and fentanyl. When administered in timely fashion, naloxone can mean the difference between life and death. Access to Food and Drug Administration-approved medications for the treatment of opioid use disorder, such as buprenorphine and methadone, is critical as they not only address the urge to use opioids, but they also reduce the risk of overdose. LHDs, hospitals, and community organizations can collaborate with their impacted communities to offer and initiate these medications, ensure there is no interruption in care. Employing people with lived and living experience of using drugs to expand innovative harm reduction services can provide lifesaving services to people who use alone and may overdose.[199]

By promoting the implementation of evidence-based and evidence-informed programs and interventions to address prevention priorities, NYS can ensure prevention services are accessible for vulnerable populations.

PRIMARY PREVENTION					
SMART Objective					
8.0 Reduce the percentage of high school students reporting alcohol use before the age of 13 from 17.2% to 15.5% (New York City). 8.1 Reduce the percentage of high school students reporting alcohol use before the age of 13 from 13.6% to 12.2% (New York State outside New York City).					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Decrease underage alcohol use	Percentage of high school students who had their first drink of alcohol before the age of 13 years (New York City)	YRBSS	High school students (New York City)	17.2% (2023)	15.5% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			High school students (New York State outside New York City)	13.6% (2023)	12.2% (2030)

PRIMARY PREVENTION					
SMART(IE) Objective					
9.0 Decrease episodes when an opioid-naïve patient received an initial opioid prescription, rate per 1,000 person-years from 86.5 to 77.9. 9.1 Decrease the <u>percentage of episodes when patients were opioid-naïve and received an opioid prescription of more than seven days</u> per 1,000 person-years from 15.1 to 13.6.					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Reduce exposure to opioid prescriptions and high-risk prescribing	Episodes when an opioid-naïve patient received an initial opioid prescription, rate per 1,000 person-years	New York Prescription Monitoring Program	Adults	86.5 (2023)	77.9 (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Patients who were opioid-naïve and received an opioid prescription of more than 7 days	15.1 (2023)	13.6 (2030)

SECONDARY PREVENTION					
SMART(IE) Objective					
10.0 Increase the number of unique individuals enrolled in OASAS treatment programs from 1,107.8 to 1,218.6. **10.1 Increase the number of unique individuals enrolled in OASAS treatment programs, who reported any opioid as the primary substance at admission from 465.2 to 511.7.** **10.2 Increase the number of unique individuals enrolled in OASAS treatment programs, who reported alcohol as the primary substance at admission from 402.8 to 443.1.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase treatment for substance use disorder	Unique individuals enrolled in OASAS treatment programs - rate per 100,000 population	OASAS Client Data System	People with Substance Use Disorder	1,107.8 (2023)	1,218.6 (2030)
			Subpopulation of Focus #1	**Baseline**	**Target**
			People with Substance Use Disorder who reported any opioid as the primary substance	465.2 (2023)	511.7 (2030)
			Subpopulation of Focus #2	**Baseline**	**Target**
			People with Substance Use Disorder who reported alcohol as the primary substance	402.8 (2023)	443.1 (2030)

SECONDARY PREVENTION					
SMART Objective:					
11.0 Increase the crude rate of patients per 100,000 population who received at least one buprenorphine prescription for opioid use disorder from 446.0 to 490.6.					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase treatment for SUD	Patients who received at least one buprenorphine prescription for opioid use disorder - crude rate per 100,000 population	New York Prescription Monitoring Program	People with Substance Use Disorder	446.0 (2023)	490.6 (2030)

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

TERTIARY PREVENTION					
SMART Objective:					
13.0 Increase the number of naloxone kits distributed from 397,620 to 596,430.					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Provide or increase access to naloxone to reduce overdose fatalities	Number of naloxone kits distributed (excluding NYC)	New York Community Opioid Overdose Prevention Program Dataset; New York Emergency Medical Services Data; New York Law Enforcement Naloxone Administration Dataset	Adults	397,620 (2023)	596,430 (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Provide or expand access to naloxone to reduce overdose fatalities.[200] LHD H O	Populations living in communities with high levels of alcohol retailer density (often under-resourced communities)	All ages	Population support for policy (NYS Chronic Disease Public Opinion Poll)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Expand universal implementation of Teen Intervene (TI) in primary care settings (e.g., pediatrician's offices).[201] LHD H O	Youth and young adults with problem substance use, families with substance use disorder	Youth and young adults	Number of schools and practitioners trained in Teen Intervene
Provide or expand access to Food and Drug Administration (FDA)-approved medications for opioid use disorder (OUD), such as buprenorphine and methadone, to reduce overdose fatalities, while encouraging institutions and community partners to initiate treatment and ensure continuity of care. Examples include: • Corrections and other criminal justice settings • Emergency departments and inpatient hospital settings • Emergency medical services • Nursing homes and long-term care facilities • Drug treatment • Community-based organizations • Primary care providers and other specialist services including obstetrics and gynecology (OBGYN)[200, 202-206] LHD H O	Everyone	All ages	Participation among local organizations of focus Number of people provided OUD medications
Support on-premises and off-premises alcohol and cannabis retailers to purchase and use ID scanners.[207] LHD O	Youth and young adults	Under age 21	YRBS & BRFSS questions on underage cannabis and alcohol use
Expand or promote access to lock bags and education for safe storage of medication and cannabis.[208] LHD O	General population, patients with controlled substances in need of safe disposal options	Adults over age 21	YRBS and BRFSS questions on access and availability

Interventions	Population of Focus	Age Range	Intermediate Measures
Implement a statewide environmental change strategy to increase the perception of harm from underage substance use.[209] LHD O	General population, parents, caregivers	Under age 21	YRBS and BRFSS questions on underage substance use and use under the age of 13 years
Offer evidence-based primary prevention family-focused programs to high-risk families accessing state or county-sponsored services.[210] LHD H O	Families, parents, caregivers	Adults	Participation rate among organizations providing services to population of focus Number of families served by intervention
Support the implementation of alcohol, cannabis and other substance screenings for high-risk youth and adults.[201] LHD O	Youth and young adults	Age 12+	BRFSS Screening and Brief Intervention and Referral to Treatment (SBIRT) module
Expand community-level prevention and substance misuse prevention coalitions.[211] LHD H O	Youth, young adults, high-risk communities	Age 12+	YRBS and BRFSS data & student-level survey data
Expansion of Primary Prevention Services in schools, school districts, and youth-based settings without primary prevention services.[212] LHD H O	Schools and communities without primary prevention services	Pre-K through high school	Participation rate among organizations of focus. Number of youth to whom primary prevention services are easily accessible
Expand Screening Brief Intervention and Referral to Treatment Services (SBIRT) across the life span.[213] LHD H O	Youth, adults with problem substance use	Age 12+	Medicaid reimbursement for SBIRT

Lead Partner Agencies and Organizations

NYS Department of Health
NYS Office of Mental Health
NYS Office for Addiction Services and Supports
NYS Office of Cannabis Management
NYS Liquor Authority
Substance Abuse and Mental Health Services Administration (SAMHSA)
Community Coalitions, Chambers of Commerce
Community pharmacies

Implementation Resources

NYS Department of Health (DOH) - Opioid Overdose Prevention Program

NYS DOH - Standing Order for Naloxone in Pharmacies

NYRx, the New York Medicaid Pharmacy Program

National Council for Mental Wellbeing - Tools for Overdose Prevention

SAMHSA - Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

National Academy for State Health Policy - Funding Options for States

OASAS - Opioid Settlement Funding Initiatives

Evidence Based Prevention Programs | Office of Addiction Services and Supports

Priority: Tobacco/E-Cigarette Use

Goal: Eliminate the harms caused by commercial tobacco product use and exposure.

What is Tobacco/E-Cigarette Use and Why is it Important?

Commercial tobacco use remains a leading preventable cause of death in NYS, responsible for over 30,000 deaths annually, resulting in $9.7 billion in health care costs. Tobacco use is associated with numerous health issues, including cancer, heart disease, stroke, chronic obstructive pulmonary disease, and complications during pregnancy. Secondhand smoke exposure further contributes to preventable illnesses and deaths.

Despite significant progress in reducing cigarette use, approximately 1.6 million NYS adults (11.3%) currently smoke. Smoking rates are highest among adults with an annual income less than $25,000 (18.4%) and adults reporting frequent mental distress (18.4%).[214] Youth and young adult use of tobacco products consists primarily of e-cigarette use. While use of e-cigarettes/vaping among NYS youth has decreased since 2018, youth tobacco use in any form is a concern, and 1 in 5 high school students in NYS report currently using any tobacco products including cigarettes, e-cigarettes, cigar products, nicotine pouches, and other tobacco products (including chewing tobacco, snuff, snus, dip, dissolvables, waterpipe/hookah, pipe tobacco, and heated tobacco products).[215]

Structural inequities, such as directed marketing by the tobacco industry, greater tobacco retailer density in low-income communities, and limited access to cessation resources, drive disparities in tobacco use. Groups disproportionately impacted by commercial tobacco industry marketing include racial and ethnic minorities, members of the LGBTQIA+ community, individuals living with mental illness or substance use disorders, and those in lower-income communities. These practices have led to significant inequities in marketing exposure, tobacco use, and health outcomes. For example, menthol cigarettes, aggressively marketed to Black and Hispanic populations, worsen these disparities by increasing addiction and hindering cessation efforts. Tobacco industry marketing efforts particularly focus on youth, with strategies such as flavored products, social media campaigns, and advertising near schools and in digital spaces designed to appeal to younger audiences. These tactics not only encourage initiation but also increase the likelihood of long-term addiction

To advance health equity, every community should benefit from policies and strategies that prevent and reduce tobacco use and its associated harms. While NYS has made significant progress in tobacco control, ongoing efforts are essential to ensure that all communities, especially those disproportionately affected, are protected from the harms of tobacco. Comprehensive, evidence-based approaches include raising the price of tobacco products, implementing, and enforcing strong smoke-free air laws, restricting the sale of flavored tobacco products, adopting retailer policies to reduce the availability and promotion of tobacco products, and increasing access to tobacco use treatment and support. By promoting opportunities focused on these proven strategies, NYS can help reduce tobacco use, protect youth from initiation, and mitigate disparities.

SMART(IE) Objective:					
14.0 Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%. **14.1 Reduce the percentage of high school students who use tobacco products from 17.0% to 14.5%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Decrease tobacco use	Prevalence of cigarette smoking among adults aged 18 years and older	BRFSS	Adults aged 18 years and older	9.3% (2023)	7.9% (2030)
	Subpopulation Indicator	**Data Source**	**Subpopulation of Focus**	**Baseline**	**Target**
	Prevalence of any tobacco use among high school students	Youth Tobacco Survey (YTS)	High school students	17.0% (2024)	14.5% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** Promote the integration of cessation support that is both age-appropriate and culturally sensitive in all tobacco prevention initiatives.[216] LHD H O	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	Youth and adults	Utilization by organizations that provide cessation support, number of people served with age- and culturally appropriate services
 **Featured Intervention:** Provide access to tobacco cessation treatments, including individual, group, telephone counseling, and Food and Drug Administration-approved cessation medications.[216] LHD H O	Adults in all populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	Ages 18+	Number of referrals made to cessation treatments; number of people served by cessation treatments
 Implement policies to reduce the impact of tobacco marketing, particularly in communities disproportionately targeted by the industry, including lower-income areas, racial and ethnic minority neighborhoods, and urban and rural communities.[217-219] For example, limiting promotion, placement,	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	All ages	Prevalence and visibility of tobacco marketing (number of physical ads, number of locations for purchase of tobacco, etc.)

Interventions	Population of Focus	Age Range	Intermediate Measures
flavoring, or pricing of tobacco products. LHD O			
 Advocate for decreased availability of flavored tobacco products, including menthol flavors used in combustible and noncombustible tobacco products, flavored liquids, and electronic vapor products.[220] LHD O	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	All ages	Reach of chosen advocacy methods (number of outreach events held and attendance, number of retailers/advertisers spoken to, number of website visits, number of petition signatures), number of purchase locations available
 Educate residents on the harms of tobacco and the benefits of tobacco-free treatment.[221] LHD H O	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	All ages	Reach relevant to chosen outreach and education strategies (e.g., number of outreach events and attendance, number of flyers distributed, number of QR code scans and website visits)
 Use media and health communication campaigns to highlight the harms and health risks of commercial tobacco, promote effective tobacco control policies, and reshape social norms.[221, 222] LHD H O	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	All ages	Reach relevant to chosen outreach and education strategies (e.g., number of outreach events and attendance, number of flyers distributed, number of QR code scans and website visits)
 Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums, and co-ops, especially those that house residents with lower socioeconomic status.[223] LHD O	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	All ages	Number of multi-housing units with smoke-free policies, number of people living in units with smoke-free policies
 Connect patients with referral services.[224] LHD H O	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	Youth and adults	Number of people served by intervention; number of successful referrals made

Interventions	Population of Focus	Age Range	Intermediate Measures
 Implement screening for tobacco use and navigate to appropriate services (i.e., ask, advise, assist) in all health care practice settings.[224] LHD H O	All populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	Youth and adults	Participation among organizations of focus, number of people screened; number of successful referrals made
 Promote evidence-based training programs such as Tobacco Treatment Specialist training for health care providers to treat tobacco use disorder.[225] LHD H O	Health care providers	N/A	Number of health care providers trained, capacity of providers to treat tobacco use disorder, number of people treated by trained providers
 Advance community-wide support for restricting minors' access to tobacco products. Examples include: • Promotion of community-wide education on tobacco issues • Education to retailers about restricting the sale of tobacco to minors • Support for policy changes that encourage tobacco sale enforcement and tobacco-free environments[226] LHD O	Youth in all populations; priority focus on communities disproportionately impacted by tobacco industry marketing practices	Youth	Participation rates among CBOs, schools, retailers, and other organizations of focus, degree of accessibility of tobacco products (number of purchase locations, number of visible advertisements, especially near congregation sites for youth)

Lead Partner Agencies and Organizations

NYS Homes and Community Renewal
American Lung Association, American Heart Association, American Cancer Society

Implementation Resources

Department of Health Tobacco Control Program

NYS Quitline

Tobacco Free New York

Health Systems for a Tobacco-free New York

Talk to Your Patients – Reference Guide for Clinicians

Priority: Alcohol Use

Goal: Reduce excessive alcohol use and associated harms.

What is Excessive Alcohol Use and Why is it Important?

Excessive alcohol use includes binge drinking, heavy drinking, or any drinking among pregnant people or those under the age of 21. Excessive alcohol use can lead to short-term harms such as motor vehicle injuries or drowning; violence including homicide, suicide, sexual assault, and intimate partner violence; alcohol poisoning; and poor birth outcomes. It can also lead to chronic diseases such as heart disease, liver disease, digestive problems, and several types of cancer. Excessive alcohol use can also cause learning and memory problems, mental health problems, social problems such as lost productivity or family problems, and alcohol use disorders.[227]

Nearly 1 in 5 adults in NYS (18.4%) report excessive alcohol use in the form of either binge or heavy drinking, with an estimated 16.6% of adults in NYS reporting binge drinking and 6.1% reporting heavy drinking.[228] Twenty percent of high school students in NYS report current drinking (at least one drink in the past 30 days) and 10.2% report binge drinking. In NYS, excessive alcohol use causes more than 8,000 deaths annually, resulting in an average of 24 years of potential life lost per death.[229] Excessive alcohol use costs NYS an estimated $16.3 billion, or approximately $2.28 per drink.[230] Economic costs due to excessive drinking include losses in workplace productivity, health care expenses, criminal justice expenses, and motor vehicle crash costs.

Excessive alcohol use is more likely in environments with lower-cost alcohol products and greater availability. Structural racism and commercial determinants of health such as greater alcohol retailer density, increased availability of alcohol products, and increased marketing of alcohol products to specific population groups contribute to disparities in the burden of excessive alcohol use and its associated outcomes. To advance health equity in communities, every community should benefit from policies and approaches that reduce excessive alcohol use and prevent the harm that it can cause. By promoting opportunities to support evidence-based policies and programs making alcohol less available, harder to access, and higher in price, NYS can prevent excessive drinking and related harms.

SMART(IE) Objective:					
15.0 Decrease the prevalence of binge or heavy drinking among all adults aged 18 years and older from 16.2% to 14.6%. **15.1 Decrease the prevalence of drinking by high school students from 16.8% to 13.4% (New York City).** **15.2 Decrease the prevalence of drinking by high school students from 23.9% to 19.1% (New York State outside New York City).**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Reduce excessive alcohol use among adults	Prevalence of binge or heavy drinking among adults aged 18 years and older	BRFSS	Adults	16.2% (2023)	14.6% (2030)
	Subpopulation Indicator	**Data Source**	**Subpopulation of Focus**	**Baseline**	**Target**
Reduce drinking among high school students	Prevalence of alcohol use among high school students (any alcohol use in past 30 days) (New York City)	YRBSS	Youth/High school students (New York City)	16.8% (2023)	13.4% (2030)
	Prevalence of alcohol use among high school students (any alcohol use in past 30 days) (New York State outside New York City)	YRBSS	Youth/High school students (New York State outside New York City)	23.9% (2023)	19.1% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Assist health care organizations and provider groups in establishing policies, procedures, and workflows to facilitate the delivery of in-person or electronic alcohol screening, brief intervention and referral to treatment. For example, providing personalized feedback about the risks and consequences of excessive drinking using electronic screening and behavioral counseling interventions to adults in primary health care settings and emergency rooms.[231, 232] LHD H O	Adults with excessive alcohol use	Ages 18+	Self-report of receipt of screening and brief intervention at last health care visit
Featured Intervention: Develop and/or disseminate educational materials and resources to communicate with the public	Populations living in communities with high levels of alcohol retailer density (often	All ages; particularly effective for youth	Population support for policy (NYS Chronic Disease Public Opinion Poll)

Interventions	Population of Focus	Age Range	Intermediate Measures
about the harms associated with excessive alcohol use, including the association between excessive alcohol use and chronic disease outcomes (e.g., cancer, cardiovascular disease, and liver disease).[233,234] LHD H O	under-resourced communities)		
Build awareness and advocacy for policy action to increase the price of alcohol products. This includes increasing the tax and setting minimum prices on alcohol beverages products.[235,236] LHD O	General population; Price-sensitive populations (youth, those living in under-resourced communities)	All ages; particularly effective for youth	Population support for policy (NYS Chronic Disease Public Opinion Poll)
 Build awareness and advocacy for policy action to reduce the availability of alcohol products, including reducing alcohol retailer density, and limiting or maintaining limits on the days and hours of alcohol sale.[237-239] LHD O	Populations living in communities with high levels of alcohol retailer density (often under-resourced communities)	All ages; particularly effective for youth	Population support for policy (NYS Chronic Disease Public Opinion Poll)
 Use media and health communications to highlight the harms associated with excessive alcohol use and educate about effective policy solutions to community leaders and organizational and governmental decision makers.[233,234] LHD H O	Populations living in communities with high levels of alcohol retailer density (often under-resourced communities)	All ages; particularly effective for youth	Population support for policy (NYS Chronic Disease Public Opinion Poll)
 Educate patients and communities about options for alcohol treatment for those who have alcohol use disorder.[233,240] LHD H O	Individuals with alcohol use disorder	All ages	Participation among organizations of focus who would provide outreach, data on reach based on chosen strategy (number of flyers distributed, number of patients counseled, etc.), number of referrals made to alcohol use disorder treatment, number of people receiving treatment for alcohol use disorder

Interventions	Population of Focus	Age Range	Intermediate Measures
 Build advocacy for policy action to reduce youth exposure to alcohol marketing, including restrictions on the marketing of alcohol products in media and in locations frequented by youth, such as near schools, on public transportation, and at points of sale.[241] LHD O	Youth, communities of color, under-resourced communities (this policy would address aggressive industry marketing within communities)	Youth and adults	Population support for policy (NYS Chronic Disease Public Opinion Poll)
 Use health communications and earned media to educate individuals on the benefits of drinking less alcohol or choosing not to drink. For example, including strategies such as alcohol awareness observations and campaigns designed to encourage less drinking, etc.[240,242,243] LHD O	People who drink excessively	All ages	Number of messages disseminated campaign reach
 Collaborate with local and statewide organizations to implement safety programs to reduce binge drinking, including organizations such as: • Institutes of higher education • Large employers • Health insurance companies • Health care systems[244] LHD O	College students who binge drink	All ages	Number of programs/interventions delivered
 Support the enforcement of laws prohibiting alcohol sales to minors and other public policies that discourage underage drinking.[245,246] LHD O	Youth	Ages under 21	Number of enforcement visits Number of stores cited for underage sale
Promote the use of family-based interventions, providing instruction or training to parents and caregivers to enhance substance use preventive skills and practices for children and adolescents.[248] LHD H O	Youth	Ages under 21	Number of interventions delivered

Interventions	Population of Focus	Age Range	Intermediate Measures
Encourage community coalitions and collaborative partnerships between schools, faith-based organizations, law enforcement, health care, and public health agencies to reduce excessive alcohol use, including binge and heavy drinking among adults, drinking during pregnancy, and drinking under the age of 21.[249] LHD H O	Youth	Ages under 21	Number of coalitions formed Number of coalition meetings held Number of actions implemented by coalitions

Lead Partner Agencies and Organizations

U.S. Centers for Disease Control and Prevention (CDC)
NYS Office of Addiction Services and Supports (OASAS)
NYS Department of Health
NYS Office of Mental Health
NYS Liquor Authority
Local public health agencies
CUNY School of Public Health
Substance Use/Misuse Prevention Coalitions, Drug Free Coalitions, Prevention Resource Centers
Schools, parent-teacher organizations
Faith-based organizations
Law enforcement agencies
Health care organizations/practices
American Heart Association
American Cancer Society
Center for Science in the Public Interest

Implementation Resources

NYS Liquor Authority - Enforcement

OASAS - Evidence Based Prevention Programs

OASAS - Community Coalitions

OASAS - Procurement and Funding Opportunities

CDC - Drug-Free Communities Coalitions

Priority: Adverse Childhood Experiences

Goal: Prevent and address the impact of Adverse Childhood Experiences.

What are Adverse Childhood Experiences and Why are they Important?

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years). Numerous studies have found a direct link between adverse childhood experiences and adult onset of chronic disease, incarceration, and employment challenges. Frequent exposure to these stressors and adverse experiences can increase the likelihood that individuals face more health challenges and poor outcomes later in life.

The National Survey of Children's Health indicates that 23% of NYS children aged 0-17 years had one ACE and 15% had 2 or more ACEs, such as the death or incarceration of a parent, witnessing or being a victim of violence, or living with someone with mental health, drug, or alcohol problems. The prevalence of having one or more ACEs increased with age, from 25.3% of children aged 0-5 years to 49.2% of those aged 12-17 years.[250]

The Centers for Disease Control and Prevention (CDC) estimates preventing ACEs could potentially reduce many health conditions. Estimates show up to 1.9 million heart disease cases and 21 million depression cases potentially could have been avoided by preventing ACEs. Reducing the risk of ACEs, as well as the provision of resources and support, could reduce suicide attempts among high school students by as much as 89%, prescription pain medication misuse by as much as 84%, and persistent feelings of sadness or hopelessness by as much as 66%.[251]

By promoting opportunities to support increasing the screening of adults and children for ACEs and enhancing clinical and community supports and prevention efforts for children and families, NYS can reduce the detrimental effect that ACEs can have on the health and well-being of children and families.

SMART(IE) Objective:					
16.0 Increase the percentage of adults who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met from 65.1% to 66.9%. **16.1 Increase the percentage of Hispanic adults who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met from 51.0% to 52.7%**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase protective factors reported by adults	Percentage of adults who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met, aged 18 years and older	BRFSS	Adults (Aged 18 years and older)	65.1% (2021)	66.9% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Hispanic Adults (Aged 18 years and older)	51% (2021)	52.7% (2030)

SMART(IE) Objective:					
17.0 Reduce the percentage of adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 25.3% to 23.8%. **17.1 Reduce the percentage of Black, non-Hispanic adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 29.0% to 27.5%.** **17.2 Reduce the percentage of Hispanic adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 28.5% to 26.1%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Reduce the percentage of adults experiencing three or more adverse childhood experiences (ACEs)	Percentage of adults who, as a child, experienced three or more adverse childhood experiences (ACEs), aged 18 years and older	BRFSS	Adults (Aged 18 years and older)	25.3% (2021)	23.8% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Black, non-Hispanic Adults (Aged 18 years and older)	Black, non-Hispanic adults 29.0% (2021)	Black, non-Hispanic adults 27.5% (2030)
			Hispanic adults (Aged 18 years and older)	Hispanic adults 28.5% (2021)	Hispanic adults 26.1% (2030)

SMART(IE) Objective:					
18.0 Reduce the rate of indicated reports of abuse/maltreatment per 1,000 children and youth aged 0-17 years from 11.3 to 9.8. **18.1 Reduce the rate of indicated reports of abuse/maltreatment per <u>1,000 Black, non-Hispanic children and youth</u> from 21.8 to 19.9.** **18.2 Reduce the rate of indicated reports of abuse/maltreatment per <u>1,000 Hispanic children and youth</u> from 13.9 to 12.5.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Reduce indicated reports of abuse/maltreatment rate per 1,000 children and youth aged 0-17 years.	Indicated reports of abuse/maltreatment, rate per 1,000 children and youth, aged 0-17 years	Disproportionate Minority Representation (DMR) Dashboard for OCFS	Children and youth, 0-17	11.3 (2023)	9.8 (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Black, non-Hispanic children and youth	21.8 (2023)	19.9 (2030)
			Hispanic children and youth	13.9 (2023)	12.5 (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** Identify Adverse Childhood Experiences (ACEs) and other types of trauma in primary care settings through screening and referrals.[252] LHD H O	Children and Families	All ages	Percentage of primary care settings that screen for ACEs Percentage of support referrals followed through within 6 months of screening
 **Featured Intervention:** Promote education to prevent and/or mitigate ACEs by engaging with public health professionals and community partners. For example: • Classes (e.g., continuing education, newborn care, and parenting) • Engaging professionals (e.g., prenatal/postpartum doulas, community service workers, family doulas, mental health providers) • Head Start programs • Early Intervention (EI) screenings • Hospital staff training on infant cues • Kangaroo care[253] LHD H O	Birthing people, new parents, and young children	All ages	Number of campaigns and outreach efforts
 Promote education to improve prenatal care and maternal mortality prevention by engaging with public health professionals and community partners. For example: • Health checkups • Housing needs • Access to nutrition support resources such as Women, Infants, and Children (WIC) • Mental health resources and risk assessments • Employment resources • Child care assistance • Temporary Assistance for Needy Families (TANF)[253] LHD H O	Birthing people, new parents, and young children	All ages	Number of campaigns and outreach efforts

Interventions	Population of Focus	Age Range	Intermediate Measures
 Strengthen community partnerships to support education, case coordination, and referrals of at-risk families to local health departments, hospitals, and other community-based organizations to increase participation in home visiting programs (e.g., Healthy Families, Community Health Worker (CHW), Nurse Family Partnership (NFP)).[255] LHD H O	Children and Families	Birth to adulthood	Number of referrals
 Promote resilient families and children to mitigate ACEs and promote protective factors through education, positive engagement, community, healthy habits, access to Cognitive Behavioral Therapy (CBT), access to Family Opportunity/Resource Centers, and personal growth by enhancing collaboration between state, LHD, and community-based organizations.[256] LHD H O	Children and Families	Birth to adulthood	Number of partnerships created by LHDs and other organizations
 Conduct public education campaigns to promote and shift social norms around a shared responsibility for the health and well-being of all children. Examples include positive norms around gender, masculinity, help-seeking, and violence prevention towards intimate partners, children, and peers.[253] LHD H O	Children and Families	All ages	Number of people in general population educated about ACEs through awareness campaign
 Build collaborative partnerships between various community members and organizations to address SDOH and ACEs, to prevent Child Welfare system involvement.[257] LHD H O	Children and Families	All ages	Number of partnerships created by LHDs and other organizations
 Strengthen Economic Supports to Families by promoting Family Friendly Work, Child Care, and Educational and Employment Policies that strengthen household financial stability via	Parents of At-Risk Youth	Adulthood with special attention to younger parents or disabled parents	Number of campaigns and outreach efforts

Interventions	Population of Focus	Age Range	Intermediate Measures
social media campaigns, community, and business outreach.[253] LHD H O			
 Partner with and support organizations that connect children to caring adults and activities. These include mentoring, afterschool programs, sports, and other extracurricular activities (e.g., Boys and Girls Club, YMCA, Big Brother Big Sister, LEAPS After School).[253] LHD O	Youth	Birth to adulthood	Number of youths participating in community services
 Integrate principles of trauma-informed approach in workforce development, training, and practices within agencies and across communities to promote a trauma-informed culture. This could include: • Governance and leadership • Policy • Physical environment • Engagement and involvement • Cross-sector collaboration • Screening • Assessment and treatment services • Progress monitoring and quality assurance • Financing • Evaluation[258,259] LHD H O	Workforce	Adults	Number of staff at hospital, LHD, or organization who complete trauma-informed approach training
 Screen for ACEs with evidence-based tools that identify individuals at high risk who may benefit from additional assessment and interventions.[260] LHD H O	Indigenous and self-sustained communities	All ages	Number of partnerships created by LHDs and other organizations with underrepresented populations

Lead Partner Agencies and Organizations

NYS Department of Health
Office of Mental Health
NYS Office of Children and Family Services
Local Departments of Social Services
Local Legislative Officials
Community Businesses
Community-Based Organizations
American Academy of Pediatrics

Implementation Resources

Centre of Excellence for Women's Health - Trauma-Informed Practice & the Opioid Crisis

Adverse Childhood Experiences (ACEs) Resources | CDC

American College of Preventive Medicine: Resources for ACEs

Priority: Healthy Eating

Goal: Promote healthy eating and make nutritious, culturally appropriate foods available.

What is Healthy Eating and Why is it Important?

A healthy diet can reduce the risk of many chronic diseases, such as cardiovascular disease, diabetes, osteoporosis, some cancers, and conditions associated with weight gain. The Dietary Guidelines for Americans (DGA) recommend human milk as the first food for infants and a healthy eating pattern for children and adults that includes a variety of fruits and vegetables and limits foods and beverages that contain added sugars, like sugar-sweetened beverages (SSBs). Many adults in New York do not meet the recommendations in the DGA. About 1 in 5 adults consume SSBs daily and less than one vegetable daily.[261] Even more adults, more than one-third, consume less than one fruit daily.[261]

The 2023 recommendations from the American Academy of Pediatrics and the World Health Organization (WHO) recommend that infants be exclusively fed human milk for the first 6 months and support continued breastfeeding/chest feeding, along with introducing appropriate complementary foods for 2 years of age or beyond.[262] At the federal level, Healthy People 2030 objectives were established to increase the proportion of infants who are breastfed through 1 year to 54.1% and to increase the proportion of infants who are exclusively breastfed at 6 months to 42.4%.[263] NYS falls below both national goals, based on data from 2020 births.[264]

It's harder for some groups to meet healthy eating and breastfeeding recommendations due to differences in SDOH, driven by systemic and structural forces. This leads to unfair, unjust, and avoidable health disparities. Among groups most impacted by nutrition and breastfeeding disparities include communities of color and people with low income.[261,264] By promoting policy, system, and environmental change strategies for groups who experience the greatest nutrition and breastfeeding disparities, NYS can support improved health equity and healthy eating across the lifespan.[7]

SMART(IE) Objective:					
19.0 Decrease the percentage of adults who consume no fruits or vegetables daily from 28.4% to 27.0%. **19.1 Decrease the percentage of adults <u>with an annual household income less than $50,000</u> who consume no fruits or vegetables daily from 31.7% to 30.1%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increased consumption of nutritious foods recommended by the Dietary Guidelines	Percentage of adults who consumed fewer than one fruit and fewer than one vegetable daily (no fruits or vegetables), aged 18 years and older	BRFSS	Adults (Aged 18 years and older)	28.4% (2023)	27.0% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Adults in households that earn less than $50,000 per year	31.7% (2023)	30.1% (2030)

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

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** Adopt and implement food service and nutrition guidelines in places where food is served, sold, or distributed. The Food Service Guidelines for federal facilities can be used in worksite and community settings. The Healthy Eating Research Nutrition Guidelines for the Charitable Food System can be used in food banks and pantries.[265] LHD H O	Institutionalized groups, working adults, people with low food and nutrition security	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of school settings that improve nutrition policies and best practices
 **Featured Intervention:** Foster community environments that proactively promote, protect, and support breastfeeding and chest feeding.[266] LHD H O	Pregnant and postpartum people, breastfeeding/ chest feeding parents	Adults of reproductive age	Number of settings that improve lactation policies and best practices
 Adopt and implement policies and best practices that support improved nutrition, breastfeeding and chest feeding support, and increased physical activity in early learning and child care (ECE) settings. Examples include: • Limit juice to 4-6 oz for children per day • Do not serve fruit drinks and other sugary beverages that are not 100% real fruit juice • Increase food acceptance through repeated exposure to whole fruits and vegetables (taste-testing activities and games, etc.) • Increase food acceptance by involving children in food preparation • Provide child nutrition training to ECE providers[267] LHD O	Children in child care centers and family and group day care homes	Ages 0-5	Number of settings that improve nutrition policies and best practices
 Adopt policies and implement best practices to reduce overconsumption of sugar-sweetened beverage in schools and workplace settings. Examples include: • Change what is offered in vending machines • Put less sugary options at eye level	Children and adolescents, working adults	School: Children up to age 11, Adolescents (Ages 13-21) Workplace: Adolescents (Ages 13-21), Adults (Ages 21-	Number of school settings/workplace settings that improve nutrition policies and best practices

Interventions	Population of Focus	Age Range	Intermediate Measures
• Make less sugary options cheaper than high-sugar options • Provide easy access to free water in cafeterias and throughout school and worksite facilities (e.g., water bottle refill stations) • In schools, consider bans on sugary drinks on school property & in vending machines • In workplaces, consider not offering sugary beverages in vending machines at all • In workplaces that provide free drinks, consider setting a sugar content limit for beverages offered to employees[268-271] LHD O		60), Older Adults (Ages 60+)	
 Adopt and implement policies and best practices that increase the availability of minimally processed whole foods in schools. Examples include: • Increase cafeteria availability of whole food, plant-predominant foods (opportunity for student engagement in designing menus) • Offer more snack foods made with whole ingredients and minimal processing • Offer fewer highly processed foods and beverages • Promote farm-to-school programs to purchase more regionally produced whole fruits, vegetables, and whole grains (opportunity for collaboration with community-based organizations (CBOs) (community gardens), which could also include student engagement) • Promote healthy celebration practices aimed at reducing high-calorie/high-sugar foods at school/company parties[268,272-275] LHD H O	Children and adolescents	Children up to age 11, Adolescents (Ages 13-21)	Number of school settings that improve nutrition policies and best practices
 Promote healthy eating practices by implementing awareness and education campaigns in schools. Examples include: • Offer nutrition classes OR include nutrition as part of curriculum for health, PE, or other appropriate classes	Children and adolescents	Children up to age 11, Adolescents (Ages 13-21)	Number of school settings that improve nutrition policies and best practices

Interventions	Population of Focus	Age Range	Intermediate Measures
• Provide nutrition information about school meals and snacks *(opportunity for student engagement through clubs such as Future Farmers of America (FFA), Family, Career, and Community Leaders of America (FCCLA), cooking club (food science-focused), audiovisual (AV) club, art club (marketing focused) OR an assignment for health or home & careers class at a particular grade level) • Post nutrition awareness materials in hallways and other common spaces • Increase student knowledge of healthy eating through culinary and garden-based education *(opportunity for collaboration with CBOs or farm-to-school programs) • Promote creation of chapters of FFA, FCCLA, 4-H and similar organizations that promote development of skills and knowledge related to food production and consumer sciences[268] LHD H O			


Adopt and implement policies and practices that promotes healthier eating choices in workplace settings. Examples include:
• Provide infrastructure that encourages home-prepared lunches (refrigeration and food heating options)
• In workplaces that have cafeterias, increase availability of whole foods, and decrease availability of highly processed foods
  o Provide nutrition information regarding foods offered in cafeterias
  o Consider feasibility of competitive pricing for whole food-based options
  o Promote farm-to-institution programs for procurement of food for cafeterias
• Adopt policies regarding availability of highly processed snacks in vending machines:
  o Change what is offered in vending machines
	Working adults	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of worksite settings that improve nutrition policies and best practices

Interventions	Population of Focus	Age Range	Intermediate Measures
○ Put less-processed options at eye level ○ Make less-processed options cheaper • For workplaces that provide free food to employees, implement nutritional standards for budgetary allowance of snacks, free meals, and workplaces[268] LHD H O			
 Promote healthier eating choices in workplace settings through education and public awareness activities. Examples include: • Offer education through "lunch and learn" programs • Promote nutrition services available through workplace benefits packages • Post awareness materials (signage, flyers, etc.) regarding nutrition topics (e.g., consumption of sugar, sodium, highly processed foods vs. benefits of whole foods, non-sugary beverages) near vending machines and in areas where employees eat[268] LHD H O	Working adults	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of worksite settings that improve nutrition policies and best practices
 Promote digital health and telephone interventions focused on improving healthy eating and physical activity using websites, mobile apps, text messages, emails, or one on one telephone calls in community-based, worksite, and higher education settings. Examples include: • Educational information plus one or more of the following: coaching or counseling from trained professionals; self-monitoring to record healthy eating, physical activity, or weight; goal setting; or computer-generated feedback that provides tailored information • Social support from peers or motivational strategies such as incentives, rewards, and gaming techniques[276] LHD H O	Adolescents and adults interested in improving health behaviors	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of settings that implement interventions

Interventions	Population of Focus	Age Range	Intermediate Measures
 Adopt healthy, values-aligned local and territory government food purchasing policies and practices. For example, adopt nutrition guidelines in food purchasing bids and contracts.[265] LHD O	Institutionalized groups	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of settings that improve nutrition policies and best practices
 Provide regular training to family services providers on evidence-based lactation education and support. [266] LHD H O	Pregnant and postpartum people, breastfeeding/chest-feeding parents	Adults of reproductive age	Number of settings that improve lactation policies and best practices
 Provide family-centered lactation care that responds to a wide range of needs, including access to nutritious and affordable food and other factors related to their infant feeding journey.[266] LHD H O	Pregnant and postpartum people, breastfeeding/chest-feeding parents	Adults of reproductive age	Number of settings that improve lactation policies and best practices
 Promote fruit and vegetable incentive programs such as produce prescriptions, bonus dollars, market bucks, produce coupons, and nutrition incentives.[277] LHD H O	Lower income adults	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of settings that improve nutrition policies and best practices
 Provide free healthy school meals and/or snacks for all students that meet recommended nutrition guidelines.[278] LHD O	Children and adolescents	Children up to age 11, Adolescents (Ages 13-21)	Number of settings that improve nutrition policies and best practices
 Adopt policies and practices that discourage unhealthy food and beverage marketing in hospitals, school districts, recreation centers, libraries, public buildings, transportation systems, and restaurants.[279-281] LHD H O	Children and adolescents	Children up to age 11, Adolescents (Ages 13-21)	Number of settings that improve nutrition policies and best practices

Interventions	Population of Focus	Age Range	Intermediate Measures
 Provide media literacy education on food marketing in hospitals, school districts, recreation centers, libraries, public buildings, transportation systems, and restaurants.[279,280,282-285] LHD H O	Children and adolescents	All ages	Number of settings that improve nutrition policies and best practices
 Provide nutrition education about products high in sodium and sugar in restaurants and other food retail settings, using table tents and posters.[286-288] LHD H O	Adolescents and adults eating in food retail settings	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of settings that improve nutrition policies and best practices
 Implement food literacy and tailored nutrition education program interventions to promote healthy eating, such as the Faith, Activity, and Nutrition (FAN) program in faith-based organizations.[289,290] O	Adolescents and adults in faith communities	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of settings that improve nutrition policies and best practices
 Offer cooking demonstrations for SNAP-Ed eligible populations as part of comprehensive nutrition education at food pantries, housing community centers, older adult centers, family enrichment centers, food retail settings, and for parent groups at schools to demonstrate how to prepare healthy foods.[291.292] LHD H O	People eligible for Supplemental Nutrition Assistance Program (SNAP) benefits	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of settings that improve nutrition policies and best practices
 Adopt and implement policies and best practices that make plant-based meals the default in hospitals, schools, universities, and other settings. Examples include: • Make the default meal that is offered plant-based • Offer an alternative plant-based meal as the second choice • Offer an animal-based meal as a third choice alternative[293, 294] LHD H O	Institutionalized groups, college/university students, working adults	Adolescents (Ages 13-21), Adults (Ages 21-60), Older Adults (Ages 60+)	Number of settings that improve nutrition policies and best practices

Interventions	Population of Focus	Age Range	Intermediate Measures
$  Establish, enhance, or expand Food as Medicine programs (e.g., produce prescriptions, medically tailored meals, or food boxes) and connect these programs with disease prevention and management programs (e.g., National Diabetes Prevention Program).[295-297] LHD H O	People with/at risk for chronic disease, people at nutritional risk	All ages	Number of settings that improve nutrition policies and best practices, number of practices who participate in Food as Medicine programs

Lead Partner Agencies and Organizations

U.S. Centers for Disease Control & Prevention (CDC)
NYS Office of Children and Family Services
NYS Education Department
NYS Department of Labor
NYS Department of Health (Creating Healthy Schools and Community Program, Breastfeeding, Chestfeeding, and Lactation Friendly New York)
NYS Department of Agriculture
NYS Office for the Aging
NYC Department of Health and Mental Hygiene

Implementation Resources

National Resouce Center for Health and Safety in Child Care and Early Education - Caring for Our Children

CDC - Early Care Education Resources

CDC - Early Care Education Obesity Prevention Standards

CDC - School Health Index (SHI)

CDC - Food Service Guidelines

CDC - Workplace Health Promotion

CDC - Strategies for Fruit and Vegetable Voucher Incentives and Produce Prescriptions

Society for Public Health Education - WellSAT: Wellness School Assessment Tool

Union Community Health Center & Urgent Care - The Bronx Healthy Beverage Zone

Community Guide - CPSTF Recommends Digital Health Interventions to Increase Healthy Eating and Physical Activity

Center for Science in the Public Interest - Centering Equity: Healthy Food Purchasing Policies

National Association of County & City Health Officials (NACCHO) - Breastfeeding Continuity of Care Blueprint

Domain 3:

Neighborhood and Built Environment

Priorities:

- Opportunities For Active Transportation and Physical Activity
- Access to Community Services and Support
- Injuries and Violence

Priority: Opportunities for Active Transportation and Physical Activity

Goal: Improve safe, affordable, and accessible active transportation, physical, and social activity.

What are Opportunities for Active Transportation and Physical Activity and Why are They Important?

Regular physical activity has significant benefits across the lifespan, including reduced risk of chronic diseases such as heart disease, stroke, type 2 diabetes, and several types of cancers, and can lead to stronger muscles and bones, improved mental health and sleep function, and increased life expectancy.

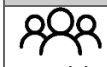
The 2018 Physical Activity Guidelines for Americans recommends adults of all ages and abilities engage in moderate-intensity physical activity for at least 150 minutes per week, or vigorous-intensity physical activity for 75 minutes per week. Approximately 5.5 million adults in New York State do not meet this recommendation and over 4 million do not participate in any leisure-time physical activity. Physical activity indicators demonstrate disparities by race, ethnicity, income, education, and ability. Participation in any physical activity is lowest among adults who are Hispanic (63.7%), have a household income of less than $25,000 (56.7%), have less than a high school education (52.3%), or are living with disability (58.4%).[148]

Not all individuals have the same access or ability to engage in physical activity in the same ways. Disparities are often related to structural inequities such as lack of accessible opportunities or built environments that are unsafe or not designed inclusively for all populations. The opportunity to engage in physical activity is most often directly influenced by factors in the social and physical environments. Social factors may include income and education inequality and community traits such as social cohesion and perceived benefits and attitudes towards physical activity. Factors in the physical environment may include access to public green spaces and trails, provision of safe walking and biking routes, and residential design that can promote walkable neighborhood routes, including more compact, mixed-use neighborhood design.

Active transportation, such as walking or biking to get from one place to another, provides opportunities for people to be physically active as part of their daily lives. This is easier to do when everyday destinations are connected by activity-friendly routes and close to one another. By focusing on improvements to transportation systems such as pedestrian or bicycle paths and promoting land use and community design that supports Smart Growth to expand access to community or neighborhood destinations such as stores, businesses, health care, civic activities, community centers, and parks, NYS can increase opportunities for active transportation and physical activity.

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

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Work with partners to establish or update: • Master plans • Land use and zoning policies and plans • State pedestrian, bicycle, and parks and recreation plans • Housing, conservation, or economic development plans[300] LHD O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
Featured Intervention: Collaborate with multidisciplinary partners to implement plans, policies, and strategies to support activity-friendly communities. Examples include: • Policies (Complete Streets, Safe Routes, and Vision Zero policies, including relevant city, school district, or parks and recreation department policies. Also includes policies to promote mixed land uses, transit-oriented development, and residential density) • Plans (Active transportation, trails, and greenways plans; Complete Streets, Safe	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans

Interventions	Population of Focus	Age Range	Intermediate Measures
Routes for All, and Vision Zero action plans; Incentives for activity-friendly project evaluation) • Projects (demonstration projects with evaluation measurement, including speed reduction, increased active travel, or use of new places; placemaking; bike racks, crosswalks, or traffic calming measures; new or improved sidewalks, protected bike lanes, transit routes) • Codes (zoning, building, subdivision, or other codes, including those that integrate land use regulations with other municipal goals, or regulate the form of buildings rather than land uses, such as Form-Based Codes and activity-friendly districts) • Programs (safe routes to school or parks) • Systems (increase transit, bicycle, and pedestrian network connectivity and access, park coverage and accessibility, and incentives for activity-friendly project evaluation or supportive land development) • Community (innovative ideas and key priorities to design communities for physical activity that are community-sourced and created, demonstrating that residents are valued and appreciated)[300] O			
 Foster environments conducive to healthy lifestyles and living by providing access to outdoor physical and recreational activities and everyday destinations, including but not limited to libraries, parks, farmers' markets, schools.[301,302] LHD O	Everyone	All ages	Number of new healthy outdoor spaces created, number of improvements made, data regarding reach relevant to outreach activities (e.g., number of community events in parks, libraries, etc. and attendance), utilization of community sites conducive to healthy lifestyles
 Establish, expand, or participate in a cross-sectoral coalition. Members should include but are not limited to: • People affected by inequities in community design	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans

Interventions	Population of Focus	Age Range	Intermediate Measures
• Representatives of public health, transportation, community planning, and parks and recreation • Leaders who can help with specific issues, such as housing and healthy food access • Early care and education, K–12 schools, and universities • Public safety and public works[300] LHD O			
 Collaborate with local organizations and subject matter experts to develop targeted solutions aligned with community needs and promote active lifestyles.[300] LHD O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
 Provide training and technical assistance related to community engagement and organizing, coalition building, needs assessment, action planning, and evaluation.[300] LHD O	Everyone	All ages	Communities adopt or enhance plans/policies to connect pedestrian, bicycle, or transit transportation networks (e.g., activity-friendly routes to everyday destinations) Communities implement visible changes to connect pedestrian, bicycle, or transit transportation networks Increased access to places for physical activity, both routes and destinations in communities, among priority populations Increased access to places for physical activity, both routes and destinations in communities
 Work with Metropolitan Planning Organizations (MPOs) or Rural Planning Organizations (RPOs) and state transportation departments to integrate health considerations into project scoring criteria in support of active transportation project components. Such components may include: • Ensuring connections with destinations	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans

Interventions	Population of Focus	Age Range	Intermediate Measures
• Considering a focus on high-need areas (e.g., places with limited networks of activity-friendly infrastructure; places at risk for pedestrian or bicyclist injuries or fatalities; places with inequities) • Tracking and improve walking, bicycling, and transit conditions • Working in places with population densities that support these activities [300] LHD O			
 Work with partners to conduct health equity assessments. These could include an analysis of active transportation and public transit access, convenience, and reliability; strategies to prevent gentrification and displacement; park, trail, and greenway access and safety.[300] LHD O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
 Work with a cross-sector team to complete the Centers for Disease Control and Prevention (CDC) Active Communities Tool to assess your community design and create an action plan to make it more activity-friendly. Examples include: • Pedestrian, bicycle, and public transit transportation systems that offer a direct and convenient connection with everyday destinations • Offering physical protection from cars and making it easy to cross the street. These can include crosswalks, protected bicycle lanes, multiuse trails, and pedestrian public transit bridges[300] LHD O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
 Identify relevant state, regional, and local data. Use data on health conditions, health behaviors, and local capacity to increase physical activity through community design. Prioritize communities with health disparities. Examples include:	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans

Interventions	Population of Focus	Age Range	Intermediate Measures
• Collect health data such as physical activity levels, weight status, chronic diseases and risk behaviors, or pedestrian and bicycle injuries and deaths • Note health equity assessment findings, the number of champions or level of political consensus, existence of a cross-sectoral coalition or current action plan, experience with evaluation experience addressing health inequities • Use mapping software when appropriate to identify areas where resources may best be focused[300] LHD O			
Conduct walk/move audits with local decision-makers and community members who represent diverse perspectives, such as age, ability, race/ethnicity, gender, and income.[300] LHD O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
Rate access to parks, trails, greenways, and recreational facilities and work with community coalitions to create or improve safe access to these locations.[300] LHD O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
Work with partners to update zoning codes to include activity-friendly design. Examples include form-based codes and activity-friendly districts: • Pedestrian, bicycle, and public transit transportation systems that offer a direct and convenient connection with everyday destinations • Offering physical protection from cars and making it easy to cross the street, including crosswalks, protected bicycle lanes, multiuse trails, and pedestrian public transit bridges[300] O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans

Interventions	Population of Focus	Age Range	Intermediate Measures
 Provide and/or promote training to opinion leaders, state and local staff, and coalition members about increasing physical activity through community design.[300] LHD O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
 Conduct and evaluate inclusive demonstration projects with the goal of influencing permanent infrastructure changes that lead to policy, systems, and environmental improvements, such as connecting active transportation networks and destinations.[300] O	Everyone	All ages	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans
 Implement pedestrian-centered policies such as Complete Streets and Vision Zero to require consideration of active transportation in all future developments.[303,304] O	Everyone	All ages	Number of active transportation-focused initiatives implemented, trends in walkability scores, trends in utilization of active transport, safety score of areas with high pedestrian traffic based on safety audit checklists
 Enhance active transportation infrastructure through opportunities to expand existing networks. • Encourage public and private sector businesses to adopt programs with alternative commuting methods; promote and participate in NYS's annual Green Your Commute Day • For state agencies, promote the use of 511NY Rideshare within state government agencies • For the private sector, promote greater use of carpooling[305] LHD O	People vulnerable to climate change (older adults, children, low-income, etc.)	All ages	Increase in uptake of programs transportation programs

Lead Partner Agencies and Organizations

NYS Department of Transportation
NYS Department of Health
NYS Parks, Recreation & Historic Preservation
NYS Office for the Aging
NYS Department of Environmental Conservation
U.S. Department of Transportation
Local departments of transportation
Local parks and recreation agencies
Local offices for the aging
Climate Smart Communities NY
Local departments of environmental conservation
Local transit authorities
Local transportation businesses
Local housing authorities
Regional Planning and Development Commission
Local planning agencies
Public works agencies
Land use organizations
Economic development agencies
Hospitals, primary care providers, regional health networks
Local businesses, chambers of commerce, tourism agencies
Local advocates, volunteer organizations, Rotary Clubs
Schools, BOCES programs
YMCA, youth services organizations
Bicycle and pedestrian consultants and organizations
Lawmakers, elected officials
Law enforcement, code enforcement
511NY Rideshare, other rideshare organizations

Implementation Resources

CDC - Physical Activity Community Design Resources

NYS Department of Transportation - Grants Dashboard

US Department of Transportation - Grants Dashboard

NYS Department of Transportation - Bicycle and Pedestrian Safety Funding Opportunities

NYS Department of Environmental Conservation - Climate Smart Communities Funding

511NY Rideshare - NY Green Your Commute

Priority: Access to Community Services and Support

Goal: Improve awareness, affordability, accessibility, and acceptability of community services and supports.

What is Access to Community Services and Support and Why is it Important?

Responding to the impacts of climate change is an important priority for NYS. Climate change is causing NYS weather to become hotter and wetter. From 1901 to 2022, average temperatures in NYS increased by almost 2.6°F, and the warmest 10-year periods in recorded history have occurred since 2000.[306] Climate projections indicate temperatures will continue to rise and extreme heat events will be more frequent and intense. Current research suggests that increases of a few degrees in temperature can substantially increase the risk of heat-related illnesses.

In January 2020, the NYS Climate Leadership and Community Protection Act (Climate Act) went into effect. The Climate Act's greenhouse gas (GHG) emissions targets are among the most rigorous of any major economy in the world. The Climate Smart Communities program (supported by the NYS Department of Environmental Conservation) is one program that supports efforts towards Climate Act goals by helping local governments reduce their GHG emissions and adapt to a changing climate. Local governments can receive credit towards Climate Smart Communities certification by making community improvements and offering services that help individuals throughout New York.[307]

While many people have access to a cool spot in their home, BRFSS data from 2018 suggests that 16.5% of people in New York do not have air conditioning in their homes. This proportion is higher among households reporting less than $35,000 in income and among Black, non-Hispanics.[308] NYS has prioritized climate adaptation by developing a statewide extreme heat action plan to address the effects of extreme heat on residents' health.

The Heat Vulnerability Index maps identify areas of the state with larger proportions of people who may be vulnerable to heat. The Climate Act requires the identification and consideration of Disadvantaged Communities (DACs) in implementing the Climate Act and other State-led actions. By leveraging and promoting existing policies, programs, and resources, NYS can adapt to increasing temperatures and reduce the risk of heat-related illnesses.

SMART(IE) Objective:

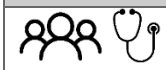
22.0 Increase the number of completed Climate Smart Community Actions related to community resilience from 363 to 382.
22.1 Increase the percentage of higher vulnerability areas that have a cooling center from 24.5% to 27.0%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Ensure the availability and accessibility of cooling centers or other places where people can cool off during extreme heat	Count of Climate Smart Community Actions related to community resilience	Climate Smart Community Application Data	Everyone	363 (2024)	382 (2030)
	Subpopulation Indicator	**Data Source**	**Subpopulation of Focus**	**Baseline**	**Target**

events in high heat vulnerable areas and disadvantaged communities.	Percentage of higher vulnerability areas that have a cooling center	NYSDOH Cooling Center Finder Data	Individuals in high heat vulnerable areas and disadvantaged communities	24.5% (2024)	27.0% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** Identify and promote the availability and use of cooling centers and other extreme heat resources; improve access to cooling centers, especially in areas designated as disadvantaged communities and/or have a high heat vulnerability index score.[309] LHD O	People who live in disadvantaged communities and/or high-heat vulnerable areas; people who are more vulnerable to heat (older adults, children, low-income, people who are pregnant, people with certain chronic diseases)	All ages	Increase in cooling centers in disadvantaged communities and/or with high heat vulnerability index scores
 **Featured Intervention:** Increase health and wellness among older adults by promoting age-friendly environments that support active lifestyles and enhance access to supportive services. Examples include: • Developing accessible parks, walking paths, and recreational programs that encourage regular physical activity • Creating integrated age-friendly ecosystems that provide access to health care services, social services, and assistance programs tailored to older adults' needs which should include: o Partnerships across universities, health care, public health, workplaces, and community services to ensure comprehensive care o Implementation of features like ramps, elevators, and benches in public areas enable older adults to navigate their environments more easily o Tailoring to both urban and rural settings, ensuring broad access and engagement[310] LHD H O	Older adults	Ages 50+	AARP Annual Survey, Public Health Local and State Data, State Community Assessment measures and plans

Interventions	Population of Focus	Age Range	Intermediate Measures
$ Promote programs that help low-income residents adapt to a changing climate, reduce their greenhouse gas emissions, and become more energy efficient. Examples include: • The Home Energy Assistance Program (HEAP): Offered by the Office of Temporary and Disability Assistance, this program helps eligible low-income residents efficiently heat and cool their homes, providing resources such as free air conditioners or fans • NYSERDA Programs: The New York State Energy Research and Development Authority (NYSERDA) offers various incentives and programs to help consumers reduce emissions and enhance energy efficiency • Low-income residents may qualify for programs such as: Appliance Upgrade Program, EmPower+, Residential Financing Programs[311] LHD O	Adults in low-income households	Ages 18+	Increase in applications to programs
 Become a certified Climate Smart Community (CSC). CSC is a NYS program that helps local governments take action to reduce greenhouse gas emissions and adapt to a changing climate, which also has co-benefits to public health. To become a Client Smart Community (CSC): • Register by taking the CSC pledge • Complete and document a suite of actions that mitigate and adapt to climate change at the local level Besides the environmental and public health benefits, certification also facilitates better scores for some state funding programs, including NYSDEC's CSC grant program.[312,313] LHD O	People vulnerable to climate change (older adults, children, low-income, etc.)	All ages	Completes certification; Completes Climate Smart Certified actions
Adopt decarbonization efforts by utilizing the New York Healthcare Decarbonization Guide and utilize NYSERDA's Clean Green Hospitals Programs and Opportunities.[314] H	People vulnerable to climate change (older adults, children, low-income, etc.)	All ages	Number of actions taken to reduce greenhouse gases

Interventions	Population of Focus	Age Range	Intermediate Measures
 Increase health and wellness through age-friendly environments that promote active lifestyles through parks, walking paths, and recreational programs.[315,316] O	Older adults	Ages 50+	Number of available age-friendly wellness programs, utilization of age-friendly wellness programs (how many people participation, participation trends)
 Promote and prioritize age-friendly initiatives by educating primary care providers during annual wellness visits, ensuring they are equipped to discuss and implement these practices. Examples include: • Raising awareness through public information at health fairs, TV, and radio advertisements, and in retail clinics, highlighting the benefits of age-friendly care • Increasing participation in public health campaigns that emphasize healthy aging, preventative care, and access to health resources by hosting senior center events • Distributing targeted public health materials in both urban and rural settings, ensuring that older adults are aware of available resources and services[317] LHD H O	Older adults	Ages 50+	Number of older adults who participate in screenings, assess knowledge/awareness in preventive care options, assess engagement with health resources
 Facilitate social interaction and community engagement to combat isolation and loneliness by offering structured programs and creating inclusive spaces for participation. Examples include: • Community centers hosting regular social activities, such as group exercise classes, hobby clubs, and support groups, as well as organizing local events like cultural festivals, intergenerational programs, or volunteer opportunities • Annual wellness visits including assessments of social interactions and community involvement, helping identify individuals at risk of isolation • TV and radio advertisements to promote local programs, health fairs, immunization clinics, and other events that encourage social engagement[318-321]	Older adults	Ages 50+	Surveys tracking participation in social and community programs for older adults. Decreased rates of loneliness/isolation among older adults, improved mental well-being, reports for Adult Protective Services

Interventions	Population of Focus	Age Range	Intermediate Measures
O			
 Educate policymakers and health care leaders on promoting age-friendly practices in health care and community infrastructures, focusing on integrating aging into core health care practices. • For hospitals: o Implement continuous education programs for staff on age-friendly care and adopting the Age-Friendly Health Systems status • For local health departments: o Incorporate aging into health assessments and planning, and prioritizing aging as a core competency o Collaborate with public health institutes (PHI) to develop age-friendly policies and community programs that address senior wellness, accessible housing, and transportation and more[322] LHD H O	Older adults	Ages 50+	Changes in policy, the addition of aging-related initiatives on the political agenda, partner engagement
 Promote evidence-based initiatives such as Age-Friendly Health Systems to improve the quality of care delivered to older adults.[323,324] LHD H O	Older adults	Ages 50+	Increased research output (can be tracked by looking at the number of papers published focusing on this topic, tracking publications), increased funding for research, policy shifts
 Support quality improvement initiatives that focus on enhancing comprehensive, age-friendly, coordinated care provided to older adults within health care settings through the Age Friendly Health Systems (AFHS) movement. Examples include: • Improving outcomes in chronic disease management • Enhancing medication management • Optimizing transitions of care to prevent hospital readmissions[325,326] LHD H O	Older adults	Ages 50+	Number of health care sites that are AFHS, number of ED that are age-friendly, outcomes of various age-friendly locations in terms of quality, satisfaction and cost

Interventions	Population of Focus	Age Range	Intermediate Measures
 Provide education and training programs for health care providers on best practices for caring for older adults. These programs emphasize age-friendly practices, enabling health care professionals to better understand and address the specific health challenges faced by the aging population.[327] LHD H	Older adults	Ages 50+	Participation among health care organizations, number of trainings delivered, number of providers and staff trained, capacity of health care staff to implement best practices
 Hold a Poverty Simulation (evidence-based activity) for community-based organization (CBO) leaders, Medicaid directors, discharge planners, social workers, care managers and others who work to connect individuals to needed resources. A local legislative body would also benefit from this exercise.[328] LHD H O	Everyone	All ages	Number attending, quality analysis of debriefing session
 Implement and promote Healthy Neighborhoods Programs in communities with high rates of asthma to provide home environmental assessments and low-cost interventions to address asthma-triggering conditions and asthma self-management.[329] LHD	Lower-income neighborhoods facing high presence of substandard housing conditions	All ages	Percentage of home visits for individuals with poorly controlled asthma under the Healthy Neighborhoods Program

Lead Partner Agencies and Organizations

U.S. Department of Health and Human Services
NYS Office of Temporary and Disability Assistance
NYS Energy Research and Development Authority
NYS Office for the Aging
NYS Department of Health
    Cooling Centers Team
    Building Resilience Against Climate Effects (BRACE) Program
NYS Department of Environmental Conservation
    Climate Smart Communities Program
    Local Emergency Management Offices
National Institute on Aging
Local Social Services Departments
NYC Department for the Aging
Local offices for the aging
Local sustainability agencies
Local planning agencies
Local certified Climate Smart Communities
Administration for Community Living (Region 1)
Economic Development Collaborative
AARP Age-Friendly Communities
AARP Public Policy Institute, senior centers
NY Foundation for Elder Care
National Council on Aging
Gerontological Society of America
John A. Hartford Foundation
Trust for America's Health Age-Friendly Ecosystem Initiative
Local health care organizations, primary care providers, hospitals, federally qualified health centers (FQHCs)
Healthcare Association of NYS (HANYS)
Institute for Healthcare Improvements
Health Foundation of Western and Central NY
Academic institutions

Implementation Resources

NYSERDA - Residential and Property Owner Income Eligible Programs

NYSERDA - Clean Green Hospitals

OTDA - Home Energy Assistance Program (HEAP)

NYSDOH - Cooling Center Finder

Climate Smart Communities

NYSDEC - Climate Smart Communities Funding

New York Healthcare Decarbonization Guide

NYSDEC - Grants for Climate Action

U.S. Climate Resilience Toolkit - Funding Opportunities

Institute for Healthcare Improvement - Age-Friendly Health Systems

Priority: Injuries and Violence

Goal: Prevent intentional and unintentional injuries.

What are Injuries and Violence and Why are they Important?

Injuries, unintentional and intentional, occur where people live, learn, work, and play. Injuries are a leading cause of death and disability among all age groups in NYS and are the leading cause of death for individuals 1-44 years of age. Each year, more than 13,000 individuals die due to an injury, 94,000 are hospitalized, and another 1.2 million are treated at an emergency department in NYS.[330] Many unintentional injuries are caused by motor vehicle crashes, falls, and drug overdoses, with intentional injuries being a result of assaults and self-harm.

Structural racism and health disparities contribute to an increase in injuries and poorer health outcomes among racial and ethnic minorities. Black, Non-Hispanic, Hispanic, American Indian/Alaskan Native, and Asian Pacific Islander individuals are all more likely to be hospitalized or treated at an emergency department for an injury sustained as a pedestrian than White, Non-Hispanic individuals. [331] Older adults are much more likely to be injured due to a fall than younger adults, with falls being the leading cause of unintentional injury deaths for those 65 years and older.[148] Women of color, especially multiracial, Black, and Indigenous individuals, are at highest risk for all forms of sexual violence.[332] The neighborhoods with the highest rates of gun violence today reflect the redlining maps dating back to the 1930s, and the systemic disinvestment in Black communities. Black people are 10 times more likely to be killed and 12 times more likely to be injured by a gun than their White counterparts.[333] Nearly 25% of fatal occupational injuries in New York during 2018-2022 occurred to Hispanic or Latino workers even though they account for only about 17% of the workforce during the same period.[334]

Injuries occur in predictable patterns, with recognizable risk and protective factors, and among identifiable populations. Injuries are preventable. By promoting available evidence-based strategies such as exercise programs, streetscape improvements, and community and environmental design guidelines for individuals and communities at high risk for injuries that can lower risk factors and strengthen protective factors, NYS can prevent injuries and create safer places to live, work, and play.

SMART(IE) Objective:

23.0 Decrease the rate of emergency department visits of motor vehicle-related pedestrian injuries per 10,000 people from 3.4 to 3.2.
23.1 Decrease the ratio of motor vehicle-related pedestrian injury emergency department visits of Black, non-Hispanic persons compared to White, non-Hispanic persons from 4.0 to 3.8.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Decrease Motor Vehicle-Related Pedestrian Injuries	Rate of emergency department (ED) visits of motor vehicle-related pedestrian injuries per 10,000 New York Residents	SPARCS (Statewide Planning and Research Cooperative System)	Everyone	3.4 (2022)	3.2 (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Black, non-Hispanic persons	4.0 (ratio of rates, Black, non-Hispanic compared to White, non-Hispanic) (2022)	3.8 (2030)

SMART(IE) Objective:					
24.0 Decrease the rate of emergency department visits of assault-related injuries per 10,000 people from 32.1 to 30.5. **24.1 Decrease the ratio of assault-related emergency department visits of Black, non-Hispanic persons compared to White, non-Hispanic persons from 4.2 to 4.0.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Decrease Assault-Related Injuries	Rate of emergency department (ED) visits of assault-related injuries per 10,000 New York residents	SPARCS	Everyone	32.1 (2022)	30.5 (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Black, non-Hispanic persons	4.2 (ratio of rates, Black, non-Hispanic compared to White, non-Hispanic) (2022)	4.0 (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Conduct comprehensive education and awareness activities about pedestrian/bicycle laws that incorporate multimedia platforms in various settings, enforcement and engineering partners, and pedestrian/bicycle safety organizations.[335] LHD H O	Everyone	All ages	Data regarding reach of chosen outreach methods (number of outreach events held and attendance, number of awareness materials distributed, number of website visits, etc.)
Featured Intervention: Implement multi-sector violence prevention programs such as the SNUG Street Outreach program, also known as Cure Violence, and hospital-based intervention programs, in high-risk communities, including those where gangs are prevalent. Example sectors include: • LHDs • Criminal justice • Local enforcement agencies • Hospitals	Communities at high risk for violence	All ages	High-risk areas defined, community members engaged, funding secured

Interventions	Population of Focus	Age Range	Intermediate Measures
• Social services • Job training • Community-based organizations These programs work best when they include wraparound services to support victims, families, and other community members impacted by crime.[336-340] LHD H O			
 Use a home fall prevention checklist to assess the homes of older adults for fall hazards and make modifications, as necessary.[341] LHD H O	Older adults	Ages 65+	Participation among organizations that perform home safety assessments, multi-housing units for older adults, and other organizations of focus, number of homes inspected, number of homes modified, data on which most frequent/least frequent modifications
 Connect older adults and people with disabilities with evidence-based falls prevention programs such as Tai Chi for Arthritis, Stepping On, and A Matter of Balance.[341,342] LHD H O	Older adults	Ages 65+	Number of staff or community partners trained to provide evidence-based programs, number of older adults that have taken evidence-based classes
 Improve roads, sidewalks, and crossings to encourage walking and bicycling to school.[343,344] LHD O	Children and youth	School-age	Participation in safety improvement initiatives among municipalities and schools, safety rating of active transport infrastructure near schools (using safety audit checklists - Safe Routes to School, US DOT)
 Conduct school-based programs that focus on skill building centered around emotional control and self-awareness, problem solving, and teamwork to reduce/prevent violent behavior among children.[345] H O	Children and youth	School-age	Participation among schools and youth organizations, number of children receiving intervention

Interventions	Population of Focus	Age Range	Intermediate Measures
Provide focused outreach activities and promote safe work practices during extreme heat through engagement with local partners. Resources such as the NYS Department of Labor Extreme Weather Guidance and the Occupational Safety and Health Administration Heat Rule should be utilized to inform employers and workers on how to protect health during extreme heat.[346] LHD H O	People who work in outdoor settings	Ages 18+	Increase in trainings and educational materials developed
Integrate the Building Resilience Against Climate Effects framework into existing Community Health Improvement Planning processes to enhance consideration of the impact of climate change on communities.[347] LHD H O	People vulnerable to climate change (older adults, children, low-income, etc.)	All ages	Increase in climate related activities and policies
Support development and implementation of multiagency and locally coordinated regional and local heat emergency plans that result in efficient response to heat events. Incorporate tools such as National Weather Service Heat Risk.[348-350] LHD	People vulnerable to extreme heat	All ages	Development of a heat emergency plan
Reduce access to firearms for children and individuals at high risk for harming themselves or others. Initiatives could include promoting safe storage of firearms and policies around purchasing of firearms.[351-352] LHD H O	Children and individuals at high risk for harming themselves and others	All ages	Number of gun locks distributed, number of guns turned into law enforcement

Interventions	Population of Focus	Age Range	Intermediate Measures
 Reduce neighborhood environmental risks. This can be done by reducing the number of abandoned buildings, increasing neighborhood lighting, and reducing the number of deserted streets.[353] LHD H O	Disadvantaged neighborhoods	All ages	Number of neighborhoods revitalized
 Establish bicycle safety programs inclusive of helmet distribution, education, and fitting for recipients.[354-355] LHD H O	Children	Ages 0-19	Number of helmets fitted and distributed
 Promote health care provider screening for fall risk among older adults and people with disabilities and engage health care providers in identifying modifiable risk factors and developing a fall prevention plan of care. A fall prevention plan of care may include but is not limited to physical or occupational therapy, community-based programs, medication management, Vitamin D supplements, updated eyeglasses, and changes to footwear.[356-358] LHD H O	Older adults	Ages 65+	Number of older adults screened for fall risk, number of older adults at risk for falls given a falls plan of care
 Improve safety measures, including better street lighting, traffic calming measures, and vigilant community policing, which contribute to a greater sense of security among older populations.[356-358] H O	Older adults	Ages 50+	AARP survey and crime stats

Lead Partners and Organizations

NYS Department of Health
- Office of Occupational Health and Injury Prevention
- Building Resilience Against Climate Effects (BRACE) Program

NYS Office of Emergency Management
NYS Department of Environmental Conservation
NYS Department of Labor
- Gun Violence Prevention Initiative

NYS Office for the Aging
- Elder Abuse Prevention and Interventions Initiative

NYS Office of Children and Family Services
NYS Department of Transportation
NYS Department of Motor Vehicles
NYS Division of Criminal Justice Services
NYC Department for the Aging
Local Departments of Social Services
Local departments of transportation, local transit authorities
Local departments of motor vehicles
Local criminal justice authorities
NYC Office of Gun Violence Prevention
Land management organizations
Economic development agencies, urban planning agencies
Neighborhood associations
Law enforcement
Policy makers
Cure Violence
SNUG Neighborhood Violence Prevention Program
Firearm retailers, Firearm owners
Legal services organizations
Assisted living facilities
AARP
American Automobile Association (AAA)
Managed care organizations, primary care providers, geriatric care providers, health plans
Mental health care providers, mental health advocacy organizations
Healthcare Association of NYS (HANYS)
Association of State and Territorial Health Officials (ASTHO)

Implementation Resources

OSHA - Heat Injury and Illness Prevention in Outdoor and Indoor Work Settings

CDC Climate and Health - About Building Resilience Against Climate Effects (BRACE) Framework

NYSDOL - Extreme Weather Guidance

Climate Smart NY Heat Emergency Plan Guidelines

NYSDEC - Brownfield Cleanup Program

NYS DOS - Opportunities Waiting to Happen: Redeveloping Abandoned Buildings and Sites to Revitalize Communities

National Highway Traffic Safety Administration - Road Safety

NYS Governor's Traffic Safety Committee

NYSDOT - NYS Strategic Highway Safety Plan

NYS Pedestrian Safety Programs

Pedestrian and Bicycle Information Center

NYSDOH - Injury Prevention - Bicycles

NYSDOH - Injury Prevention - Pedestrians

NYSDOH - Injury Prevention - Falls

CDC - STEADI - Older Adult Fall Prevention

National Council on Aging - Evidence-Based Falls Prevention Program

Cure Violence Global - Proven Strategies for Safer Communities

NYS Division of Criminal Justice Services - Gun Violence Reduction

ASTHO - How to Prevent Firearm Injury Using a Public Health Approach, with Examples and Resources

Everytown for Gun Safety - Hospital-Based Violence Intervention Programs: A Guide to Implementation and Costing

Everytown for Gun Safety - Secure Gun Storage

Youth Violence Prevention Center - Busy Streets

Prevention Institute - Gun Violence Must Stop. Here's What We Can Do to Prevent More Deaths

American Academy of Pediatrics - Safe Storage of Firearms

Harvard University - Means Matter: Suicide, Guns, and Public Health

Domain 4:
Health Care Access and Quality

Priorities:

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

Priority: Access to and Use of Prenatal Care

Goal: Increase accessibility, availability, timeliness, and quality of equitable prenatal care for all birthing persons.

What is Access to and Use of Prenatal Care and Why is it Important?

Prenatal care is one of the most common preventive care services in the US and aims to improve the health of 4 million birthing persons and their children each year. The 3 main components of prenatal care are: risk assessment, health promotion and education, and therapeutic intervention.

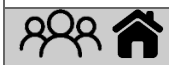
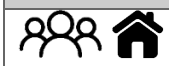
Prenatal care is most effective when it starts early and continues throughout pregnancy. The World Health Organization (WHO) recommends that birthing persons have at least 8 contacts with a health professional during their pregnancy, with the first contact taking place within the first 12 weeks of pregnancy. Increased frequency of fetal and maternal assessment helps early detection of potential complications and improves the birthing person's prenatal care experience.[359]

Increasing access to health care can help more birthing persons get the prenatal care they need. Prenatal care has been proven to reduce the rate of poor pregnancy outcomes, including preterm birth, low birth weight, stillbirth, and infant and maternal mortality. Some of these risk factors include late or no prenatal care, cigarette smoking, alcohol and other drug use, being HIV positive, spacing of pregnancies, maternal age, poor nutrition and socioeconomic status. Birthing persons from minority groups are more likely to have poorer birth outcomes than the general population.

NYS is committed to addressing risk factors that lead to poor birth outcomes, especially in the hard-to-reach populations of the state. Infant mortality in New York State has decreased by about 14.8% over the past 10 years, taking the state from 32nd in the nation to ninth. Nationally the decline over the same period was 6.7%.[360] By promoting existing programs focused on increasing access to prenatal and perinatal care for birthing persons from underserved populations, NYS can continue to make the health of women and children a priority.

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

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Provide screenings to prenatal and postpartum patients using validated tools, for example: • Mental Health: Edinburgh; Community-based Perinatal Support Model (CPSM) • Substance Use Disorder: Verbal Screening tools (4P's Plus, ASSIST-lite, DAST-10, BSTAD, etc.) • Social Care Needs: 1115 NYHER Waiver • Pregnancy Risk Assessment: Perinatal Risk Assessment (PRA); Antepartum Risk Score (APRS); Rotterdam Reproductive Risk Reduction (R4U); Maternal Venous Thromboembolism (VTE) Risk Assessment[43, 361-367] LHD H O	Birthing persons, especially those more susceptible or at risk of mental illnesses or disorders associated with pregnancy or postpartum	Ages 15-44	Number of people screened, number of successful referrals made
Featured Intervention: Establish policies and practices to support doula care and services, especially in areas of maternal deserts and historic underinvestments. This could include supporting doula training, certification, enrollment in Medicaid for reimbursement for services, and public-facing promotion about being a doula-friendly hospital.[368, 369] H	Birthing persons, infants	Ages 15-44	Number of hospitals that institute doula-friendly policies, number of births involving doula care, utilization of doula Medicaid benefit

Interventions	Population of Focus	Age Range	Intermediate Measures
 Offer Centering Pregnancy, the evidence-based group prenatal care session.[370-372] LHD O	Birthing persons	Ages 14-55	Number of hospitals/health care practices that adopt group prenatal care models, number of birthing persons enrolled in group prenatal care
 Connect birthing people at high risk to evidence-based or evidence-informed home visitation programs (e.g., Healthy Families which is in every county, Nurse Family Partnership, and the Perinatal and Infant Community Health Collaborative which utilizes community health workers).[55, 373-376] LHD H O	Birthing persons at high risk for experiencing symptoms of perinatal mood and anxiety disorders	Ages 14-55	Number of people served by home visiting programs, number of home visits per patient, number of screenings performed for medical or social care needs, number of successful referrals made for medical or social care needs
 Integrate telemedicine and home-based connectivity devices into routine prenatal care check-ins to increase accessibility.[377] LHD H	Birthing persons	Ages 14-55	Number of prenatal visits per patient, number of cancelled appointments
 Connect hospitals with local health departments, community-based partners, and philanthropic organizations to support the establishment of midwifery practices, especially in areas of maternal deserts and historic underinvestments.[378-380] LHD H	Health care organizations, Midwives	N/A	Number of midwifery practices established
 Integrate hospital-based midwifery model of care that supports the employment of midwives in leadership roles, the institution of formal policies and practices supportive of midwives as independent clinical professionals, and emphasis on the value and benefit of such programs.[378-380] H	Hospitals, Midwives	N/A	Number of hospitals and practices that integrate midwife care, number of births involving midwife care
 Encourage the development and implementation of birth plans. This could include providing a birth plan template to help expecting parents to create a vision of	Birthing persons	Ages 14-55	Number of birth plans created, number of trainings delivered

Interventions	Population of Focus	Age Range	Intermediate Measures
their birth experience and incorporating literacy around doula support, pain management, induction and possible surgical delivery.[378-380, 381] LHD H O			
 Offer free childbirth education classes or financial support for participants with high need.[382] LHD H O	Birthing persons, particularly low-income individuals	Ages 14-55	Number of trainings delivered, number of people trained, number of people given financial support, number of people seeking financial support
 Encourage Obstetrics and Gynecology (OB-GYN) and midwifery practices to adopt the Collaborative Care model and/or enroll in New York State's Collaborative Care Medicaid Program to support maternal mental health needs.[383-385] LHD H	OB-GYN and midwifery practices	N/A	Number of practices enrolled in NYS Collaborative Care Medicaid Program, number of applications for enrollment, number of people served by practices enrolled in program
 Develop peer support services for the prevention of perinatal depression and connect birthing persons to peer support services as part of prenatal care.[386-388] LHD H O	Birthing persons	Ages 14-55	Number of successful referrals made, number of patients connected to peers, number of peer support specialists available, number of new certifications for peer support specialists
 Promote use of Project TEACH (pediatric and perinatal psychiatry access program) for primary care, pediatric, OB-GYN practices, doulas, nurses, CHWs, to improve provider knowledge and capacity to address maternal mental health needs.[386-388] LHD H O	Birthing persons	Ages 14-55	Number of inquiries made, number of practices/providers who contact Project TEACH, perceived capacity of providers to address perinatal mental health needs
 Develop training for Community Health Workers/Doulas that is culturally responsive to assist families in navigating the health system and accessing care.[389-393] LHD O	Community Health Workers & Doulas	N/A	Number of trainings delivered, number of birthing persons who receive doula or CHW care, number of people who have newly enrolled in insurance, number of attended/cancelled appointments

Interventions	Population of Focus	Age Range	Intermediate Measures
 Provide support with health insurance navigation assistance to improve health insurance literacy (e.g., NYS Growing Up Healthy Hotline; NYS Perinatal Quality Collaborative).[394,395] LHD H O	Birthing Persons	Ages 14-55	Number of people served, number of insured birthing persons who were previously uninsured

Lead Partner Agencies and Organizations

US Centers for Disease Control and Prevention (CDC)
NYS Department of Health
- NYS Medicaid
- WIC Program
- New York State Perinatal Quality Collaborative
- Perinatal Infant Community Health Collaboratives
- Breastfeeding, Chestfeeding, Lactation Friendly New York

NYS Office of Children and Family Services
NYS Office of Mental Health
Local child and family services agencies
Health care providers, health plans, insurance brokers
American College of Obstetricians and Gynecologists (ACOG)
Alliance for Innovation in Maternal Health (AIM)
Project TEACH
Postpartum Support International, Postpartum Resource Center of New York
Regional Food Banks
Medicaid Social Care Network
Nurse Family Partnership, Healthy Families NY
Local midwifery and doula practices
Local childcare organizations

Implementation Resources

Project TEACH

NYSDOH - Doula Services Information for Medicaid Members

New York Center for the Advancement of Behavioral Health Integration - Collaborative Care Medicaid Program (CCMP)

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HRSA - Title V Maternal and Child Health Services Block Grant Program

Groundswell Fund - Birth Justice Fund

Priority: Prevention of Infant and Maternal Mortality

Goal: Improve health outcomes by lowering mortality and morbidity rates for infants and birthing persons.

What is Prevention of Infant Mortality and Why is it Important?

Infant mortality is an important marker of the overall health of a society and gives us key information about the health of pregnant people and infants. Infant mortality is defined as the death of an infant before the age of one. The infant mortality rate is the number of infant deaths for every 1,000 live births. In 2019, the infant mortality rate in the United States (US) was 5.6 deaths per 1,000 live births.[396]

Nationally, the top 5 causes of infant mortality in 2022 were birth defects; pre-term birth and low birth weight; sudden infant death syndrome (SIDS); unintentional injuries, and maternal complications of pregnancy. In 2022, New York State (NYS) ranked 7th overall in infant mortality compared to the other US states. The number of NYS infant deaths declined by 14.8% from 5.0 deaths per 1,000 live births in 2012 to 4.26 deaths per 1,000 live births in 2022.[360]

Despite national and NYS efforts to address and eliminate racial and ethnic disparities in infant mortality, these disparities continue. In NYS, the infant mortality rate for Black, non-Hispanic individuals (8.5/1,000 live births) and Hispanic individuals (4.1) is significantly greater than the infant mortality rate among White, non-Hispanic individuals (3.3/1,000 live births).[360] The factors driving disparities in infant health are complex. These factors include the birthing person's employment status, income, housing, transportation, food security, access to healthy foods, stress, social supports, health care coverage, and quality of medical care received. Historic and persistent racism and discrimination also play a role in driving racial disparities in infant health. Even when controlling for insurance status, income, age, and severity of conditions, people of color are less likely to receive routine medical procedures and experience a lower quality of care overall.

What is Prevention of Maternal Mortality and Why is it Important?

Maternal deaths are devastating events with profound and prolonged effects on surviving family members, friends, communities, and health care workers. The US is one of the only countries in the world that has seen a rise in its maternal mortality ratio since 2000. Contributing risk factors to maternal mortality in the US include preexisting chronic health conditions, mental health conditions, gestational diabetes or preeclampsia, and complications, such as having a Cesarean section, problems in labor, and postpartum bleeding.

A 2020 Commonwealth Fund report comparing the US to 10 other wealthy nations revealed that the US's ratio was twice as high as any of the comparison countries, and 10 times as high as the country with the lowest ratio. The US maternal mortality ratio of 17.4 deaths per 100,000 live births would place it at roughly 55th among all countries, according to the WHO's latest report, adjacent to Russia, Saudi Arabia, and Uruguay.[397]

The maternal mortality ratio in NYS peaked at 24.4 per 100,000 live births in 2008-2010 but decreased to 19.3 per 100,000 live births in 2018-2020. The 2018-2020 maternal mortality ratio for New York City is 18.9 deaths per 100,000 live births, while the Rest of State ratio is 19.6 deaths. The maternal mortality ratio for NYS has remained below the national ratio since 2011.[398]

Nationwide, Black birthing women die at more than double the rate of White birthing persons (37.1 and 14.7 deaths per 100,000 live births, respectively). Racial disparities in maternal mortality ratios in NYS have persisted over time, despite fluctuations between individual three-year rolling periods. For 2018-2020, the statewide maternal mortality ratio for Black, non-Hispanic birthing people was 55.8 deaths per 100,000 live births, while the maternal mortality ratio for White

birthing people during the same period was 13.2 deaths per 100,000 live births. The Black to White mortality ratio in NYS for 2018-2020 was 4.2 to 1.[397,398]

By focusing on equity in health care and addressing SDOH for birthing persons, NYS can prevent the widening of disparities and advance maternal and infant health.

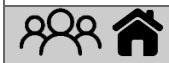
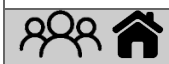
SMART(IE) Objective:					
26.0 Decrease the rate of infant mortality per 1,000 live births from 4.3 to 3.5.					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Decrease the rate of infant mortality	Infant mortality rate per 1,000 live births	National Vital Statistics System	Infants	4.3 (2022)	3.5 (2030)

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

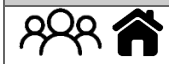
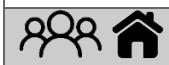
SMART(IE) Objective:					
28.0 Decrease percentage of birthing persons who experience depressive symptoms <u>during pregnancy</u> from 12.4% to 11.5%. **28.1 Decrease percentage of birthing persons <u>aged 20-24 years</u> who experience depressive symptoms <u>during pregnancy</u> from 26.2% to 19.0%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Decrease percentage of birthing persons who experience depressive symptoms during pregnancy	Percentage of birthing persons who report depression during pregnancy	PRAMS	Birthing persons	12.4% (2022)	11.5% (2030)
			Subpopulation of Focus 2	**Baseline**	**Target**
			Birthing persons aged 20-24 years	26.2% (2022)	19.0% (2030)

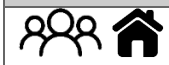
SMART(IE) Objective:					
29.0 Decrease percentage of birthing persons who experience depressive symptoms <u>after birth</u> from 11.9% to 9.9%. **29.1 Decrease percentage of birthing persons <u>aged 20-24 years</u> who experience depressive symptoms <u>after birth</u> from 19.2% to 18.0%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Decrease percentage of birthing persons who experience depressive symptoms after birth	Percentage of birthing persons who report depressive symptoms after giving birth	PRAMS	Birthing persons up to 1 year postpartum	11.9% (2022)	9.9% (2030)
			Subpopulation of Focus 2	**Baseline**	**Target**
			Birthing persons aged 20-24 years up to 1 year postpartum	19.2% (2022)	18.0% (2030)

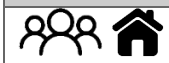
Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Implement the Alliance for Innovation on Maternal Health Bundle for Safe Reduction of Primary Cesarean Birth in birthing hospitals to reduce low-risk cesarean deliveries.[398] H	Birthing persons, especially those more susceptible or at risk of mental illnesses or disorders associated with pregnancy or postpartum	Ages 15-44	Number of hospitals that adopt use of bundles, number of trainings delivered to hospital staff for implementation of bundles, capacity of hospital staff to implement bundles
Featured Intervention: Provide free sleep sacks and/or portable cribs to families in need during prenatal period or before discharge from the hospital.[399] LHD H O	Low-income families with infants	Ages up to 1 year	Number of sleep sacks requested, number of sleep sacks distributed, number of families served
Featured Intervention: Establish policies and practices to support doula care and services, especially in areas of maternal deserts and historic underinvestments. This could include: • Supporting doula training • Supporting doula certification • Enrollment in Medicaid for reimbursement for services • Public-facing promotion about being a doula-friendly hospital[368,369] H	Birthing persons, infants	Ages 15-44	Number of hospitals that institute doula-friendly policies, number of births involving doula care, utilization of doula Medicaid benefit
Provide screenings to prenatal and post-partum patients using validated tools, for example: • Mental Health: Edinburgh; community-based Perinatal Support Model (CPSM) • Substance Use Disorder: Verbal Screening tools (4P's Plus, ASSIST-lite, DAST-10, BSTAD, etc.) • Social Care Needs: 1115 New York Health Equity Reform (NYHER) Waiver • Pregnancy Risk Assessment: Perinatal Risk Assessment (PRA); Antepartum Risk Score (APRS); Rotterdam Reproductive Risk Reduction (R4U); Maternal Venous Thromboembolism (VTE) Risk Assessment[361-367] LHD H O	Birthing persons, especially those more susceptible or at risk of mental illnesses or disorders associated with pregnancy or postpartum	Ages 15-44	Number of people screened, number of successful referrals made

Interventions	Population of Focus	Age Range	Intermediate Measures
 Implement postpartum depression screening for women participating in the Women, Infants, Children (WIC) program and collaborate with Local Health Departments (LHDs) and community-based organizations (CBOs) to provide referrals to comprehensive pregnancy, birthing, and postpartum services.[400] LHD O	Birthing persons participating in WIC	Ages 14-55	Number of WIC clients screened for mental health needs, number of successful referrals made
 Ensure full and up-to-date implementation of the American College of Obstetricians and Gynecologists' (ACOG) Safe Motherhood Initiative Hemorrhage Bundle, including: • Following a standard protocol for massive transfusions • Implementing a universal system for quantification of blood loss • Working with anesthesia teams to follow their facility's emergency management plan for response to hemorrhage during delivery and postpartum • Utilizing checklists and algorithms to assist with decision-making • Conducting training/drills on bundle implementation[401] H	Birthing persons	Ages 14-55	Number of hospitals that adopt use of bundle, number of trainings delivered to hospital staff for implementation of bundles, capacity of hospital staff to implement bundles
 Promote use of Alliance for Innovation on Maternal Health (AIM)/ACOG patient safety bundles: "Perinatal Mental Health Conditions" and "Care for Pregnant and Postpartum People with Substance Use Disorders" in hospital settings to provide care responsive to high-acuity psychiatric symptoms among birthing people.[402,403] H	Birthing persons with mental health and substance use challenges	Ages 14-55	Number of hospitals that adopt use of bundle, number of trainings delivered to hospital staff for implementation of bundles, capacity of hospital staff to implement bundles
 Connect birthing people, particularly those at high risk for postpartum mental health	Birthing persons	Ages 14-55	Number of people served by home visiting programs, number of home visits per patient, number of screenings

Interventions	Population of Focus	Age Range	Intermediate Measures
and substance use challenges, to evidence-based or evidence-informed home visitation programs (e.g., Healthy Families, Nurse Family Partnership, and the Perinatal and Infant Community Health Collaborative).[55,373-376] LHD H O			performed for medical or social care needs, number of successful referrals made for medical or social care needs
Implement "Hypertension in Pregnancy Change Package" proposed by Million Hearts and Centers for Disease Control and Prevention (CDC).[404] H	Birthing persons	Ages 14-55	Number of patients screened for high blood pressure, number of follow-up screenings, number of patients who receive blood pressure control interventions
Implement community-based Doula programs. [384, 405, 406, 407] LHD O	Birthing persons	Ages 14-55	Number of programs established, number of birthing persons who receive doula care during (1) prenatal period, (2) birth, (3) postpartum, and number of doulas registered with Medicaid
Implement the utilization of birth certificate information by LHDs to identify and contact new mothers for virtual health check-in post-delivery to increase potential for direct referral to external home visiting programs through Healthy Families New York (HFNY), Perinatal and Infant Community Health Collaboratives (PICHC), or CBOs providing in person home visiting services.[408] LHD	Birthing persons, infants	Ages 14-55, under 1 year	Number of records used to contact postpartum birthing persons for checkups, number of referrals made to home visiting programs
Implement a lactation care coordination system that begins during the prenatal period and continues through weaning stages. The system can include formal referral systems, follow-up accountability, and hand-off protocols during transitions of lactation care from one provider or setting to another.[266] LHD H	Postpartum birthing persons, infants	Ages 14-55, under 1 year	Number of patients served, number of successful referrals made
	Birthing persons	Ages 14-55	Number of people screened, number of successful referrals

Interventions	Population of Focus	Age Range	Intermediate Measures
Implement universal screening for maternal food insecurity and offer resources, such as existing grants and apps to find available food and resources, to women struggling to feed themselves and their families.[409,410] LHD H O			made to (1) food security resources and (2) Food as Medicine resources
 Connect hospitals with LHDs, community-based partners, and philanthropic organizations to support the establishment of midwifery practices, especially in areas of maternal deserts and historic underinvestments.[378-380] LHD H O	Health care organizations, Midwives	N/A	Number of midwifery practices established
 Integrate hospital-based midwifery model of care that supports: • The employment of midwives in leadership roles • The institution of formal policies and practices supportive of midwives as independent clinical professionals • The emphasis on the value and benefit of such programs[378-380] H	Hospitals, Midwives	N/A	Number of hospitals and practices that integrate midwife care, number of births involving midwife care
 Provide targeted health literacy education for pregnant patients regarding the importance of immunization for both birthing person and newborn including guided strategies for immunization that outlines locations patients can go to get both services.[411] LHD H O	Birthing persons, infants	Ages 14-55, under 1 year of age	Number of trainings delivered, number of people who received training, number of timely immunizations for infants
 Promote the use of harm reduction toolkits such as Pregnancy and Substance Use: A Harm Reduction Toolkit, among people who use substances and their families.[412] LHD O	Birthing persons with substance use challenges	Ages 14-55	Number of hospitals and practices that adopt use of toolkits, number of trainings delivered to hospital staff in implementing toolkits, number of patients served using toolkits
	Infants	Ages under 1 year	Number of childcare centers that adopt healthy nutrition

Interventions	Population of Focus	Age Range	Intermediate Measures
Support the adoption of healthy nutrition policies and standards at early childcare centers.[413] LHD O			policies, number of children served by childcare centers that adopt healthy nutrition policies
 Implement ZERO TO THREE's Healthy Steps Program in pediatric primary care offices.[414] H	Birthing persons, infants	Ages 14-55, under 1 year	Number of practices that implement Healthy Steps, number of enrolled participants
 Collect and stratify clinical data by race, ethnicity, and language (REAL) data to analyze and identify drivers of inequity and targets for quality improvement.[415, 416] H	Hospitals and health care organizations	N/A	Number of records analyzed, intermediate findings of likely drivers contributing to inequities
 Encourage obstetrics and gynecology (OB-GYN) and midwifery practices to adopt the Collaborative Care model and/or enroll in New York State's Collaborative Care Medicaid Program to support maternal mental health needs.[383-385] LHD H	OB-GYN and midwifery practices	N/A	Number of practices enrolled in NYS Collaborative Care Medicaid Program, number of applications for enrollment, number of people served by practices enrolled in program
 Develop peer support services for the prevention of perinatal depression and connect birthing persons to peer support services as part of prenatal care.[386-388] LHD H O	Birthing persons	Ages 14-55	Number of successful referrals made, number of patients connected to peers, number of peer support specialists available, number of new certifications for peer support specialists
 Promote use of Project TEACH (Training and Education for the Advancement of Children's Health) pediatric and perinatal psychiatry access program to improve provider knowledge and capacity to address maternal mental health needs across diverse settings.[417] This may include: • Primary care practices • Pediatric practices • OB-GYN practices • Nurses • Community health workers (CHWs)	Birthing persons	Ages 14-55	Number of inquiries made, number of practices/providers who contact Project TEACH, perceived capacity of providers to address perinatal mental health needs

Interventions	Population of Focus	Age Range	Intermediate Measures
LHD H O			
 Provide support with health insurance navigation assistance to improve health insurance literacy (e.g., NYS Growing Up Healthy Hotline; NYS Perinatal Quality Collaborative).[394] LHD H O	Birthing Persons	Ages 14-55	Number of people served, number of insured birthing persons who were previously uninsured

Lead Partner Agencies and Organizations

US Centers for Disease Control and Prevention (CDC)
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HRSA - Title V Maternal and Child Health Services Block Grant Program

Groundswell Fund - Birth Justice Fund

Priority: Preventive Services for Chronic Disease Prevention and Control

Goal: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

What are Preventive Services for Chronic Disease Prevention and Control and Why are they Important?

Most chronic diseases are preventable and linked to modifiable risk factors such as poor nutrition, physical inactivity, tobacco use, and excessive alcohol consumption. They are a leading driver of health care costs and a major strain on the health care system. In NYS, chronic diseases such as heart disease, stroke, cancer, chronic obstructive pulmonary disease, diabetes, and obesity are the leading causes of disability and death. They have a significant burden and fundamentally reduce one's overall quality of life, causing 6 out of 10 deaths.

Social and structural inequities lead to stark racial and ethnic disparities and disproportionately impact the most vulnerable populations, including people of color. Hospitalization and mortality rates in NYS for both heart disease and stroke are highest among Black non-Hispanic individuals.[418] The prevalence of high blood pressure is also considerably higher among Black non-Hispanic adults (37.7%) and American Indian or Alaskan Native non-Hispanic adults (41.3%) when compared to White non-Hispanic adults (31.3%). White non-Hispanic individuals are more likely to be diagnosed with cancer, but their Black non-Hispanic counterparts are more likely to die. Asthma morbidity and mortality rates among Black non-Hispanic and Hispanic communities remain consistently higher when compared to other racial and ethnic populations. In 2021, asthma emergency department visit rates for Black non-Hispanic children aged 0-17 (160.2 per 10,000) were 5 times higher than White non-Hispanic children (18.1 per 10,000). The prevalence of diabetes and obesity among Black non-Hispanic and Hispanic adults is also greater.[148]

Many people across NYS live with more than one chronic disease. The importance of early screening and detection, the promotion of self-management skills, and increased access to providers and referral services can largely impact the incidence and severity of chronic diseases. Thus, evidence-based prevention and management is integral for improving overall quality of life and narrowing the gap on health inequities. By focusing on community environments and systems developing evidence-based policies, practices, and interventions; and prioritizing vulnerable populations, NYS can assist with dismantling systemic barriers and allowing all people to achieve optimal health.

SMART(IE) Objective:					
30.0 Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year from 78.1% to 82.4%. **30.1 Increase the percentage of younger adults aged 35-44 years who had a test for high blood sugar in the past year from 62.4% to 65.5%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
(Increase screening/early detection) Increase the percentage of adults who had a test for high blood sugar or diabetes within the past year, aged 35 years and older	High blood sugar/diabetes screening among adults, aged 35 years and older	BRFSS	Adults aged 35 years and older	78.1% (2023)	82.4% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Younger adults aged 35-44 years	62.4% (2023)	65.5% (2030)

SMART(IE) Objective:					
31.0 Decrease the asthma emergency department visit rate per 10,000 among children aged 0-17 years from 93.8 to 89.1. **31.1 Decrease the asthma emergency department visit rate per 10,000 among Black, non-Hispanic children aged 0-17 years from 235.9 to 212.3.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
(Management of diseases) Decrease the asthma emergency department visit rate per 10,000, aged 0-17 years	Asthma emergency department visit rate per 10,000, aged 0-17 years	SPARCS	Children aged 0-17 years	93.8 (2022)	89.1 (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Black, non-Hispanic children aged 0-17 years	235.9 (2022)	212.3 (2030)

SMART(IE) Objective:					
32.0 Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%. **32.1 Increase the percentage of adult Medicaid members aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
(Management of disease) Increase the percentage of adults with hypertension who are currently taking medication to manage their high blood pressure	Hypertension management (percentage of adults reporting medication use to manage their hypertension, aged 18 years and older)	BRFSS	Adults aged 18 years and older with hypertension	77.0% (2023)	81.7% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Medicaid members aged 18 years and older with hypertension	66.9% (2023)	75.5% (2030)

SMART(IE) Objective:					
33.0 Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 73.7% to 82.3%. **33.1 Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 55.8% to 63.4%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the percentage of adults aged 45-75 years who receive a colorectal cancer screening based on the most recent guidelines	Cancer Screening (percentage of adults who receive colorectal cancer screening)	BRFSS	Adults aged 45-75 years	73.7% (2023)	82.3% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Adults aged 45-54 years	55.8% (2023)	63.4% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** (Chronic Disease, generally) Expand screening for social care needs among all adults and those with chronic diseases (prediabetes, diabetes, hypertension, cancer screening), and provide referrals to appropriate community resources and supports.[419] LHD H O	Adults in underserved communities	Ages 18+	Increased referrals to social services and support needs
 **Featured Intervention:** (Chronic Disease, generally) Partner with community-based organizations to promote access to prevention and screening services.[420] LHD H O	Adults	Ages 18+	Increased number of screenings in areas that are underserved
 (Chronic Disease, generally) Integrate community health workers into health care teams to improve chronic disease management for patients experiencing health inequities.[421] LHD H O	Multiple	Multiple	Availability of community health workers
 (Chronic Disease, generally) Improve utilization of peers/community health workers by establishing certification and/or training opportunities to build upon lived experiences while simultaneously assessing ways for peer delivered services to be reimbursed to providers/programs.[422] LHD H O	N/A	N/A	Curriculum development, trainings completed, peers utilized, job postings
 (Chronic Disease, generally) Include community voices in identifying changes, solutions, and innovations needed to address disparities.[423,424] LHD H O	Multiple	Multiple	Partnerships, community forums

Interventions	Population of Focus	Age Range	Intermediate Measures
 (Chronic Disease, generally) Introduce and promote policies, practices, and programs that support and increase the primary care workforce and promote team-based, person-centered primary care at the local level. This may include: • Local health departments or hospitals involving primary care at local educational events for local schools, health fairs or community health events • Local health departments of hospitals coordinating local projects and available resources with primary care systems in their areas • Local entities advocating alongside their primary care colleagues to prioritize funding for primary care[425] LHD H O	Multiple	Multiple	Increased longevity of providers and reduced number of providers reporting burnout
 (Chronic Disease, generally) Implement or increase health insurance enrollment outreach and support programs.[426] LHD O	Adults	Ages 18+	Decreased in uninsured or underinsured individuals
 (Chronic Disease, generally) Expand the number of health care providers who provide chronic disease self-management education in areas with high chronic disease burden.[427] LHD H O	Adults	Ages 18+	Number of providers who have taken continuing education classes on chronic disease self-management
 (Chronic Disease, generally) Enhance the number of providers in New York State who are trained in Lifestyle Medicine.[428] H O	Providers (i.e., primary care providers, board-certified specialists)	N/A	Increased number of providers certified in Lifestyle Medicine
 (High Blood Pressure) Implement treatment and follow-up protocols within hospitals and ambulatory care settings, such as, Federally Qualified	Multiple	Multiple	Increased referrals to specialists of patients with documented hypertension

Interventions	Population of Focus	Age Range	Intermediate Measures
Health Centers (FQHCs) for patients exhibiting two or more in office blood pressure readings indicating stage 1 hypertension: 130-139/80-89 per American Heart Association guidelines.[429,430] H O			
(High Blood Pressure) Recruit, train, and deploy community health workers to deliver evidence-based, "self" monitoring blood pressure management programs.[431] LHD H O	Health Departments	Multiple	Programs have been implemented with Community Health Workers trained in blood pressure monitoring at home
(High Blood Pressure/Stroke) Provide evidence-based stroke prevention education in communities that are disproportionately affected by a high prevalence of undiagnosed and/or uncontrolled hypertension.[432] LHD H O	Everyone	All ages	Number of participating organizations, data regarding reach relevant to outreach method (number of education or outreach events held and attendance, number of awareness materials distributed, number of website clicks, etc.), trends in screening for hypertension
(High Blood Pressure/Stroke) Provide evidence-based education on stroke recognition and the use of emergent Emergency Medical Services (EMS) care within communities disproportionately affected by a high prevalence of stroke hospitalizations.[432] LHD H O	Everyone	All ages	Number of participating organizations, data regarding reach relevant to outreach method (number of education or outreach events held and attendance, number of awareness materials distributed, number of website clicks, etc.), number of EMS calls for stroke-related services
(High Blood Pressure) Implement community screenings to detect and address hypertension.[433] H O	Adults	Ages 18+	Decreased number of emergency room visits resulting in diabetes diagnosis
(High Blood Pressure) Implement community screenings to detect and address high cholesterol.[433] H O	Adults	Ages 18+	Decreased number of emergency room visits resulting in diabetes diagnosis

Interventions	Population of Focus	Age Range	Intermediate Measures
(Asthma) Adopt streamlined workflows, well-functioning electronic health records, clinical decision support tools, and patient registries to assess asthma control, step-up/down therapy, and ensure appropriate follow-up and preventive care.[434] H	Multiple	Multiple	Workflow and electronic medical record (EMR) improvements
(Asthma) Ensure care providers offer personalized, culturally appropriate asthma action plans using the patients and caregivers' language and level of health literacy.[435] H O	Multiple	Multiple	Variety and availability of Asthma Action Plans
(Asthma) Provide evidence-based asthma education tailored to family needs and health literacy.[434] LHD H O	Multiple	Multiple	Number of participating organizations, data regarding reach relevant to outreach method (number of education or outreach events held and attendance, number of awareness materials distributed, number of website clicks, etc.)
(Diabetes) Improve diagnosis of prediabetes and referrals to the National Diabetes Prevention Program (DPP) lifestyle change programs among high-burden NYS adults.[436] H O	Adults	Ages 18+	Increased number of participants in Lifestyle Change Program
(Diabetes) Implement community screenings to detect and address diabetes.[433] H O	Adults	Ages 18+	Decreased number of emergency room visits resulting in diabetes diagnosis
(Diabetes) Improve access to specialty care for diabetes patients through telehealth.[437] H O	Adults	Ages 18+	Increased number of participants in Lifestyle Change Program

Interventions	Population of Focus	Age Range	Intermediate Measures
 (Cancer Screening) Work with local cancer screening programs such as the NYS Cancer Screening Program, to improve access to cancer screening and diagnostic testing for individuals without health insurance.[438-440] LHD H O	Staff at the NYS Cancer screening program	Ages 18+	Number of practices participating in local cancer screening programs, number of cancer screenings delivered to uninsured individuals
 (Cancer Screening) Improve provider participation in cancer screening programs that benefit individuals without health insurance.[439,440] LHD H O	Health care providers who perform cancer screenings	N/A	Number of cancer screenings delivered to uninsured individuals
 (Cancer Screening) Encourage the use of client reminders by providers to increase cancer screening per the Community Guide national guidelines.[439] H O	Adults	Ages 18+	Number of practices that use client reminders, number of screenings performed
 (Cancer Screening) Encourage health systems to employ provider assessment and feedback systems to increase cancer screening per national guidelines.[439] LHD H O			Number of health systems that adopt provider assessment and feedback systems, number of cancer screenings performed
 (Cancer Screening) Use small media to promote cancer screening.[439] H O	Adults	Ages 18+	Practices that have an Electronic Health Record that enables them to track who is up to date with screening or not
 (Obesity) Develop and implement targeted social marketing programs aimed at reducing/deterring the consumption of unhealthy food and beverage options in alignment with national dietary standards and clinical practice guidelines.[437] LHD H O	Everyone	All ages	Decrease in the percentage of children, adolescents, and adults diagnosed with obesity

Interventions	Population of Focus	Age Range	Intermediate Measures
 (Obesity) Develop and implement targeted social marketing programs aimed at promoting increased physical activity which align with national standards and clinical practice guidelines.[437] LHD H O	Everyone	All ages	Decrease in the percentage of children, adolescents, and adults diagnosed with obesity
 (Obesity) Provide weight-bias education and sensitivity training to health care providers (e.g., primary care providers, board-certified specialists) focused on creating safe spaces for patients, improving patient-provider relationships, and reducing obesity stigma.[441] H O	Providers (i.e., primary care providers, board-certified specialists)	N/A	Increase in the percentage of children, adolescents, and adults already diagnosed with obesity, who are newly seeking management and treatment

Lead Partner Agencies and Organizations

U.S. Centers for Disease Control and Prevention (CDC)
U.S. Department of Health & Human Services (DHHS)
U.S. Department of Agriculture (USDA)
NYS Department of Health
- Medicaid Program
- Office of Primary Care & Health Systems Management
- Office of Health Insurance Plans

NYS Energy Research and Development Agency (NYSERDA)
NYS Education Department
American Cancer Society
NYS Cancer Consortium
NYS Cancer Services Program
American Academy of Pediatrics
NYS Academy of Family Physicians
American College of Lifestyle Medicine
American Society of Metabolic & Bariatric Surgery
American Medical Association
American Heart Association
American Lung Association
American Diabetes Association
The Obesity Society
Community Health Care Association of NYS (CHCANYS)
Primary Care Development Corporation
NYS Association of County Health Officials (NYSACHO)
Health care providers, health plans, insurance brokers
Nursing Schools, Medical Schools
Medicaid Social Care Networks
Youth-Based Organizations
School-based health centers
Springboard to Active Schools
Community Service Society
Azara
Empowering People with Invisible Chronic Illness (EPIC) Foundation

Implementation Resources

NYSDOL - Community Health Worker Training Program

American Lung Association - Asthma Educator Institute

New York Peer Specialist Certification Board

Dietary Guidelines for Americans

Office of Disease Prevention and Health Promotion - Physical Activity Guidelines for Americans

UConn Rudd Center Obesity Action Coalition - Stop Weight Bias Campaign

NYSDOH - Social Care Networks

Priority: Oral Health Care

Goal: Reduce disparities in accessing and utilizing preventive oral health services.

What is Oral Health Care and Why is it Important?

Oral health is a significant public health concern. It includes oral diseases such as dental caries, periodontal disease, and tooth loss; all of which can have negative psychosocial effects. Poor oral health can impact speech, the ability to chew, nutritional intake, and lower self-esteem, making it more difficult to develop social relationships with peers.

Children with poor oral health have a harder time focusing on school and miss more school days due to dental pain. Adults experience greater challenges interviewing for employment, which can impact their socioeconomic position. Populations that struggle with mental illness, pain management, and substance abuse disorders (e.g., alcohol, tobacco, opioids, and other illicit drugs) experience an increased risk to their oral health. Oral health impacts systemic health and is a key driver of overall well-being. In fact, it has been linked to chronic diseases such as heart disease, stroke, cancer, diabetes, and obesity, with research indicating a bidirectional relationship.

Data from the 2017-2018 National Health and Nutrition Examination Survey (NHANES) found that 13.2% of children aged 2-11 had untreated caries in their primary teeth. However, oral diseases are not equitably distributed within society. Like with many other diseases, the most vulnerable populations are disproportionately impacted. The prevalence of untreated dental caries in primary teeth for children aged 2-11 was higher for Asian non-Hispanic (20.6%), Hispanic (17.8%), and Black non-Hispanic children (13.2%) when compared to White non-Hispanic children (9.7%). From 2019-2020, only 77.2% of New York children and adolescents aged 1-17 had preventative dental visits within the past year; more strikingly, only 51% of children aged 1-5. [442]

Oral health should be viewed as a modifiable risk factor, as many oral diseases are largely preventable. It is critical for a good oral health routine to be established as early as possible. This will assist in avoiding the short-term and long-term consequences of dental disease such as the development or progression of early childhood dental caries. Regular attendance to preventive dental visits, having access to optimally fluoridated water, and applying childhood dental sealants through school-based health centers and dental programs are public health interventions that promote good oral health. With the use of Medical-Dental Integration (MDI) models, interdisciplinary teams can collaborate to improve the quality and coordination of care across NYS. By focusing on these prevention measures, NYS can address poor oral health and impact overall health and well-being.

SMART(IE) Objective:					
34.0 Increase the percentage of Medicaid enrollees with at least one preventive dental visit within the last year from 20.3% to 21.3%. **34.1 Increase the percentage of Medicaid enrollees aged 2-20 years with at least one preventive dental visit within the last year from 39.1% to 41.1%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the percentage of Medicaid enrollees with at least one preventive dental visit within the last year	Percentage of Medicaid enrollees with at least one preventive dental visit within the last year	NYS Medicaid Program	Medicaid enrollees	20.3% (2022)	21.3% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Medicaid enrollees aged 2-20 years	39.1% (2022)	41.1% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Increase the proportion of people whose water systems have the recommended amount of fluoride.[443,444] LHD O	All Communities	All ages	Decrease in caries statewide
Featured Intervention: Promote oral health literacy by sharing education materials via different means (such as smartphone apps, videos, games, text messages).[445-447] LHD H O	Everyone	All ages	Increased dissemination of educational material via electronic means
Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride, including areas with predominant well water use.[448] H O	Children, adolescents	Ages 6 months – 18 years	Decreased number of caries in children who predominantly use well water

Interventions	Population of Focus	Age Range	Intermediate Measures
 Incorporate oral health education into nursing programs including how to apply fluoride varnish.[449] O	Nursing students	College-age students	Number of nursing students trained, number of nursing programs offering dental education
 Collaborate with and train health care professionals on oral health promotion, early detection of oral diseases, and fluoride varnish application.[450] LHD O	Train health care professionals - public health detailing	All ages	Number of health professionals trained
 Promote use of more affordable, less complex, minimally invasive care (MIC), to address caries disease early on.[451] H O	Dentists	All ages	Number of dentists who received training on minimally invasive care
  Promote use of tele-dentistry to provide access to care for geographically isolated patients.[451] H O	Article 28 (clinics) in rural and/or underserved areas	All ages	Number of clinics/tele-dental encounters, tracking Community Health Worker care coordination
 Provide and maintain updated lists of Medicaid-enrolled dental providers who are accepting new patients.[452] LHD	Local health department administrators/CHW	All ages	Number of local health departments that maintain a list and have policies in place that ensure list is current
 Implement written protocols and standard operating procedures for providing oral care to non-ventilated patients for prevention of aspiration pneumonia (hospitals, residential care, and long-term care facilities).[453] H O	Hospital and long-term care facility administrators, hospital and long-term care staff	All ages	Number of hospitals and/or long-term care facilities that have implemented written protocols

Interventions	Population of Focus	Age Range	Intermediate Measures
 Develop page dedicated to oral health on LHD websites which provides education on: • The importance of oral health beginning during pregnancy • Early caries prevention through nutritional counseling • The benefits of fluoride varnish application in the primary care physician (PCP) office at well childcare visits • The benefits of fluoridated water • The risks for and early detection of oral cancer[452] LHD O	Local health department and IT departments	All ages	Number of local health departments that have a page on their website dedicated to oral health

Lead Partner Agencies and Organizations

U.S. Centers for Disease Control and Prevention (CDC)
NYS Department of Health (Medicaid/CHIP)
NYC Department of Health and Mental Hygiene
American Academy of Pediatrics
NYS Dental Association
Dental Society, Local District Dental Societies
National Network for Oral Health Access
Community Health Care Association of NYS (CHCNYS)
NYS Association of Long-Term Care Administrators
Oral Health Nursing and Education Program, Dental Hygiene Programs, Dental Schools, Community Health Worker training programs, Community Dental Health Coordinators
Municipalities/local governments, local water providers/utilities
Local colleges, educational institutions, School-based health care centers, BOCES programs
Health care providers, health plans, insurance brokers

Implementation Resources

NYSDOH - Oral Health

NYSDOH - Drinking Water Fluoridation ROA

NYSDOH - Improving the Oral Health of Young Children: Fluoride Varnish Training Materials and Oral Health Information for Child Health Care Providers

NYC Department of Health and Mental Hygiene - Oral Health

CDC Fluoridation Engineering Opportunities - Fluoridation Trainings

CDC - Healthcare Association Infections - Oral Health in Healthcare Settings to Prevent Pneumonia Toolkit

CDC Community Water Fluoridation - What CDC is Doing

Association of State & Territorial Dental Directors - Championing Minimally Invasive Care - Aligning Advocacy to Transform Oral Health

Association of State & Territorial Dental Directors - Best Practice Approach: Early Childhood Caries: Prevention and Management

NYSDOH - Provider Network Data System

NYSDOH - Medicaid Enrolled Provider Listing

American Dental Association - Find a Dentist

Insure Kids Now - Improving Oral Health

MouthHealthy - Brushing Your Teeth

CHW Training - Oral Health Disparities: What CHWs Can Do

American Dental Association - Community Dental Health Coordinator

Teledentistry

Orthodontic Products - Quip Partners with Walmart on Teledentistry Offering

Priority: Preventive Services

Goal: Increase utilization of evidence-based preventive services for children.

What are Preventive Services and Why are they Important?

Preventive services for children, including immunizations and health care screenings (including lead testing, hearing, and vision), are an important way to ensure they get the care and support they need to stay healthy. Immunizations prevent a host of communicable diseases that are particularly dangerous for children. Health care screenings allow providers to identify concerns early and provide necessary treatment to reduce adverse health outcomes. US vaccination rates and preventive health care visit rates for children declined in the wake of the COVID-19 pandemic, so ongoing focus is vital.

Disparities also exist in access to and uptake of preventive services in NYS due to social and structural inequities that lead to racial and ethnic disparities and disproportionately impact the most vulnerable populations. These populations may have a distrust of medical care due to the history of racism within medical practice. Other barriers may include access to health insurance and reliable transportation.[454]

For members of these vulnerable populations throughout NYS, trust can be established through a diversified network of health care professionals that reflect the communities and populations they serve and include community-based leaders and advocates. Access to and continuation of family-centered prevention services involving establishment and regular contact with a health care home will improve the health of children and families.[454] A community health hub model can be used to deliver preventive services such as psycho-social, cognitive and physical developmental screening, nutrition assessments, immunizations, environmental health assessments as needed to ensure that all children reach their potential. Education and outreach to neighborhoods by trained community health partners can increase engagement for timely screening and management of acute and chronic health needs of children and families. By focusing on strengthening public health trust and eliminating barriers to accessible preventive care, NYS can improve health for children and their families.

SMART(IE) Objective:					
35.0 Increase the percentage of infants who received a diagnostic hearing evaluation after not passing their newborn hearing screening from 23.4% to 35.1%. **35.1 Increase the percentage of infants who received a diagnostic hearing evaluation after not passing their newborn hearing screening by 3 months of age from 15.6% to 23.4%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the percentage of infants who received a diagnostic hearing evaluation after not passing their newborn hearing screening	Percentage of infants who received a diagnostic hearing evaluation after not passing their newborn screening	Early Hearing Detection and Intervention (EHDI)	Infants (0-6 months of age)	23.4% (2022)	35.1% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Infants (0-3 months of age)	15.6% (2022)	23.4% (2030)

SMART Objective:					
36.0 Increase the up to date seven-vaccine immunization rate for children aged 24-35 months from 59.3% to 62.3%.					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase seven-vaccine series rate	Percentage of 24-35 month old children with the 4:3:1:3:3:1:4 combination series by their second birthday	NYSIIS, CIR	Children (Aged 24-35 months)	59.3% (2024)	62.3% (2030)

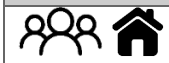
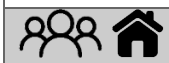
SMART Objective:
37.0 Increase the percentage of 13-year-old adolescents with a complete Human Papillomavirus (HPV) vaccine series from 25.7% to 28.7%.

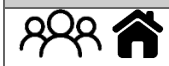
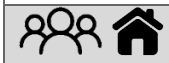
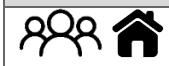
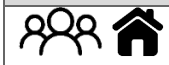
Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase on-time completion of HPV vaccine series by age 13 years	Percentage of 13-year-old adolescents with a complete HPV vaccine series	NYSIIS, CIR	Children and adolescents aged 9-13 years	25.7% (2024)	28.7% (2030)

SMART Objective:
38.0 Increase the percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age from 61.0% to 70.0%.

Desired Outcome	Indicator	Data Source	Population	Baseline	Target
Increase the percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age	Percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age	NYS Lead Poisoning Prevention Program	Infants and children in single birth cohort year aged 0-36 months	61.0% (2018-2021)	70.0% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Deliver evidence-based programming to schools to help combat the spread of anti-vaccination communication, restore parent's vaccine confidence and improve student vaccine compliance. [455,456] LHD O	Schools, School-age children and families	All ages	Increased numbers of school-age children that meet vaccine requirements
Featured Intervention: Conduct outreach in communities that have older, poorly maintained housing with high-risk for lead exposure and provide education regarding lead exposure prevention to families. [457] LHD O	Everyone	All ages	Decreased incidence of elevated lead levels in children

Interventions	Population of Focus	Age Range	Intermediate Measures
 Implement evidence-based interventions as listed in the Community Guide to increase HPV vaccine rates using small media to promote awareness, establish provider reminder and recall systems in clinics, and use patient navigators to address patient barriers.[458,459] H O	Health system leadership	Youth and adults	Practices that have an EHR that enables them to track who is up to date with vaccinations
 Partner with community-based organizations, local governments, and vaccine providers to increase community demand for vaccines through community outreach strategies including reminder and recall systems and home visits. [458] LHD O	Community-based organization, providers and local governments	All ages	List of partnerships with community-based programs
 Ensure the integration of refugees and migrant communities into immunization policies, plans and service delivery. [460] LHD O	Community-based organization, providers and local governments	All ages	Combination of resources across agencies, needs assessments
 Promote diversity within the health care workforce, along with training in evidenced-based strategies for culturally competent vaccine communication, in counties where the child vaccination rates fall below the state average.[461] LHD H O	Children	Ages 0-18	Increased rate of Measles, Mumps, Rubella (MMR) vaccines in targeted counties
 Increase the use of initial and follow-up screening protocols for high-risk children and those with elevated finger sticks, while educating parents on lead exposure prevention, following Centers for Disease Control and Prevention (CDC) recommended actions for blood	Children	Ages 0-18	Increase in testing rates for both initial lead screening and follow up screening occurring within each county via New York State Immunization Information System (NYSIIS) data/LeadWeb data

Interventions	Population of Focus	Age Range	Intermediate Measures
lead levels, and ensuring Medicaid recipients and high-risk children are tested per federal guidelines.[462,463] LHD H			
 Implement and promote lead poisoning educational programs such as the Pediatric Lead Assessment Network Training (PLANET) for healthcare professionals. [464] H O	Providers	N/A	Increase in number of physicians using PLANET in practice
 Provide appropriate referrals to supportive services which could include environment assessment, dietary and developmental needs, and complete blood lead level testing follow-up per CDC guidelines.[465] H O	Children	Ages 5-18	Decrease in number of children that are lost to follow-up after abnormal lead level testing result
 Implement programs for infants to receive a referral to an audiology center prior to discharge from birth hospital if they fail two hearing screenings.[466] H	Infants who have failed two hearing screenings but have not had an audiological evaluation	Infants who have not been discharged from their birth hospital	Number of birth hospitals who have given their staff training about this goal
 Identify a failed hearing screening as a critical result in health care settings.[466] H O	Children	Ages 0-18	Increase in number of health care systems adopt a failed hearing screening as a critical result value
 Increase educational partnerships with health care providers, pharmacies, and community-based organizations. [467,468] LHD H O	Health system leadership	N/A	Initiation of new programs and program evaluation

Interventions	Population of Focus	Age Range	Intermediate Measures
 Implement clinical systems to ensure clinicians provide or refer children and adolescents 6 years or older with a high body mass index (BMI) to comprehensive, intensive behavioral interventions.[448] H O	Children 6 years and old with high BMI	Ages 6-18	Practices that have an EHR that enables them to track children with high BMI

Lead Partner Agencies and Organizations

NYS Department of Health
NYS Office of Children and Family Services
NYS Education Department
Local child welfare agencies
American Cancer Society, NYS Cancer Consortium
Secondary and postsecondary schools, trade unions, local businesses
Health care providers, health plans, insurance brokers
Greater New York Hospital Association (GNYHA)
Healthcare Association of NYS (HANYS)

Implementation Resources

U.S. Food and Drug Administration

CDC - About the Childhood Lead Poisoning Prevention Program

CDC - State Physical Activity and Nutrition

CDC - Racial and Ethnic Approach to Community Health (REACH) 2023–2028

CDC - Academic Partnerships

NYSDOH - Early Hearing Detection and Intervention Program (EHDI)

NYSDOH - Healthy Homes

NYS Council for Community Behavioral Healthcare

Community Service Society - Community Service Society Navigator Network (CNN)

National Resource Center for Refugees, Immigrants, and Migrants

Decade of Vaccine Economics (DOVE) - Immunization Economics

CUNY - Lead and Leadership Guide

Medicaid - Lead Screening

Harvard Medical School Center for Primary Care - Advancing Health Equity and Value-Based Care: A Mobile Approach

Ryan Health Launches New Mobile Health Center to Provide Primary Care to New York City's Underserved Communities

Priority: Early Intervention

Goal: Increase the access and utilization of early intervention services.

What is Early Intervention and Why is it Important?

The Early Intervention Program serves one of the most vulnerable populations in New York – infants and toddlers from birth to age 3 with disabilities and delays, and their families. The mission of the Program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide appropriate intervention to improve child and family developments.

A child's first years provide a critical window for intervention. Research shows that the earlier a developmental delay or disability is identified, and the sooner services begin, the less likely it is that the child will need more intensive and expensive special education services later. Young children missing these opportunities for early intervention services are potentially at greater risk of significant developmental and learning delays.

To identify those children who are not meeting their developmental milestones and get the help they need to develop and grow, it is vital that both caregivers and primary health care providers know about the Early Intervention Program and how to make a referral for a child. In 2022, only 23.8% of parents of NYS children aged 9 months to 35 months reported that they received a standardized developmental screening using a parent-completed screening tool, compared to 34.4% nationally.[469]

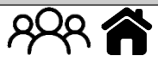
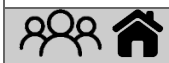
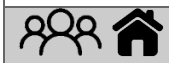
Additionally, only 28.2% of NYS parents reported that their child's doctor or health care provider asked if they had any concerns about their child's learning, development, or behavior for children aged 0-5 years, compared to 34% nationally. As such, some children who would benefit from the Program aren't receiving services.

In addition, there are disparities across the state in the referral and inclusion of children into the Program, as well as in the availability of providers and access to Program services. Equity is also an issue, with White children generally being referred at a younger age than children of most other races and ethnicities.

It is important to look at children's access to the Program and to identify and address barriers to equitable access to the Program. Increasing the access and utilization of early intervention services not only positively impacts the individual child, but also their family.[470] By promoting equitable access and utilization of the Early Intervention Program, NYS can ensure that the positive impacts of this program extend to the most vulnerable populations.

SMART(IE) Objective:					
39.0 Increase the percentage of children under 3 years old who have Individual Family Service Plans (IFSPs) from 8.3% to 11.0%. **39.1 Increase the percentage of <u>Black, non-Hispanic</u> children under 3 years old who have Individual Family Service Plans (IFSPs) from 7.0% to 10.0%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the percentage of children who receive Individual Family Service Plans (IFSPs) by age 3.	Percentage of children under 3 years old with an Individual Family Service Plan (IFSP)	NYS Early Intervention Program (NYS EIP) Data System (NY Early Intervention System (NYEIS/EI-Hub))	Children under 3 years old	8.3% (2021)	11.0% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Black, non-Hispanic Children under 3 years old	7.0% (2021)	10.0% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Increase developmental screening in nonclinical settings (day cares, early childhood learning centers, etc.) by promoting the use of standardized developmental surveillance tools through social media, digital marketing, and traditional marketing and partnership.[471,472] LHD O	Children eligible for Early Intervention (EI)	Ages 0-3	Increase in referrals from non-clinical setting to EI
Featured Intervention: Educate parents and caregivers of young children about the Early Intervention Program by providing primary care providers with materials to get in the hands of parents.[473] LHD H O	Children eligible for EI	Ages 0-3	Increase in family-generated EI referrals
Engage with health care providers to increase developmental screenings through quality improvement incentives,	Children eligible for EI	Ages 0-3	Increase in the number of screenings provided

Interventions	Population of Focus	Age Range	Intermediate Measures
partnership/relationship building, and communications.[474] H O			
 Educate primary care providers about the Early Intervention Program and using developmental surveillance tools to identify children with developmental delays and disabilities earlier. [473] LHD H O	Children eligible for EI	Ages 0-3	Increase in the number of screenings provided
 Implement the "Learn the Signs. Act Early." program in pediatrician offices and primary care settings. [475] LHD H O	Children eligible for EI	Ages 0-3	Number of organizations that implement the program and provide educational materials to families
 Promote the use of the Bright Futures Periodicity Schedule.[476] LHD H O	Children eligible for EI	Ages 0-3	Number of primary care settings that indicate adherence to the periodicity schedule
 Utilize social media to increase awareness of, access to, and enrollment in the Early Intervention Program.[477] LHD O	Children eligible for EI	Ages 0-3	Number of organizations that post about EI program, access, etc. in a year, number of interactions with posts about EI
 Create transition plans for children who are aging out of the Early Intervention Program to ensure they continue to receive the services they need.[478] H O	Children in the EI Program	EI Program participants - especially those aging out of the program (Ages 0-3)	Increase in the proportion of children with a timely transition from EI

Lead Partner Agencies and Organizations

State Department of Health
State Office of Children and Family Services
State Education Department
American Academy of Pediatrics
NYS Council on Children and Families and their partner agencies
Early Intervention Programs
Home visiting programs
Childcare providers
Children and Youth with Special Health Care Needs (CYSHCN) Program
Help Me Grow NY
Prenatal care programs
Secondary and postsecondary schools, trade unions, local businesses
Health care providers (pediatric, primary care and obstetric offices), health plans, insurance brokers

Implementation Resources

CDC - Learn the Signs. Act Early

NYSDOH - Early Intervention Program

Priority: Childhood Behavioral Health

Goal: Improve the mental health and well-being of children and adolescents.

What is Childhood Behavioral Health and Why is it Important?

Childhood Behavioral Health has often been defined in terms of disorders, such as behavior or conduct problems.[479] However, increasingly, it is understood that children's behavioral health is broader than mental health conditions and includes preventive actions to support their overall well-being, such as ensuring children are connected to supportive peers and adults, know how to manage stress, live in healthy homes, and learn and play in safe spaces.

In 2022, 6% of NYS youth were considered "disconnected,"[480] meaning they were not in school or employed. Supporting children's behavioral health also means ensuring that children in need of mental health services receive them. In 2020-2021, approximately 52% of children and youth with a mental health condition received treatment from a mental health professional during the past 12 months.[481]

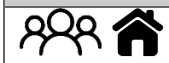
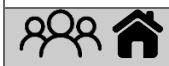
Childhood behavioral health is an important part of a child's development that has lifelong implications for their health.[482] It is just as important to support a child's behavioral health as it is to support their physical health, and the two are interconnected with people with severe mental disorders experiencing a 10-25 year shorter life expectancy than people without these mental health conditions.[483]

In 2021, the American Academy of Pediatrics and other leading child health organizations declared a national emergency in child and adolescent mental health.[484] Given that the majority of the most common mental health conditions surface in childhood[4] and that all people can benefit from mental health supports throughout their lifetime starting in childhood, focus needs to be placed on primary prevention that can benefit all children. Examples include: social emotional learning; secondary prevention such as ensuring children are screened for mental health conditions to diagnose them as early as possible; and tertiary prevention such as increasing access to treatment for those children in need of services. By integrating primary, secondary, and tertiary prevention strategies, NYS can collaborate to improve childhood behavioral health and overall child development.

SMART(IE) Objective:					
40.0 Increase the percent of children aged 0-5 years who are reported by their parent as exhibiting all 4 flourishing criteria from 72.2% to 79.4%. **40.1 Increase the percent of children aged 0-5 years who live at 0-99% of the poverty level who are reported by their parent as exhibiting all 4 flourishing criteria from 58.8% to 67.6%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the percent of children aged 0-5 years whose parent indicates they are exhibiting all 4 of the flourishing criteria	Percentage of children reported as flourishing, aged 6 months-5 years	National Survey of Children's Health (NSCH)	Children (Aged 0-5 years)	72.2% (2022-2023)	79.4% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Children (Aged 0-5 years) in a household living between 0-99% of the poverty level	58.8% (2022-2023)	67.6% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Promote the Healthy Steps program in primary care settings.[485] LHD H O	Pediatrics	Ages 0-3	Number of organizations that adopt Healthy Steps
Featured Intervention: Promote home visiting programs such as Healthy Families New York to first-time moms all parents/caregivers to increase knowledge and skills. [486] O	First-time mothers, newborns	Children aged 0-2; women of reproductive age	Number of families visited monthly
Implement classroom-based mental health education curricula to support children by providing classroom instruction focused on developing skills in self-management, responsible decision-making, relationship building, social and self-awareness including programs such as the Promoting Alternative Thinking Strategies (PATHS) Program, Project Growing Minds, and Second Step.[487] O	School-age children and adolescents	Middle and high school students (Ages 11-17)	Number of schools that implement a mental health education curriculum

Interventions	Population of Focus	Age Range	Intermediate Measures
 Increase the proportion of children & adolescents who get preventive mental health care in school by incorporating programs such as: • Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda • Targeted School-Based Cognitive Behavioral Therapy Programs to Reduce Depression and Anxiety Symptoms • Universal School-Based Cognitive Behavioral Therapy Programs to Reduce Depression and Anxiety Symptoms • School-Based Health Centers to address SDOH[488] O	School-age children and adolescents	Middle and high school students (Ages 11-17)	Number of students who receive preventative mental/behavioral health care in school
 Implement social and emotional learning into classroom, after-school, and other child/adolescent educational settings using a Collaborative for Academic, Social, and Emotional Learning (CASEL)-designated social and emotional learning (SEL) program.[163] O	School-age children and adolescents	Middle and high school students (Ages 11-17)	Number of schools that have active programs to support emotional learning
 Implement strategies to increase school connectedness for children and youth by using What Works in Schools and the Healthy Schools programs.[489] O	School-age children and adolescents	Ages 0-17	Number of schools that provide faculty training on connectedness or implement a strategy to increase student connectedness
 Implement strategies to increase family connectedness for children and youth using a CASEL-designated SEL program.[490] O	All children	Ages 0-17	Number of families connected to resources
 Increase the number of peer group programs for children and youth.[491] O	School-age children and adolescents	Middle and high school students (Ages 11-17)	Number of NYS children and youth who have convenient access to a peer support program

Interventions	Population of Focus	Age Range	Intermediate Measures
 Increase the number and diversity of mental health professionals who treat children and youth through social media and digital marketing of career and training opportunities and establishing state-wide connections among professionals through coaching and mentorship.[492] LHD H O	Young adults/students & adult health professionals	Ages 18+	Number of registered, certified, licensed pediatric providers with diverse backgrounds and actively providing services
 Expand access to infant and early childhood mental health training for providers in various settings (e.g., early intervention, childcare, child welfare, primary care, and home visiting) to understand and deliver infant and early childhood mental health (IECMH) services offered by entities such as Office of Child and Family Services (OCFS) and New York State Association for Infant Mental Health (NYS-AIMH).[493] LHD H O	Young children	Ages 0-5	Number of participants in IECMH programs
 Utilize universal developmental assessment tools that screen for optimal child development and social-emotional competencies in early care and learning settings using the Ages and Stages Questionnaires (ASQ) and Ages and Stages Questionnaires: Social-Emotional Development Screening Tool (ASQ-SE).[494] O	Young children	0-5 years	Participation among schools, early education, childcare, and other settings of focus, number of children screened, county-level screening results
 Utilize models of behavioral health integration (e.g., Training and Education for the Advancement of Children's Health (Project TEACH)) in primary care settings.[495-498] LHD O	Children	0-18 years	Number of mental and behavioral health assessments carried out by pediatric primary care providers

Lead Partner Agencies and Organizations

NYS Department of Health
Division of Family Health
NYS Office of Mental Health
NYS Office of Addiction Services and Supports
NYS Education Department
NYS Office of Children and Family Services
NYC Office of Family and Community Engagement
School-based health centers
Home visiting programs
NYS Association of School Psychologists
Association of Black Psychologists
National Alliance for Mental Illness
American Academy of Pediatrics
American Academy of Family Physicians
Project TEACH
Secondary and postsecondary schools, trade unions, local businesses
Health care providers, health plans, insurance brokers
Local community-based organizations
New York Peer Advancement Network

Implementation Resources

CDC- Reducing Health Risks Among Youth - What Schools Can Do

Collaborative for Academic, Social, and Emotional Learning - SEL with Families and Caregivers

NYS Education Department - Student Support Services - SEL Family and Community Engagement Snapshot

HRSA - Behavioral Health Workforce Education and Training (BHWET) Program for Professionals

Project TEACH

NYSOMH Request for Proposals (RFP) and Request for Information (RFI)

Nurse-Family Partnership - Helping First-Time Parents Succeed

Healthy Families New York

Domain 5:
Education Access and Quality

Priorities:

Health and Wellness Promoting Schools

Opportunities for Continued Education

Priority: Health and Wellness Promoting Schools

Goal: Increase access to health and wellness services in schools.

What is Health and Wellness Promoting Schools and Why is it Important?

The U.S. Department of Education defines chronic absenteeism as the share of students who miss at least 10% of days in a school year for any reason; excused, unexcused, or for disciplinary reasons.[499] The chronic absenteeism rate in NYS increased sharply after the COVID-19 pandemic and remained high through the 2022-23 school year, with 34.1% of high schoolers being considered chronically absent.[500]

The chronic absenteeism rate for all students in NYS from 2022-23 was 26.4%, which is significantly higher than the pre-pandemic level of about 15.5%. Chronic absenteeism has been linked to reduced student achievement, social disengagement, increased risk of dropping out of high school, poverty in adulthood, and adverse health outcomes.[500-504]

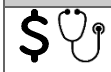
Educational attainment and health outcomes are linked, with increased levels of education being associated with better health outcomes across life.[505,506] At age 25 the remaining life expectancy in the US adult population is almost 10 years shorter for those who have not graduated high school compared to those who have graduated from college.[507] There are several modifiable factors associated with increased rates of chronic absenteeism, including physical health issues, mental health issues, substance use, school environment, and fitness.[506,508]

Chronic absenteeism rates are disproportionately higher for multiple vulnerable populations, including the economically disadvantaged who routinely have higher chronic absenteeism rates.[509] The chronic absenteeism rate for economically disadvantaged students (defined as those who participate in/family participates in economic assistance programs such as Food Stamps or Social Security Insurance) was 34.9% in 2022-23, compared to 26.4% for all students.[510]

Barriers to attending school such as poverty, increased family obligations (e.g., caring for family, working), unsafe routes to school, unreliable transportation, food insecurity, housing insecurity, and lack of supportive school environment contribute to absenteeism.[511] Increasing educational attainment for these students can increase their chances of a healthy life and breaking the poverty cycle. Reducing chronic absenteeism requires coordinated effort between school communities, the medical community (e.g., local providers, hospitals, and health departments), and the broader community. By promoting collaboration with community partners, combined with data-driven, multi-tiered strategies, NYS can reduce absenteeism in vulnerable populations and improve health outcomes.

SMART(IE) Objectives					
41.0 Decrease the percentage of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) among public school students in grades K-8 from 26.4% to 18.5%. **41.1 Decrease the percentage of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) among public school students in grades K-8 who are economically disadvantaged from 34.9% to 24.4%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Decrease the percent of public school students in grades K-8 who miss 10% or more school days in an academic year	Percentage of public school students in grades K-8 with >10% absenteeism (chronic absenteeism)	New York State Education Department (NYSED) Report Card	Public school students in grades K-8	26.4% (2023)	18.5% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Economically disadvantaged public school students in grades K-8	34.9% (2023)	24.4% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
$  **Featured Intervention:** Create and implement a district-wide school wellness policy utilizing a recognized, evidence-based framework, such as United States Department of Agriculture (USDA) Local School Wellness Policy framework or the Whole School or the Centers for Disease Control and Prevention (CDC) Whole Community, Whole Child (WSCC) framework: • Utilize the USDA-required School Wellness Policy and committee as a tool to set and communicate the wellness goals, objectives, and interventions • Develop and implement comprehensive student and staff wellness policies based on the WSCC Model • Strengthen community partnerships to support school wellness initiatives • Provide opportunities for school staff wellness • Promote the health and wellness of students, Pre-K-12 and staff, and foster relationships with schools and community partners • Facilitate partnerships with schools, community partners, and families/caregivers to enhance programing and improve health and wellness for students and staff	Students	School-age	Percentage of school districts that create school wellness policies, percentage of schools that implement school wellness policies

Interventions	Population of Focus	Age Range	Intermediate Measures
• Enhance community involvement in supporting students' health education though school wellness committees[512-515] LHD O			
 **Featured Intervention:** Improve the utilization and availability of age-appropriate mental health well-being programs throughout Pre-K to 12th grade through partnerships with mental health service providers.[516-518] LHD H O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs, Schools and staff	School-age	Participation among schools, youth organizations, and mental health service providers, number of children served by programs
 Provide access to age-appropriate health and wellness education that promotes health lifestyle choices through activities such as ensuring all students have access to physical education and encouragement to be active: • Lower grades: Include daily 20-minute recess and physical education (PE) class twice a week per New York State requirements; verify this is occurring at all schools • Higher grades: PE is currently required 2-3 times a week; monitoring the type of activity and participation level of student will provide data on true level of activity • Healthy lifestyle choices could include providing inexpensive pedometers for interested students and prizes for kids with the most steps[519,520] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	School-age	Participation among schools, youth organizations, and other organizations of focus, number of children served by programs
 Use the USDA required school wellness policies and committees as a tool to set and communicate the wellness goals, objectives, and interventions. Specific goals include the focus on making healthy food available for purchase during lunch and breakfast and ensuring physical activity during the day even if students are not able to go outside due to weather. The school district, including teachers, can create a specific wellness policy that would be appropriate to them and their resources.[512] O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	School-age	Participation among schools and youth organizations, measure progress towards attainment of School Wellness Policy goals and objectives in participating schools, number of children enrolled in schools/served by organizations that follow these policies

Interventions	Population of Focus	Age Range	Intermediate Measures
 Collaborate with school districts and communities to provide education and opportunities to increase immunization rates for both required and unrequired school vaccinations for K-12 students.[521] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	School-age	Participation among educational organizations and CBOs, data on reach relevant to promotion strategies (number of trainings delivered, number of students trained, number of awareness materials distributed), trends in immunization rates among K-12 students
 Improve schools indoor air quality (e.g., control of airborne pollutants and viral particles, providing adequate outdoor air and maintenance of acceptable temperatures and other comfort parameters) and ensure a safe learning environment by: • Implementing an Indoor Air Quality management plan • Working with the New York State Department of Health's School Environmental Health Program to access free resources and technical assistance related to indoor air quality and 8 other environmental health areas • Engaging Health & Safety Committees and facilities management staff to implement best practices in indoor air quality management, including: o Improving ventilation o Monitoring air quality (3 times per year) o Maintaining comfortable humidity and temperature ranges o Minimizing odors o Proper and effective cleaning o Integrated pest management practices o Chemical management o Managing water damage, mold, etc. [522] LHD H O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	School-age	Participation among organizations of focus, number of organizations that track air quality, number of applications for resources or technical assistance through the New York State Department of Health's School Environmental Health Program, number of facilities that meet air quality standards, number of improvements made
 Expand opportunities for youth to have Positive Childhood Experiences (PCEs) by implementing age-appropriate strategies that foster positive family and community interactions:	Pediatric providers, youth services providers, early childhood education providers,	Ages 0-18	Number of hospitals that serve pediatric population which have implemented the Strengthening Families Approach and Protective Factors Framework, decrease in number of Adverse Childhood

Interventions	Population of Focus	Age Range	Intermediate Measures
• For toddlers, this includes encouraging reading, cuddling with children, and participation in local friend/community groups e.g., YMCA • As children get older, promote communication between teachers and family, health providers and family, and access to free community programs • For older children, include High School outreach to showcase college, careers, positive life experiences after graduation[523] O	home visiting programs		Experiences (ACE score - measure on BRFSS)
 Expand opportunities for school staff wellness and foster a supportive and productive educational environment by: • Providing mental health awareness, time to disconnect during the school day (yoga, walk perimeter of school gym, etc.), and opportunities to speak with school counselor • Starting district specific employee assistant programs to accommodate the differences in needs between school districts • Provide additional support with known problematic kids or parents[524] LHD O	Schools and mental health providers	Ages 18+	Participation among schools and mental health providers, number of staff served by intervention, staff participation in specific wellness programs, number of successful referrals made to needed services, stress levels among school staff
 Develop and implement comprehensive student and staff wellness policies based on the Whole School, Whole Community, Whole Child (WSCC) Model.[512] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	All ages	Participation among education and youth organizations, number of organizations that are compliant with WSCC standards, number of students and staff receiving benefit of wellness policies
 Improve the utilization and availability of age-appropriate mental health well-being programs throughout Pre-K to 12th grade through partnerships with mental health service providers.[516-518] LHD H O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	School-age children	Participation among schools, youth organizations, and mental health service providers, number of children served by programs

Interventions	Population of Focus	Age Range	Intermediate Measures
 Provide enhanced educational opportunities and quality for K-12 students through healthy role modeling, healthy mentoring, and increased holistic counseling.[525,526] LHD O	Students	School-age children	Participation among schools, youth organizations, and other organizations of focus, number of children served by programs
 Establish partnership with schools to provide Pre-K through 5th grade nutrition literacy programs that provide and promote healthy foods in schools through programs such as farm-to-school programs or school gardens.[121,526,527] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	Elementary school-age children	Participation among schools, youth organizations, and other organizations of focus, number of children served by programs, number of schools that establish farm to school programs, number of schools that establish school gardens, student participation in school gardens
 Promote and expand nutrition literacy programs that support and encourage healthy food choices for middle and high school students.[526-528] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	Middle school and high school-age children	Participation among schools, youth organizations, and other organizations of focus, number of children served by programs, number of screenings performed, number of successful referrals to needed services made
 Promote age-appropriate healthy lifestyle choices through adoption of hands-on gardening and cooking activities, fostering a love of physical activity, and/or relaxation and stretching exercises to increase wellness to: • Provide access to age-appropriate health and wellness education that promotes health lifestyle choices • Promote the health and wellness of students Pre-K-12 and staff and foster relationships with schools and community partners • Facilitate partnerships and programming with schools, community partners, and families/caregivers to improve health and wellness for students and staff[527-531] LHD O	Students	School-age	Percentage of schools that implement student gardening activities or create a school garden, percentage of schools that implement programs aimed at fostering a love of physical activity, percentage of schools that implement programs to teach relaxation and stretching techniques

Interventions	Population of Focus	Age Range	Intermediate Measures
 Use the Strengthening Families Approach and Protective Factors Framework within agencies serving young families to expand opportunities for youth to have Positive Childhood Experiences (PCEs).[532,533] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs	Ages 0-18	Number of hospitals that serve pediatric population which have implemented the Strengthening Families Approach and Protective Factors Framework, decrease in number of Adverse Childhood Experiences (ACE score - measure on BRFSS)
 Collaborate with school districts and communities to provide education and opportunities for student immunization for both required and recommended vaccines for K-12 students by: • Providing recall/reminders to parents/caregivers • Increasing immunization rates for both required and unrequired recommended school vaccinations[534] LHD O	Health Departments, Pediatric Providers, Pharmacies	Ages 0-18	Increased rates of required vaccinations, decreases in vaccine-preventable disease rates in children
 Conduct organizational health literacy program in schools and other childcare organizations to: • Increase schools, child caregivers, and other childcare organizations' ability to equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others (i.e., Organizational Health Literacy) • Improve communication with providers and increase participant understanding and engagement in their health through English courses for speakers of other languages - improve health and English literacy and proficiency[535] LHD O	Schools, Teachers, Early Childhood Educational Staff	All ages	Number of schools which have implemented health literacy training for staff, number of hospitals that meet the Ten attributes of Health Literate Health Care Organizations (AHRQ)
 Increase educational opportunities and educational quality for K-12 students by providing enhanced healthy role modeling, healthy mentoring and increased holistic counseling; increase youth mentoring in schools by reaching out to local organizations such as the YMCA or other nongovernmental organizations.[536-538] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs,	School-age children	Percentage of schools that implement student gardening activities or create a school garden, percentage of schools that implement programs aimed at fostering a love of physical activity, percentage of schools that implement

Interventions	Population of Focus	Age Range	Intermediate Measures
			programs to teach relaxation and stretching techniques
 Promote annual wellness screens that include education and facilitate access to age-specific immunizations; explore administration of immunizations by school nurse during the school day to support working parents and children with low access to quality health care.[515, 539] LHD H O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs, Schools and staff	All ages	Increased rates of required vaccinations, decreases in vaccine-preventable disease rates in children
 Implement activities and programs that increase the proportion of school-age children that meet the 150 minutes or more of aerobic physical activity weekly.[540] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs, Schools and staff	School-age children	Participation among schools and youth-centered organizations, number of students served by interventions
 Install central air conditioning and/or air purifiers using capital funding to improve indoor air quality which includes control of airborne pollutants and viral particles, providing adequate outdoor air and maintenance of acceptable temperatures and other comfort parameters.[516-518,541] LHD O	Pediatric providers, youth services providers, early childhood education providers, home visiting programs, Schools and staff	All ages	Percentage of school districts that monitor air quality twice a year
 Promote Pre-K through 5th grade nutrition literacy programs that provide and promote healthy foods in school.[527] LHD O	Schools, Teachers, Early Childhood Educational Staff	Elementary school-age children	Percentage of schools that implement student gardening activities or create a school garden, percentage of schools that introduce healthy options such as vegetarian, vegan, or whole grains, percentage of schools that have classroom time learning about healthy options

Interventions	Population of Focus	Age Range	Intermediate Measures
 Promote middle and high school nutrition literacy programs that support and encourage healthy food choices.[527] LHD O	Schools, Teachers, Early Childhood Educational Staff	Middle school and high school-age children	Percentage of schools that implement student gardening activities or create a school garden, percentage of schools that introduce healthy options such as vegetarian, vegan, or whole grains, percentage of schools that have classroom time learning about healthy options
 Implement peer programs in schools to increase education, promotion, and access to health screening and services to improve outcomes, enhance community engagement, and promote equity.[519,521,542] LHD O	Students, program staff, community organizations	K-12; higher education	Participation among schools and youth-centered organizations, number of students served by interventions, student interest in becoming peer counselors, number of screenings performed, number of successful referrals made to needed services
 Facilitate Physical Activity Leader (PAL) clubs in schools in partnership with LHDs, Hospitals, and CBOs to reduce high-burden health conditions, and develop leadership skills in older students while providing role models for younger students.[543] LHD H O	Students, program staff	K-12; higher education	Participation among schools and youth-centered organizations, number of students served by interventions, student interest in becoming peer leaders

Lead Partner Agencies and Organizations

NYS Department of Health
    Medicaid/CHIP
NYS Education Department
NYS Office of Children and Family Services
    Office of Youth and Wellness
NYS Department of Environmental Conservation
Secondary and postsecondary schools, trade unions, local businesses
Health care providers, health plans, insurance brokers, electronic medical record (EMR) vendors, pharmacies
NYS United Teachers (NYSUT)
NYS Association of Early Childhood Teachers
NYS Association of School Nurses
Parent-Teacher Associations, School district leadership
Coordinated Approach to Child Health (CATCH) Program
Decade of Vaccine Economics (DOVE)
NYS Pediatric Society
Association of New York State Youth Bureaus
Local sports teams, local fitness centers, local health & wellness centers

Implementation Resources

New York Agriculture in the Classroom

Seed Your Future

USDA - Patrick Leahy Farm to School Grant Program

U.S. Department of Education - Physical Education Program Grant

SHAPE America - Impact Schools Grant Program

Calming Kids - Movement Grant

CDC - Reminder Systems and Strategies for Increasing Childhood Vaccination Rates

Center for the Study of Social Policy Strengthening Families Framework

Children's Trust Fund - Strengthening Families Protective Factors

Institute of Medicine of the National Academies - Ten Attributes of Health Literate Health Care Organizations

Priority: Opportunities for Continued Education

Goal: Enhance continued education to expand personal and professional development opportunities.

What are Opportunities for Continued Education and Why are they Important?

In 2018, the last year for which data is available, 72% of high school graduates in NYS enrolled in postsecondary education. According to the NYS Department of Labor statistics, the median weekly salaries of individuals 25 and over with college degrees is $1540 compared to $950 earned by employees with High School diploma/General Education Development (GED); a 62% increase in median weekly income. Individuals with a bachelor's degree are 2.1% less likely to be unemployed than individuals with a high school diploma/GED. Overall, the data demonstrate a significant lifetime earnings difference between people with a bachelor's degree and those with a high school diploma/GED.

In addition to earnings, individuals with a bachelor's degrees have improved health, safer jobs, and safer housing when compared to individuals with a high school degree/GED. Not only are employees with bachelor's degrees more likely to have access to better health care through insurance, but they are also less likely to have chronic health conditions such as diabetes, depression, and cardiac disease.[544,545,546]

Access to higher education is not always equal. A significant barrier to secondary education is affordability. In 2017, The Excelsior Scholarship was introduced, allowing individuals below a certain income threshold to attend The City University of New York (CUNY) and The State University of New York (SUNY) colleges tuition free.

Additionally, lower income students may be more inclined to apply and enroll in less competitive colleges. To provide better access to highly competitive colleges in NYS, a new program called "The Top 10% Promise" provides a pathway for high achieving students in the top 10% of their high school class to gain direct admission into selective SUNY institutions.[15,547] By promoting access to higher education, NYS can increase economic and educational opportunities that lead to improved health outcomes.

SMART(IE) Objective:					
42.0 Increase the percentage of high school seniors that attend a 2- or 4-year college from 70.2% to 77.0%. **42.1 Increase the percentage of high school seniors who are economically disadvantaged that attend a 2- or 4-year college from 63.1% to 69.4%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the percentage of high school seniors that attend a 2- or 4-year college within 5 years of graduation	Percentage of high school seniors that attend a 2 or 4 year college within 5 years	NYSED report card	High school seniors	70.2% (2023)	77.0% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Economically disadvantaged high school seniors	63.1% (2023)	69.4% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
Featured Intervention: Incorporate the CDC's Hi-5 and 6|18 initiatives into the Raise the Bar framework from the US Department of Education to ensure every student has an onramp to postsecondary education and training, including establishing and scaling innovative systems of college and career pathways that integrate high schools, colleges, careers, and communities and lead to students earning industry-recognized credentials and securing in-demand jobs; making sure public health and health care careers are featured to build capacity.[548] O	Higher education students, faculty, and staff	Higher education students	Participation among educational organizations, track graduation rates year-to-year and compare between participating and nonparticipating schools, student engagement in career pathway programs, trends in local employment rate
Featured Intervention: Facilitate partnerships within the community that improve the percent of 18- to 24-year-olds enrolled in school or work programs:	Young adults	Ages 18-24	Participation among educational organizations and local businesses, number of participants enrolled in school or work programs, data on reach of chosen outreach method (e.g., number of views, number of website visits)

Interventions	Population of Focus	Age Range	Intermediate Measures
• Communicate paid apprenticeships that could be advertised on social media and during high school • Collaborate with local community colleges and BOCES[549] O			
 Provide training opportunities focusing on health literacy awareness that target medical professionals and public health practitioners; utilize continuing education for medical professionals, facilities, and public health practitioners to increase health literacy awareness and incorporation into communication with patients.[550] LHD H O	Health Departments, Hospitals, Pediatric Providers	All ages	Percent of staff who have a completed continuing medical education (CME) course(s) focused on health literacy or have attended a facility-approved health literacy training
 Implement learning opportunities for mental health training and Trauma Informed Practices.[551] LHD H O	Students, teachers, staff	K-12, higher education	Participation among educational organizations, number of trainings delivered, number of staff trained, number of students served by trained staff
 Provide comprehensive professional development for health and physical education teachers to promote and lead wellness initiatives and effective strategies to communicate the importance of the health and wellness of the students and its impact on learning.[530,552-555] O	Students, teachers, staff	K-12, higher education	Participation among educational organizations, number of teachers and staff trained, number of students served by staff trained through this intervention
 Collaborate with advisory boards of local career and technical education (CTE) schools to develop work transition programs such as work-based learning opportunities and educate school and community partners of public health resources to	Advisory Board members, as applicable	N/A	Participation among educational organizations and advisory boards, number of work transition programs available, number of participants in work transition programs, track graduation rates year-to-year and compare participating vs. non-participating schools

Interventions	Population of Focus	Age Range	Intermediate Measures
increase awareness and access for stronger graduation outcomes.[556] O			
$ Implement outreach initiatives and partnerships to increase awareness and access to continued education opportunities for adults at higher education institutions; collaborate with schools, LHDs, hospitals, CBOs to bolster the development of foundational and professional skills.[557-561] LHD H O	Higher education students, faculty, and staff	Higher education students	Participation among organizations of focus, number of continued education programs available, number of participants enrolled in continued education programs, local employment trends

Lead Partner Agencies and Organizations

Healthcare Association of New York State (HANYS)
Greater New York Hospital Association (GNYHA)
Schools, School district leadership
NYS United Teachers (NYSUT)
NYS School Nurses Association

Implementation Resources

CDC - Health Literacy Training

NYS Center for School Health

NYS Association for Health, Physical Education, Recreation and Dance

Workforce GPS - Work-Based Learning for Out-of-School Youth and Disadvantaged Adults

Coordinated Approach to Child Health (CATCH) - Professional Development for Educators

SHAPE America

OPEN Phys Ed

Implementation

The Prevention Agenda is implemented and monitored over a six-year period, from March 1, 2025 – Dec 31, 2030. The Prevention Agenda seeks to use the identified interventions to make progress toward goals, objectives, and tracking indicators by Dec 31, 2030.

Implementation Partners

The Prevention Agenda's goals, objectives, and interventions provide flexible options for communities to improve outcomes throughout NYS. While LHDs and hospitals lead implementation efforts, addressing the Prevention Agenda priorities requires thoughtful mobilization of community assets and collaboration with community leaders and other partners.

Many partners at the state and local level contribute to achieving the vision of the Prevention Agenda. Implementation partners may include but are not limited to:

Figure 14: State and Local Partners

State and Local Partners:

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

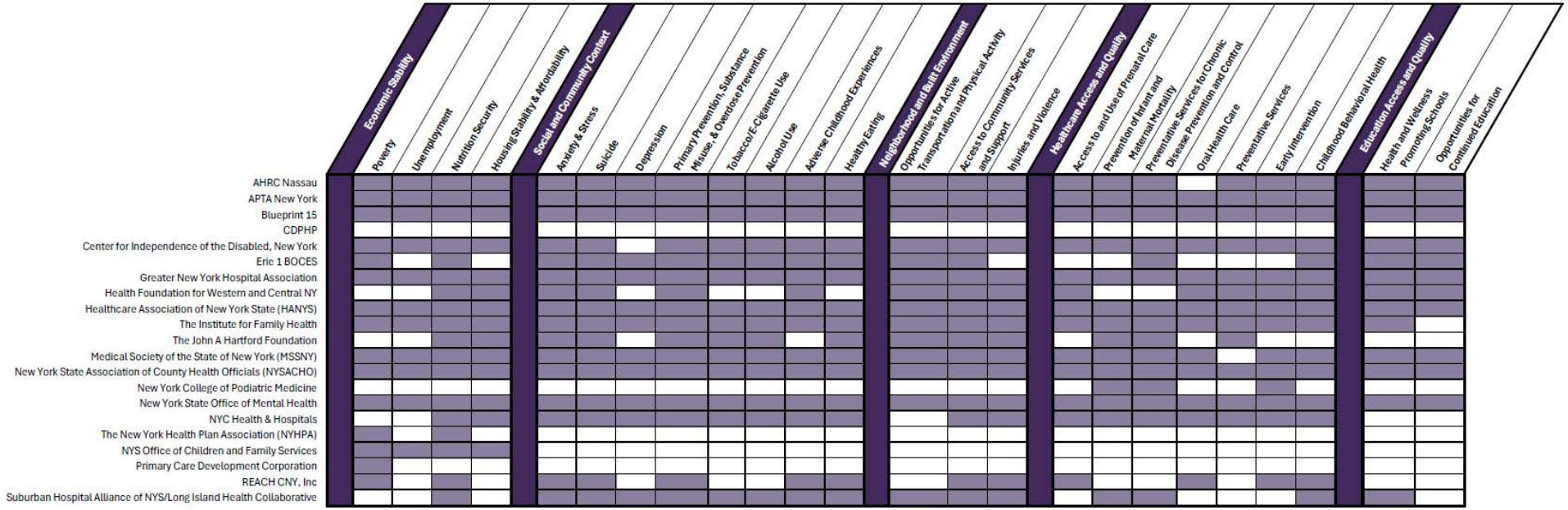
Interagency Collaboration

The New York State Department of Health, in collaboration with local partners, recognizes the importance of fostering cross-sector collaborations to achieve collective impact in addressing the priorities outlined in the Prevention Agenda. Members of the Ad Hoc Committee and Domain workgroups were asked to identify Prevention Agenda priorities that align with their respective organizational or constituent goals. Figure 14 outlines the state and local partners contributing to the implementation of the 2025-2030 Prevention Agenda and achieving its vision.

In addition, the Department established an SDOH Interagency Workgroup, which held its initial meeting in February 2025. The Workgroup comprises experts in SDOH, health equity, health disparities, economics, and vulnerable populations. This Workgroup serves as a platform for agencies to identify shared goals, resources, and opportunities to collaboratively address the Prevention Agenda priorities and SDOH. The Workgroup will convene quarterly to review progress on the Prevention Agenda and explore interagency strategies to advance and prioritize health equity across New York State.

Figure 15 shows state and regional organizations collaborating with NYSDOH to advance Prevention Agenda priorities, reflecting ongoing cross-sector efforts. The matrix will be updated as additional collaborations are established.

Figure 15: Prevention Agenda Implementation Matrix



Community Health Improvement Plans and the Prevention Agenda

New York State requires LHDs and hospitals to conduct a comprehensive Community Health Assessment (CHA) and develop a Community Health Improvement Plan (CHIP) or Community Service Plan (CSP).[1] The CHA includes an analysis of county-level secondary data and, where available, primary data on health status, demographics, and community resources. Based on this assessment, LHDs and hospitals identify key community health priorities and develop a plan to address them, ensuring a strategic approach to improving public health outcomes.

The CHIP/CSP must align with Prevention Agenda priorities and objectives and incorporate evidence-based interventions to address selected priorities. CHIPs/CSPs are updated annually, with the Office of Local Health Services assisting LHDs and hospitals in monitoring performance. For details on how CHIPs/CSPs are linked to the 2025-2030 Prevention Agenda, please see the Community Health Improvement Planning Guidance.

During the 2019-2024 Prevention Agenda cycle, LHDs and hospitals submitted CHAs/CHIPs/CSPs every 3 years. However, for the 2025-2030 Prevention Agenda:

- LHDs will transition to a six-year CHA/CHIP cycle, with a mid-cycle assessment update.
- Hospitals will continue a three-year submission cycle (2025-2027, 2028-2030) to meet Internal Revenue Service (IRS) requirements for tax-exempt hospitals.

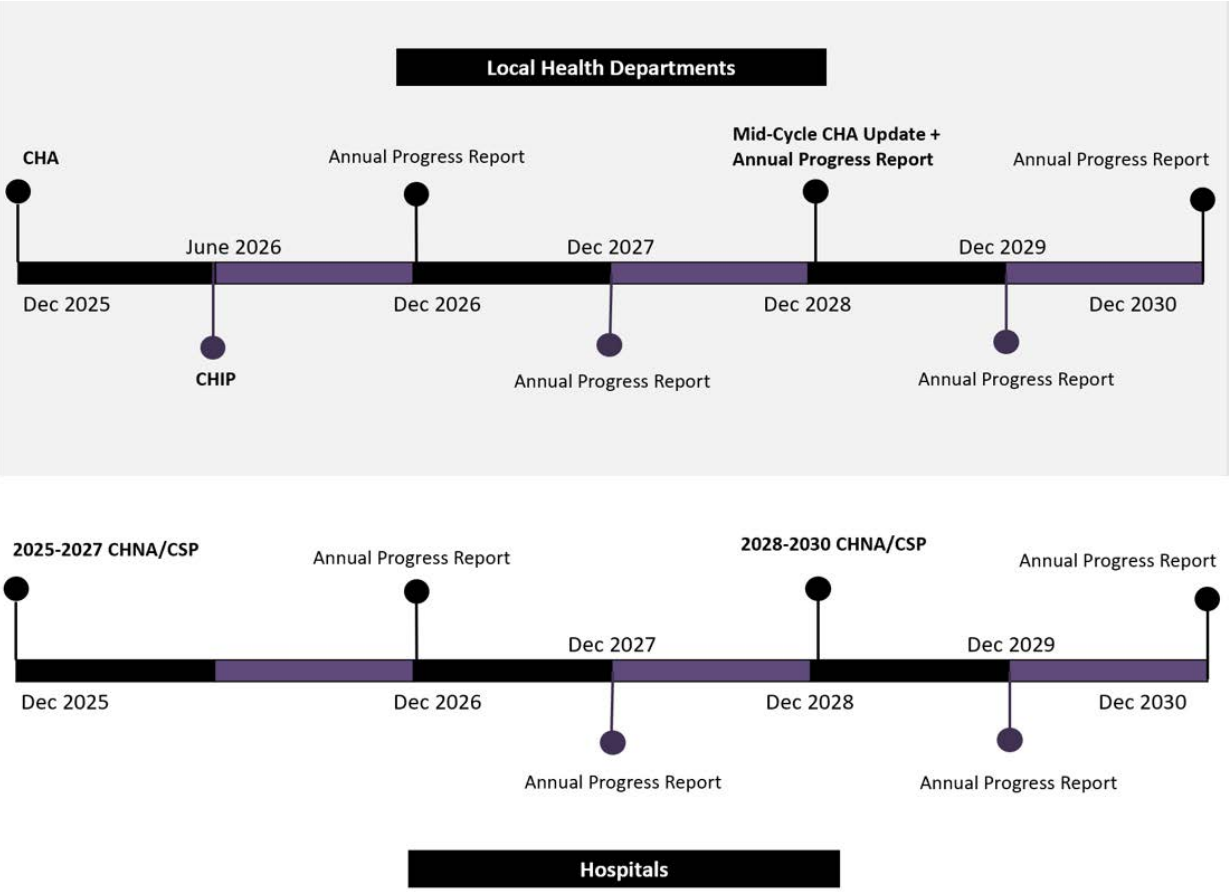
Table 2 provides details on the national and New York State requirements for CHAs/CHIPs/CSPs, while Figure 14 outlines the plans' submission timeline.

Table 2: Requirements for Hospitals and Local Health Departments

Organization	National Requirements	NYS 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 5 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 assessment plans to New York State Department of Health for 2025-2030.
Hospitals 501(c)(3) tax-exempt 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 3 years.	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 New York State Department of Health for 2025- 2027. Community benefit expenditures: Hospitals are encouraged to submit Schedule H of IRS Form 990 to New York State Department of Health annually, including any attachments.

[1] *Hospitals typically refer to the Community Health Assessment (CHA) as the Community Health Needs Assessment (CHNA) and the Community Health Improvement Plan (CHIP) as the Community Service Plan (CSP), though the content is similar.*

Figure 16: Timeline for CHA/CHIP/CSP Submissions



LHDs and hospitals are encouraged to collaborate and involve other community partners throughout the assessment, priority selection, planning, implementation, and evaluation process. In addition, LHDs and hospitals are also strongly encouraged to collaborate with community partners to develop a joint assessment and improvement plan with regional partners to maximize resources, improve effectiveness, and reduce duplication of efforts.

Monitoring and Evaluation

Monitoring and evaluation of Prevention Agenda activities is an essential component of implementation. Evaluation of the 2025-2030 Prevention Agenda will assess progress on all 90 objectives; track implementation of interventions and supporting activities at the state and local levels; show accountability and communicate progress to Prevention Agenda contributors and the public; and inform the development of the future SHA and Prevention Agenda cycles.

State-Level Outcome Evaluation

The Prevention Agenda Dashboard is an interactive, visual presentation of data used to track the progress of Prevention Agenda indicators and objectives at the state and county levels. Updated at least annually, the dashboard serves as a key source for monitoring statewide progress in achieving Prevention Agenda objectives. The state dashboard homepage provides:

- A quick overview of the most recent data and the 2030 targets for 84 tracking indicators.
- Indicators grouped by Domain area with historical trends, if available.
- Visualizations of the differences in particular indicators by major socio-demographic characteristics such as age group, race and ethnicity, sex, geographic region, health insurance status, level of education, etc., where available.
- General health indicators tracked in the prior Prevention Agenda will continue to be monitored this cycle, with new targets set for 2030.

The Prevention Agenda County Dashboard includes the most current data available for tracking indicators at a county level where they are available, grouped by Domain. In addition, the dashboard provides county maps, graphs, and cross-county comparisons. Where available, data at sub-county level, including zip code, school district, and minor civil division/community district are included.

Local-Level Process Evaluation

New York State Department of Health staff will review Community Health Improvement Plans and Community Service Plans submitted by LHDs and hospitals, respectively, during the 2025-2030 Prevention Agenda implementation process. Reviewers will evaluate all plans to ensure alignment of priorities within counties. Reviewers will extract the following elements from each plan:

- Selected priorities, goals, and objectives
- Evidence of collaboration between LHDs and hospitals in the county
- Inclusion of evidence-based interventions to address the selected priorities
- Evidence of process and outcome measures to assess progress
- Identified disparities
- Evidence of strategies for sustaining community engagement and the types of participating partner organizations

Local health departments and hospitals are also required to provide annual updates on: (1) the implementation of interventions, and (2) progress made towards the achievement of selected objectives. In addition to required annual reporting, LHDs, hospitals, and their implementation partners are encouraged to extend monitoring and evaluation activities as feasible and appropriate.

Lessons Learned

In December 2024, at the close of the development process, the Department's Prevention Agenda leadership team circulated a survey to gather feedback on the planning process from those involved. 108 individual respondents provided feedback on their experiences including challenges they faced and suggestions for future planning cycles. In addition to the survey, the leadership team participated in a "lessons learned" session to share what worked well, what obstacles

and challenges existed, and opportunities to improve the process in the next cycle. The feedback received will support the Department in implementing process updates to streamline planning efforts for future Prevention Agenda cycles. Some major themes from the feedback survey are listed below:

- Include the opinions of a broader group of contributors and individuals in the prioritization process to create a more complete picture of statewide priorities.
    - Expanding involvement of LHDs, hospitals, and community-based organizations in the prioritization process
    - Identifying opportunities to engage the public to better understand community perspectives on priorities
- Lengthen the time that contributors have to develop the priority action plans. Expanding the time that contributors are engaged will reduce the time commitment per week for members.
- Enhance the orientation for volunteers, providing a more robust training and step-by-step guidance to alleviate some of the challenges regarding the lack of historical knowledge, technical experience, and understanding of processes.
- Organize the focus groups at the priority level rather than the domain level to make the best use of volunteers' time and expertise.
- Use more dynamic collaboration tools to improve efficiency, prevent version control issues, and allow for easier offline communications among workgroup members.

Appendices

Appendix I: 2025 State of the State Proposals that Support 2025-2030 Prevention Agenda Priorities

The State of the State (SOTS) is an annual speech given by the Governor of New York State that outlines the Governor's priorities and planned legislative and budgetary proposals for the coming year. The SOTS provides the first look at some of the initiatives that will be supported by the Governor in the year ahead. The State of the State (SOTS) is an annual speech given by the Governor of New York State that outlines the Governor's priorities and planned legislative and budgetary proposals for the coming year. The SOTS provides the first look at some of the initiatives that will be supported by the Governor in the year ahead.

The New York State Prevention Agenda is developed independently and establishes public health priorities for the succeeding 5-year period. Areas of alignment between the SOTS address and the Prevention Agenda may represent opportunities for partnerships or resources that may be available to support achieving the priorities outlined the Prevention Agenda.

The tables below are separated by Prevention Agenda priorities and include the proposals from the 2025 State of the State address that may strengthen the state's ability to achieve the priority goal outlined in the 2025-2030 Prevention Agenda.

Economic Stability Domain

Economic Stability Domain: Poverty Priority Area Poverty Priority Goal: *Identify, promote, and implement programs that address poverty.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Putting Money Back in New Yorkers' Pockets	Slash Middle Class Taxes Up to 5 Percent, Reaching 67-Year Lows	Building an Economy that Works for All	Facilitate New Training Pathways into High-Demand Occupations
Putting Money Back in New Yorkers' Pockets	Give Back $3 Billion in Inflation Rebates to New Yorkers	Building an Economy that Works for All	Create New Registered Apprenticeships and Pre-Apprenticeships in High Demand Fields
Putting Money Back in New Yorkers' Pockets	Vastly Expand New York's Child Tax Credit Expansion	Building an Economy that Works for All	Expand Cybersecurity Careers with Degree Reform and New Fellowships
Supporting the Youngest New Yorkers and their Families	Establish the Birth Allowance for Beginning Year Benefit	Building an Economy that Works for All	Diversify the Artificial Intelligence Pipeline with Artificial Intelligence Prep
Supporting the Youngest New Yorkers and their Families	Support Families When a Baby is Born	Building an Economy that Works for All	Leverage Federal Support to Expand Health, Behavioral, and Social Care Workforce
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Building an Economy that Works for All	Deploy State Funding to Support Health Care Training Programs
Helping Our Children Thrive	Build a Statewide Data System to Improve Education and Workforce Outcomes	Building an Economy that Works for All	Expand Enforcement Power Following an Unpaid Wage Theft Judgment
Helping Our Children Thrive	Launch College in High School Opportunity Fund	Building an Economy that Works for All	Support Workers Displaced by Artificial Intelligence
Helping Our Children Thrive	Streamline the Part-Time Tuition Assistance Program	Making Government Work Better	Digitize Youth Working Papers
Helping Our Children Thrive	Invest in Student Success at the State University of New York	Making Government Work Better	Recruit New Talent and Modernize the Civil Service System

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Investing in Safety	Expand Victim Support Services to Protect Vulnerable Populations	Making Government Work Better	Increase Access to Government Services
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Growing Housing to Drive Affordability	Extend Security Deposit Protections to Rent-Regulated Tenants
Investing in Safety	Eliminate Outdated Barriers in Public Safety Recruitment	Protecting Consumers	Enhance Oversight of Buy Now Pay Later Loans
Investing in Safety	Expand Educational Pathways to Public Service Careers	Protecting Consumers	Bolster Protections Against Overdraft and Non-Sufficient Funds Fees
Bringing Jobs to New York	Promote Opportunity with Electric Readiness for Underdeveloped Properties Fund	Protecting Consumers	Hold Energy Service Companies Accountable for Revenue Return
Bringing Jobs to New York	Grow the Semiconductor Industry and Build the Semiconductor Supply Chain	Protecting Consumers	Combat Elder Financial Exploitation
Bringing Jobs to New York	Double Down on Shovel-Ready Sites for Modern Manufacturing	Supporting Survivors of Sexual Assault, Gender-Based Violence, & Sex Trafficking	Improve Access to Public Assistance for Survivors of Gender-Based Violence
Bringing Jobs to New York	Turbocharge Hiring by Startups	Investing in Mental Health	Streamline County Oversight and Enhance Funding
Bringing Jobs to New York	Support Small Businesses with Low Interest Capital	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Bringing Jobs to New York	Transform Regional Economic Development with High-Impact Projects	Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces
Bringing Jobs to New York	Provide Artificial Intelligence Technical Assistance to Small Businesses	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Bringing Jobs to New York	Increase Capital Access for Underrepresented Startups	Investing in Social Services and Equity	Launch a Demonstration Program to Mitigate the "Benefits Cliff"

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Bringing Jobs to New York	Renew our Commitment to Our State's Capital City	Investing in Social Services and Equity	Increase Threshold to Waive Recovery of Overpayments
Bringing Jobs to New York	Position New York as a Regional Leader in Fiber Production	Investing in Social Services and Equity	Strengthen the Workers with Disabilities Employment Tax Credit
Bringing Jobs to New York	Launch a Maple Industry Growth Strategy	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Bringing Jobs to New York	Advance the Sustainability of New York's Dairy Industry	Building a Sustainable Future	Help Businesses Recover After Disasters
Building an Economy that Works for All	Fund Free Community College in High-Demand Occupations	Building a Sustainable Future	Invest in Coastal Resiliency

Economic Stability Domain: Unemployment Priority Area

Unemployment Priority Goal: *Promote equitable approaches to optimize employment.*

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Helping Our Children Thrive	Build a Statewide Data System to Improve Education and Workforce Outcomes	Building an Economy that Works for All	Diversify the Artificial Intelligence Pipeline with Artificial Intelligence Prep
Helping Our Children Thrive	Launch College in High School Opportunity Fund	Building an Economy that Works for All	Leverage Federal Support to Expand Health, Behavioral, and Social Care Workforce
Helping Our Children Thrive	Streamline the Part-Time Tuition Assistance Program	Building an Economy that Works for All	Deploy State Funding to Support Health Care Training Programs
Helping Our Children Thrive	Invest in Student Success at the State University of New York	Building an Economy that Works for All	Expand Enforcement Power Following an Unpaid Wage Theft Judgment

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Building an Economy that Works for All	Support Workers Displaced by Artificial Intelligence
Investing in Safety	Eliminate Outdated Barriers in Public Safety Recruitment	Making Government Work Better	Digitize Youth Working Papers
Investing in Safety	Expand Educational Pathways to Public Service Careers	Making Government Work Better	Recruit New Talent and Modernize the Civil Service System
Bringing Jobs to New York	Promote Opportunity with Electric Readiness for Underdeveloped Properties Fund	Making Government Work Better	Increase Access to Government Services
Bringing Jobs to New York	Grow the Semiconductor Industry and Build the Semiconductor Supply Chain	Making Government Work Better	Provide Artificial Intelligence Upskilling for State Workforce
Bringing Jobs to New York	Double Down on Shovel-Ready Sites for Modern Manufacturing	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Improve Access to Public Assistance for Survivors of Gender-Based Violence
Bringing Jobs to New York	Turbocharge Hiring by Startups	Investing in Mental Health	Streamline County Oversight and Enhance Funding
Bringing Jobs to New York	Support Small Businesses with Low Interest Capital	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Bringing Jobs to New York	Transform Regional Economic Development with High-Impact Projects	Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces
Bringing Jobs to New York	Provide Artificial Intelligence Technical Assistance to Small Businesses	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Bringing Jobs to New York	Increase Capital Access for Underrepresented Startups	Investing in Social Services and Equity	Launch a Demonstration Program to Mitigate the "Benefits Cliff"
Bringing Jobs to New York	Renew our Commitment to Our State's Capital City	Investing in Social Services and Equity	Increase Threshold to Waive Recovery of Overpayments

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Bringing Jobs to New York	Position New York as a Regional Leader in Fiber Production	Investing in Social Services and Equity	Strengthen the Workers with Disabilities Employment Tax Credit
Bringing Jobs to New York	Launch a Maple Industry Growth Strategy	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Building an Economy that Works for All	Fund Free Community College in High-Demand Occupations	Building a Sustainable Future	Build Public Power for Public Entities
Building an Economy that Works for All	Facilitate New Training Pathways into High-Demand Occupations	Building a Sustainable Future	Help Businesses Recover After Disasters
Building an Economy that Works for All	Create New Registered Apprenticeships and Pre-Apprenticeships in High Demand Fields	Building a Sustainable Future	Invest in Coastal Resiliency
Building an Economy that Works for All	Expand Cybersecurity Careers with Degree Reform and New Fellowships	Building a Sustainable Future	Invest in Our Water Infrastructure

Economic Stability Domain: Nutrition Security Priority Area Nutrition Security Priority Goal: *Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Expand Access to Vital Nutrition Programs for Mothers and Children	Making Government Work Better	Recruit New Talent and Modernize the Civil Service System
Supporting the Youngest New Yorkers and their Families	Increase Dual Enrollment in Supplemental Nutrition Assistance Program and Special Supplemental Nutrition Program for Women, Infants, and Children	Making Government Work Better	Increase Access to Government Services
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Improve Access to Public Assistance for Survivors of Gender-Based Violence
Helping Our Children Thrive	Provide Universal School Meals	Investing in Mental Health	Streamline County Oversight and Enhance Funding
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Investing in Safety	Eliminate Outdated Barriers in Public Safety Recruitment	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Bringing Jobs to New York	Enhance Local Food Supply Chains	Investing in Social Services and Equity	Continue and Expand Support for Street Outreach Activities
Building an Economy that Works for All	Fund Free Community College in High-Demand Occupations	Investing in Social Services and Equity	Launch a Demonstration Program to Mitigate the "Benefits Cliff"
Building an Economy that Works for All	Facilitate New Training Pathways into High-Demand Occupations	Investing in Social Services and Equity	Increase Threshold to Waive Recovery of Overpayments
Making Government Work Better	Digitize Youth Working Papers	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program

Economic Stability Domain: Housing Stability & Affordability Priority Area Housing Stability & Affordability Priority Goal: *Foster reliable and equitable access to safe, affordable, and secure housing options.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Build a Statewide Data System to Improve Education and Workforce Outcomes	Building an Economy that Works for All	Diversify the Artificial Intelligence Pipeline with Artificial Intelligence Prep
Helping Our Children Thrive	Launch College in High School Opportunity Fund	Building an Economy that Works for All	Leverage Federal Support to Expand Health, Behavioral, and Social Care Workforce
Helping Our Children Thrive	Streamline the Part-Time Tuition Assistance Program	Building an Economy that Works for All	Deploy State Funding to Support Health Care Training Programs
Helping Our Children Thrive	Invest in Student Success at the State University of New York	Building an Economy that Works for All	Expand Enforcement Power Following an Unpaid Wage Theft Judgment
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Building an Economy that Works for All	Support Workers Displaced by Artificial Intelligence
Investing in Safety	Eliminate Outdated Barriers in Public Safety Recruitment	Making Government Work Better	Digitize Youth Working Papers
Investing in Safety	Expand Educational Pathways to Public Service Careers	Making Government Work Better	Recruit New Talent and Modernize the Civil Service System
Bringing Jobs to New York	Promote Opportunity with Electric Readiness for Underdeveloped Properties Fund	Making Government Work Better	Increase Access to Government Services
Bringing Jobs to New York	Grow the Semiconductor Industry and Build the Semiconductor Supply Chain	Making Government Work Better	Provide Artificial Intelligence Upskilling for State Workforce
Bringing Jobs to New York	Double Down on Shovel-Ready Sites for Modern Manufacturing	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Improve Access to Public Assistance for Survivors of Gender-Based Violence

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Bringing Jobs to New York	Turbocharge Hiring by Startups	Investing in Mental Health	Streamline County Oversight and Enhance Funding
Bringing Jobs to New York	Support Small Businesses with Low Interest Capital	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Bringing Jobs to New York	Transform Regional Economic Development with High-Impact Projects	Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces
Bringing Jobs to New York	Provide Artificial Intelligence Technical Assistance to Small Businesses	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Bringing Jobs to New York	Increase Capital Access for Underrepresented Startups	Investing in Social Services and Equity	Launch a Demonstration Program to Mitigate the "Benefits Cliff"
Bringing Jobs to New York	Renew our Commitment to Our State's Capital City	Investing in Social Services and Equity	Increase Threshold to Waive Recovery of Overpayments
Bringing Jobs to New York	Position New York as a Regional Leader in Fiber Production	Investing in Social Services and Equity	Strengthen the Workers with Disabilities Employment Tax Credit
Bringing Jobs to New York	Launch a Maple Industry Growth Strategy	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Building an Economy that Works for All	Fund Free Community College in High-Demand Occupations	Building a Sustainable Future	Build Public Power for Public Entities
Building an Economy that Works for All	Facilitate New Training Pathways into High-Demand Occupations	Building a Sustainable Future	Help Businesses Recover After Disasters
Building an Economy that Works for All	Create New Registered Apprenticeships and Pre-Apprenticeships in High Demand Fields	Building a Sustainable Future	Invest in Coastal Resiliency
Building an Economy that Works for All	Expand Cybersecurity Careers with Degree Reform and New Fellowships	Building a Sustainable Future	Invest in Our Water Infrastructure

Social and Community Context Domain: Anxiety and Stress Priority Area Anxiety and Stress Priority Goal: *Increase the proportion of people living in New York who show resilience to challenges and stress.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams
Helping Our Children Thrive	Invest in Student Success at the State University of New York	Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Mental Health	Provide High School Students with Teen Mental Health First Aid Training ™
Helping Our Children Thrive	Invest in Playgrounds	Investing in Mental Health	Support Youth Mental Health in After-School Programs
Helping Our Children Thrive	Launch Get Offline, Get Outside 2.0	Investing in Mental Health	Improve Diagnoses for Children with Complex Clinical Needs
Helping Our Children Thrive	Outlaw Artificial Intelligence-Generated Child Sexual Abuse Material	Investing in Mental Health	Hold Health Insurance Companies Accountable
Helping Our Children Thrive	Make Artificial Intelligence Companion Technology Safer	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Investing in Safety	Expand Victim Support Services to Protect Vulnerable Populations	Investing in Health	Extend the Safety Net Transformation Program ™
Investing in Safety	Ensure Child Victims of Crime Are Maximally Supported	Investing in Health	Remove Unnecessary Restrictions on Health Care Workers

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Investing in Health	Advance Health Equity for Justice-Involved Youth
Investing in Safety	Launch First Responder Counseling Scholarship Program	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Investing in Safety	Establish a Mass Violence Crisis Response Team	Investing in Health	Update and Improve Network Adequacy Requirements
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Require Access to Trained Forensic Medical Examiners at All Hospitals	Investing in Social Services and Equity	Continue and Expand Support for Street Outreach Activities
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Increase Funding for Rape Crisis Programs	Investing in Social Services and Equity	Launch a Demonstration Program to Mitigate the "Benefits Cliff"
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Expand Statewide Targeted Reductions in Intimate Partner Violence	Investing in Social Services and Equity	Increase Threshold to Waive Recovery of Overpayments
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Dispossess Domestic Violence Abusers of Firearms	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Create Safer Workplaces for Survivors of Gender-Based Violence	Investing in Social Services and Equity	Enhance Veteran Suicide Prevention Initiatives
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Social Services and Equity	Combat Youth Homelessness
Investing in Mental Health	Expand Intensive and Sustained Engagement Teams	Investing in Social Services and Equity	Promote Kinship Care
Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™	Investing in Social Services and Equity	Enhance Mentoring Programs

Social and Community Context Domain: Suicide Priority Area Suicide Priority Goal: *Prevent Suicides.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Mental Health	Expand Intensive and Sustained Engagement Teams
Helping Our Children Thrive	Invest in Playgrounds	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Helping Our Children Thrive	Launch Get Offline, Get Outside 2.0	Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams
Helping Our Children Thrive	Outlaw Artificial Intelligence-Generated Child Sexual Abuse Material	Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces
Helping Our Children Thrive	Make Artificial Intelligence Companion Technology Safer	Investing in Mental Health	Provide High School Students with Teen Mental Health First Aid Training
Investing in Safety	Ensure Child Victims of Crime Are Maximally Supported	Investing in Mental Health	Support Youth Mental Health in After-School Programs
Investing in Safety	Launch First Responder Counseling Scholarship Program	Investing in Mental Health	Improve Diagnoses for Children with Complex Clinical Needs
Investing in Safety	Establish a Mass Violence Crisis Response Team	Investing in Mental Health	Hold Health Insurance Companies Accountable
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Require Access to Trained Forensic Medical Examiners at All Hospitals	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Increase Funding for Rape Crisis Programs	Investing in Health	Extend the Safety Net Transformation Program

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Expand Statewide Targeted Reductions in Intimate Partner Violence	Investing in Health	Advance Health Equity for Justice-Involved Youth
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Dispossess Domestic Violence Abusers of Firearms	Investing in Health	Update and Improve Network Adequacy Requirements
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Create Safer Workplaces for Survivors of Gender-Based Violence	Investing in Social Services and Equity	Continue and Expand Support for Street Outreach Activities
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Modernize Mental Hygiene Law to Expand Access to Care	Investing in Social Services and Equity	Enhance Veteran Suicide Prevention Initiatives
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Social Services and Equity	Combat Youth Homelessness

Social and Community Context Domain: Depression Priority Area Depression Priority Goal: *Increase screening and treatment for depression to decrease prevalence.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces
Helping Our Children Thrive	Invest in Playgrounds	Investing in Mental Health	Provide High School Students with Teen Mental Health First Aid Training™
Helping Our Children Thrive	Launch Get Offline, Get Outside 2.0	Investing in Mental Health	Support Youth Mental Health in After-School Programs
Helping Our Children Thrive	Outlaw Artificial Intelligence-Generated Child Sexual Abuse Material	Investing in Mental Health	Improve Diagnoses for Children with Complex Clinical Needs
Helping Our Children Thrive	Make Artificial Intelligence Companion Technology Safer	Investing in Mental Health	Hold Health Insurance Companies Accountable
Investing in Safety	Ensure Child Victims of Crime Are Maximally Supported	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Investing in Health	Extend the Safety Net Transformation Program
Investing in Safety	Launch First Responder Counseling Scholarship Program	Investing in Health	Remove Unnecessary Restrictions on Healthcare Workers
Investing in Safety	Establish a Mass Violence Crisis Response Team	Investing in Health	Advance Health Equity for Justice-Involved Youth

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Require Access to Trained Forensic Medical Examiners at All Hospitals	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Increase Funding for Rape Crisis Programs	Investing in Health	Update and Improve Network Adequacy Requirements
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Expand Statewide Targeted Reductions in Intimate Partner Violence	Investing in Social Services and Equity	Continue and Expand Support for Street Outreach Activities
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Create Safer Workplaces for Survivors of Gender-Based Violence	Investing in Social Services and Equity	Launch a Demonstration Program to Mitigate the "Benefits Cliff"
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Social Services and Equity	Increase Threshold to Waive Recovery of Overpayments
Investing in Mental Health	Expand Intensive and Sustained Engagement Teams	Investing in Social Services and Equity	Enhance Veteran Suicide Prevention Initiatives
Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™	Investing in Social Services and Equity	Combat Youth Homelessness

Social and Community Context Domain: Substance Misuse, Overdose Prevention Priority Area Substance Misuse, Overdose Prevention Priority Goal: *Reduce substance use, misuse, overdose and/or associated harms.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Mental Health	Hold Health Insurance Companies Accountable
Investing in Safety	Strengthen the State's Response Against Transnational Criminal Networks	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Investing in Health	Extend the Safety Net Transformation Program
Investing in Safety	Launch First Responder Counseling Scholarship Program	Investing in Health	Ensure Access to Emergency Medical Services
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Health	Advance Health Equity for Justice-Involved Youth
Investing in Mental Health	Expand Intensive and Sustained Engagement Teams	Investing in Social Services and Equity	Expand Access to Treatment Medications in Underserved Areas
Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™	Investing in Social Services and Equity	Continue and Expand Support for Street Outreach Activities
Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams	Investing in Social Services and Equity	Amend Legislation to Allow Paramedics to Administer Buprenorphine
Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces	Investing in Social Services and Equity	Allow Practitioners to Dispense Three-Day Supply of Opioid Use Disorder Medication
Investing in Mental Health	Provide High School Students with Teen Mental Health First Aid Training	Investing in Social Services and Equity	Align State Drug Schedules with Federal Standards to Improve Monitoring
Investing in Mental Health	Improve Diagnoses for Children with Complex Clinical Needs	Investing in Social Services and Equity	Enhance Veteran Suicide Prevention Initiatives

Social and Community Context Domain: Tobacco/E-Cigarette Use Priority Area Tobacco/E-Cigarette Use Priority Goal: *Eliminate the harms caused by commercial tobacco product use and exposure.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Health	Remove Unnecessary Restrictions on Healthcare Workers

Social and Community Context Domain: Alcohol Use Priority Area Alcohol Use Priority Goal: *Reduce excessive alcohol use and associated harms.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Mental Health	Provide High School Students with Teen Mental Health First Aid Training
Investing in Safety	Launch First Responder Counseling Scholarship Program	Investing in Mental Health	Improve Diagnoses for Children with Complex Clinical Needs
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Mental Health	Hold Health Insurance Companies Accountable
Investing in Mental Health	Expand Intensive and Sustained Engagement Teams	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™	Investing in Health	Extend the Safety Net Transformation Program
Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams	Investing in Social Services and Equity	Continue and Expand Support for Street Outreach Activities

Social and Community Context Domain: Adverse Childhood Experiences (ACEs) Priority Area Adverse Childhood Experiences (ACEs) Priority Goal: *Prevent and address the impact of Adverse Childhood Experiences.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Increase Funding for Rape Crisis Programs
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Expand Statewide Targeted Reductions in Intimate Partner Violence
Helping Our Children Thrive	Outlaw Artificial Intelligence-Generated Child Sexual Abuse Material	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Dispossess Domestic Violence Abusers of Firearms
Investing in Safety	Expand Support for Intelligence Sharing and Agency Coordination	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Improve Access to Public Assistance for Survivors of Gender-Based Violence
Investing in Safety	Support Safe and Vibrant Communities	Investing in Mental Health	Streamline County Oversight and Enhance Funding
Investing in Safety	Ensure Child Victims of Crime Are Maximally Supported	Investing in Mental Health	Expand Intensive and Sustained Engagement Teams
Investing in Safety	Establish a Mass Violence Crisis Response Team	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Building an Economy that Works for All	Align Child Labor Law Penalties with Severity of Violation	Investing in Mental Health	Improve Diagnoses for Children with Complex Clinical Needs
Making Government Work Better	Increase Access to Government Services	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Supporting Survivors of Sexual Assault, Gender-	Require Access to Trained Forensic Medical Examiners at All Hospitals		

Based Violence, and Sex Trafficking			

Social and Community Context Domain: Healthy Eating Priority Area Healthy Eating Priority Goal: *Promote healthy eating and make nutritious, culturally appropriate foods available.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Bringing Jobs to New York	Enhance Local Food Supply Chains
Helping Our Children Thrive	Provide Universal School Meals	Bringing Jobs to New York	Expand Agriculture Education in the New York Schools
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Making Government Work Better	Increase Access to Government Services

Neighborhood and Built Environment Domain

Neighborhood and Built Environment Domain: Opportunities for Active Transportation and Physical Activity Priority Area Opportunities for Active Transportation and Physical Activity Priority Goal: *Improve safe, affordable, and accessible active transportation, physical, and social activity.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Making Government Work Better	Engage the Dormitory Authority to Speed Municipal Projects
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Growing Housing to Drive Affordability	Empower Communities to Redevelop Vacant Properties into Housing
Helping Our Children Thrive	Invest in Playgrounds	Cutting Commutes	Make the Biggest Capital Investment in New York's Transportation History
Helping Our Children Thrive	Launch Get Offline, Get Outside 2.0	Cutting Commutes	Advance Second Avenue Subway and Other Major Transit Improvements
Helping Our Children Thrive	Double Down on NY SWIMS	Cutting Commutes	Enhance Subway Safety with Expanded Security and Outreach Measures
Helping Our Children Thrive	Get More Kids Swimming and Prevent Child Drowning	Cutting Commutes	Invest in New York Roads and Statewide Transit
Investing in Safety	Establish a Mass Violence Crisis Response Team	Cutting Commutes	Modernize Rail Service for Faster, More Reliable Travel
Bringing Jobs to New York	Build Clean Energy Zones	Cutting Commutes	Reconnect Communities in Albany and the Bronx
Bringing Jobs to New York	Transform Regional Economic Development with High-Impact Projects	Building a Sustainable Future	Make Open Space Accessible for All

Neighborhood and Built Environment Domain: Access to Community Services and Support Priority Area Access to Community Services and Support Priority Goal: *Improve awareness, affordability, accessibility, and acceptability of community services and supports.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams
Building an Economy that Works for All	Expand Access to Medical Care in the Workers' Compensation System	Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces
Making Government Work Better	Increase Access to Government Services	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Growing Housing to Drive Affordability	Strengthen Laws and Policies to Combat Home Appraisal Discrimination	Investing in Health	Extend the Safety Net Transformation Program
Growing Housing to Drive Affordability	Create a Pro-Housing Supply Infrastructure Fund	Investing in Health	Ensure Access to Emergency Medical Services
Cutting Commutes	Enhance Subway Safety with Expanded Security and Outreach Measures	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Require Access to Trained Forensic Medical Examiners at All Hospitals	Investing in Health	Update and Improve Network Adequacy Requirements
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Increase Funding for Rape Crisis Programs	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Expand Statewide Targeted Reductions in Intimate Partner Violence	Investing in Health	Increase the Affordability of Prescription Drugs

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Improve Access to Public Assistance for Survivors of Gender-Based Violence	Investing in Social Services and Equity	Expand Access to Treatment Medications in Underserved Areas
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Modernize Mental Hygiene Law to Expand Access to Care	Investing in Social Services and Equity	Continue and Expand Support for Street Outreach Activities
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Investing in Mental Health	Expand Intensive and Sustained Engagement Teams		

Neighborhood and Built Environment Domain: Injuries and Violence Priority Area Injuries and Violence Priority Goal: *Prevent intentional and unintentional injuries.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Get More Kids Swimming and Prevent Child Drowning	Making Government Work Better	Increase Access to Government Services
Helping Our Children Thrive	Outlaw Artificial Intelligence-Generated Child Sexual Abuse Material	Cutting Commutes	Enhance Subway Safety with Expanded Security and Outreach Measures
Helping Our Children Thrive	Make Artificial Intelligence Companion Technology Safer	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Require Access to Trained Forensic Medical Examiners at All Hospitals
Investing in Safety	Expand Support for Intelligence Sharing and Agency Coordination	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Increase Funding for Rape Crisis Programs
Investing in Safety	Strengthen the State's Response Against Transnational Criminal Networks	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Expand Statewide Targeted Reductions in Intimate Partner Violence
Investing in Safety	Support Safe and Vibrant Communities	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Dispossess Domestic Violence Abusers of Firearms
Investing in Safety	Expand Victim Support Services to Protect Vulnerable Populations	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Create Safer Workplaces for Survivors of Gender-Based Violence
Investing in Safety	Ensure Child Victims of Crime Are Maximally Supported	Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Modernize Mental Hygiene Law to Expand Access to Care
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Investing in Mental Health	Streamline County Oversight and Enhance Funding

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Investing in Safety	Launch First Responder Counseling Scholarship Program	Investing in Mental Health	Expand Intensive and Sustained Engagement Teams
Investing in Safety	Establish a Mass Violence Crisis Response Team	Investing in Mental Health	Create a Hospital-Based Peer Bridger Program™
Investing in Safety	Enhance Safety for Work Zones and Transportation Workers	Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams
Investing in Safety	Strengthen Drugged Driving Laws	Investing in Mental Health	Provide High School Students with Teen Mental Health First Aid Training
Investing in Safety	Improve Safety at New York City's Elementary School Intersections	Investing in Mental Health	Support Youth Mental Health in After-School Programs
Investing in Safety	Reclassify Ultra-Heavy Class 3 E-Bikes as Mopeds	Investing in Health	Extend the Safety Net Transformation Program
Investing in Safety	Allow New York City to Lower Speed Limits in Bike Lanes	Investing in Health	Ensure Access to Emergency Medical Services
Bringing Jobs to New York	Renew our Commitment to Our State's Capital City	Investing in Health	Expand Access to Air Conditioning Units for People with Chronic Conditions
Building an Economy that Works for All	Expand Access to Medical Care in the Workers' Compensation System		

Health Care Access and Quality Domain: Access to and Use of Prenatal Care Priority Area Access to and Use of Prenatal Care Priority Goal: ***Increase accessibility, availability, timeliness, and quality of equitable prenatal care for all birthing persons.***			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Investing in Health	Extend the Safety Net Transformation Program	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace
Investing in Health	Reduce Health Disparities Through Value-Based Payments	Investing in Health	Increase the Affordability of Prescription Drugs
Investing in Health	Update and Improve Network Adequacy Requirements	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program

Health Care Access and Quality Domain: Prevention of Infant and Maternal Mortality Priority Area Prevention of Infant and Maternal Mortality Priority Goal: *Improve health outcomes by lowering mortality and morbidity rates for infants and birthing persons.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Support Families When a Baby is Born	Investing in Health	Extend the Safety Net Transformation Program
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Health	Reduce Health Disparities Through Value-Based Payments
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Modernize Mental Hygiene Law to Expand Access to Care	Investing in Health	Update and Improve Network Adequacy Requirements
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace
Investing in Mental Health	Create a Hospital-Based Peer Bridger Program ™	Investing in Health	Increase the Affordability of Prescription Drugs
Investing in Health	Safeguard Abortion as Emergency Medical Care	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program

Health Care Access and Quality Domain: Preventive Services for Chronic Disease Prevention and Control Preventive Services for Chronic Disease Prevention and Control Priority Goal: *Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Expand Lactation Support Services	Investing in Health	Reduce Health Disparities Through Value-Based Payments
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Health	Advance Integrated Care for Better Health Outcomes
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Require Access to Trained Forensic Medical Examiners at All Hospitals	Investing in Health	Update and Improve Network Adequacy Requirements
Investing in Mental Health	Add Street Medicine and Psychiatry to Safe Options Support Teams	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace
Investing in Health	Extend the Safety Net Transformation Program	Investing in Health	Increase the Affordability of Prescription Drugs
Investing in Health	Increase Access to Lifesaving Obesity Drugs	Investing in Social Services and Equity	Create Regional Disability Clinics
Investing in Health	Remove Unnecessary Restrictions on Health Care Workers	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Investing in Health	Expand Access to Air Conditioning Units for People with Chronic Conditions	Building a Sustainable Future	Clean Up Our Past Via the State Superfund

Health Care Access and Quality Domain: Oral Health Care Oral Health Care Priority Goal: *Reduce disparities in in accessing and utilizing preventive oral health services.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Health	Update and Improve Network Adequacy Requirements
Investing in Health	Expand Access to Dental Care	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace

Health Care Access and Quality Domain: Preventive Services Preventive Services Priority Goal: *Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Health	Update and Improve Network Adequacy Requirements
Investing in Health	Extend the Safety Net Transformation Program	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace
Investing in Health	Expand Access to Air Conditioning Units for People with Chronic Conditions	Investing in Social Services and Equity	Create Regional Disability Clinics
Investing in Health	Advance Health Equity for Justice-Involved Youth	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Investing in Health	Reduce Health Disparities Through Value-Based Payments		

Health Care Access and Quality Domain: Early Intervention Priority Early Intervention Priority Goal: *Increase the access and utilization of early intervention services.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace
Investing in Health	Update and Improve Network Adequacy Requirements	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program

Health Care Access and Quality Domain: Childhood Behavioral Health Childhood Behavioral Health Priority Goal: *Improve the mental health and well-being of children and adolescents.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Supporting the Youngest New Yorkers and their Families	Create The Parent Partnership Project	Investing in Mental Health	Provide High School Students with Teen Mental Health First Aid Training
Helping Our Children Thrive	Provide Universal School Meals	Investing in Mental Health	Support Youth Mental Health in After-School Programs
Helping Our Children Thrive	Take Action to Ensure Distraction-Free Learning	Investing in Mental Health	Improve Diagnoses for Children with Complex Clinical Needs
Helping Our Children Thrive	Invest in New York State's Recreation Infrastructure	Investing in Mental Health	Hold Health Insurance Companies Accountable
Helping Our Children Thrive	Invest in Playgrounds	Investing in Mental Health	Support Community-Determined Wellness in Historically Marginalized Neighborhoods
Helping Our Children Thrive	Launch Get Offline, Get Outside 2.0	Investing in Health	Extend the Safety Net Transformation Program

SOTS Chapter	SOTS Proposal	SOTS Chapter	SOTS Proposal
Helping Our Children Thrive	Make Artificial Intelligence Companion Technology Safer	Investing in Health	Advance Health Equity for Justice-Involved Youth
Investing in Safety	Ensure Child Victims of Crime Are Maximally Supported	Investing in Health	Reduce Health Disparities Through Value-Based Payments
Investing in Safety	Establish a Mass Violence Crisis Response Team	Investing in Health	Update and Improve Network Adequacy Requirements
Building an Economy that Works for All	Align Child Labor Law Penalties with Severity of Violation	Investing in Health	Revamp and Improve Customer Experience on New York's Health Plan Marketplace
Making Government Work Better	Increase Access to Government Services	Investing in Health	Increase the Affordability of Prescription Drugs
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Improve Access to Public Assistance for Survivors of Gender-Based Violence	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program
Supporting Survivors of Sexual Assault, Gender-Based Violence, and Sex Trafficking	Modernize Mental Hygiene Law to Expand Access to Care	Investing in Social Services and Equity	Combat Youth Homelessness
Investing in Mental Health	Streamline County Oversight and Enhance Funding	Investing in Social Services and Equity	Promote Kinship Care
Investing in Mental Health	Expand Intensive and Sustained Engagement Teams	Investing in Social Services and Equity	Enhance Mentoring Programs
Investing in Mental Health	Create a Hospital-Based Peer Bridger Program ™	Building a Sustainable Future	Invest in Our Water Infrastructure
Investing in Mental Health	Expand the Network of Clubhouse Programs and Youth Safe Spaces		

Education Access and Quality Domain

Education Access and Quality Domain: Health and Wellness Promoting Schools Priority Area Health and Wellness Promoting Schools Priority Goal: *Increase access to health and wellness services in schools.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Provide Universal School Meals	Bringing Jobs to New York	Expand Agriculture Education in the New York Schools
Helping Our Children Thrive	Take Action to Ensure Distraction-Free Learning	Investing in Social Services and Equity	Create Indigenous Educational Materials
Helping Our Children Thrive	Boost Literacy with Free Books from Dolly Parton's Imagination Library	Investing in Social Services and Equity	Establish Fellowship to Celebrate and Advance African American History

Education Access and Quality Domain: Opportunities for Continued Education Priority Area Opportunities for Continued Education Priority Goal: *Enhance continued education to expand personal and professional development opportunities.*			
SOTS Chapter	**SOTS Proposal**	**SOTS Chapter**	**SOTS Proposal**
Helping Our Children Thrive	Boost Literacy with Free Books from Dolly Parton's Imagination Library	Building an Economy that Works for All	Facilitate New Training Pathways into High-Demand Occupations
Helping Our Children Thrive	Build a Statewide Data System to Improve Education and Workforce Outcomes	Building an Economy that Works for All	Create New Registered Apprenticeships and Pre-Apprenticeships in High Demand Fields
Helping Our Children Thrive	Launch College in High School Opportunity Fund	Building an Economy that Works for All	Expand Cybersecurity Careers with Degree Reform and New Fellowships
Helping Our Children Thrive	Streamline the Part-Time Tuition Assistance Program	Building an Economy that Works for All	Diversify the Artificial Intelligence Pipeline with Artificial Intelligence Prep
Helping Our Children Thrive	Invest in Student Success at the State University of New York	Building an Economy that Works for All	Leverage Federal Support to Expand Health, Behavioral, and Social Care Workforce
Helping Our Children Thrive	Invest in Cutting-Edge Research by Funding a New York State Innovation Fund	Building an Economy that Works for All	Deploy State Funding to Support Health Care Training Programs
Investing in Safety	Reduce Reoffending Through Innovative Justice Initiatives	Building an Economy that Works for All	Support Workers Displaced by Artificial Intelligence
Investing in Safety	Launch First Responder Counseling Scholarship Program	Making Government Work Better	Provide Artificial Intelligence Upskilling for State Workforce
Investing in Safety	Expand Educational Pathways to Public Service Careers	Investing in Health	Address Social Needs to Improve Health Equity and Outcomes
Building an Economy that Works for All	Fund Free Community College in High-Demand Occupations	Investing in Social Services and Equity	Create the New York State Interpreter Fellowship Program

Appendix II: Community Health Improvement Plan Submission Timeline

Table 3: 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.
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.

Appendix III: Selection Criteria

Selection Criteria

Table 4: Selection Criteria - Interventions

This table lists the criteria that was provided to workgroups to inform selection of interventions for each priority. This information was incorporated into workgroup brainstorming spreadsheets to ensure that all selected interventions followed the guiding principles and met the must have criteria.

Criteria	Criteria Definition/Explanation	Classification
Feasibility	Interventions that provide the best opportunities for cost-effective results.	**Guiding**
Level of Implementation	Selected interventions can be implemented across different sectors and settings, including individuals, organizations/agencies/institutions, and policies. For the action	**Guiding**

	plans, interventions will be grouped into 3 organizational levels: Interventions for hospitals. Interventions for local health departments. Interventions for other organizations.	
Magnitude	Potential to have a significant or large impact on the population's health.	**Guiding**
Sustainability	Changes resulting from the Evidence-Based Intervention are likely to go beyond the course of the interventions, such as changes that are part of the institutions' workflow.	**Guiding**
Number of Interventions	For each priority, select 6 to 10 interventions per organizational level. Priority (ranking) of interventions is given to interventions with higher impacts and/or implementing feasibility, and sustainability.	**Guiding**
Featured Interventions	The list of interventions should include two "featured interventions" for each priority. Featured interventions must have these characteristics: 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.	**Guiding**
Type	All included interventions, policies, and strategies must be evidence-based, and members must provide qualifying information such as the source (i.e., the publication if evidence-based interventions are not available, best or promising practices should be used.	**Must**
Focus on Prevention or Access	Primary prevention, including upstream activities that address SDOH. Secondary prevention, including screening and early intervention. Access to care, including innovative settings or methods (such as school-based health or telehealth).	**Must**
Close the Health Equity Gap	Intervention is likely to reduce disparities.	**Must**
CDC's Hi-5 and/or 6/18 Initiatives	Ensures alignment with high-impact interventions recommended by the CDC.	**Consideration**
Co-benefits	Has the potential to impact multiple Prevention Agenda priorities or outcomes.	**Consideration**
Alignment with Existing NYS Initiatives	Aligns with existing plans, programs, or initiatives in New York State.	**Consideration**
Classification of Criteria: **Guiding:** Provides general instructions for the intervention's selection process. **Must:** Indicates that any selected intervention must meet these criteria to be considered valid or acceptable. **Consideration:** Indicates that selected interventions are preferably expected to meet these recommended criteria, though they are not absolutely required.		

Table 5: Selection Criteria - Indicators

This table lists the criteria that was provided to workgroups to inform selection of indicators for each SMART and SMARTIE objective. This information was incorporated into workgroup brainstorming spreadsheets to ensure that all selected interventions followed the guiding principles and met the must have criteria. Workgroup liaisons from the New York State Department of Health's Office of Science and Technology supported this effort by identifying available statewide and county-level data sources.

Criteria	Criteria Definition/Explanation	Classification
Relevance	Indicator that is key to measure the implementation and intervention impacts.	**Must**
Measurability and Consistency	Data are quantifiable and collected consistently over time.	**Must**
Ongoing Availability	Data are available on a regular basis (monthly, quarterly, annually or biannually).	**Must**
Geographic Availability	Data are available at county or below county level.	**Must**
Actionability	Results can inform decision-making and guide necessary adjustments to strategies.	**Guiding**
Timeliness	Data are available for timely monitoring progress and identifying challenges.	**Guiding**
Disparity Measurement (Prioritizes indicators that measure health disparities)	Data can be broken down by race, ethnicity, gender, socioeconomic status, and other relevant demographics to assess health disparity and equity.	**Must**
Healthy People 2030	Data are comparable with HP2030 objectives for comparison.	**Must**
Public Understanding	Are the indicators easy for the public to understand, thereby promoting transparency and public engagement with the Prevention Agenda's progress?	**Must**
Inclusivity	Have key partners, including public health professionals, community members, and policymakers, been consulted in the selection of indicators?	**Consideration**
Number of Indicators	For each objective, one key indicator must be selected.	**Consideration**
Classification of Criteria: **Must:** Required criteria for selecting indicators. **Consideration:** Recommended and preferred, but not mandatory criteria. **Guiding:** Provides guidance on structure, process, and expected outcomes.		

Appendix IV: Workgroups

Table 6: Domain Workgroup Breakdown

This table includes provides information on each workgroup, including the workgroup abbreviation (example: D1W1 = Domain 1, Workgroup 1), total number of participants, and priorities covered by the workgroup.

Workgroups	Total Participants	Priorities		
D1W1	22	Poverty	Unemployment	
D1W2	22	Nutrition Security	Housing Security and Affordability	
D2W1	23	Anxiety and Stress	Suicide	Depression
D2W2	24	Substance Misuse and Overdose Including Primary Prevention	Tobacco/e-cigarette Use	Alcohol Use
D2W3	21	Adverse Childhood Experiences		
D2W4	21	Healthy Eating		
D3W1	24	Opportunities for Active Transportation and Physical Activity	Access to Community Services and Support	Injuries and Violence
D4W1	24	Access to and Use of Prenatal Care	Prevention of Infant and Maternal Mortality	
D4W2	25	Preventive Services for Chronic Disease Prevention and Control	Oral Health Care	Preventive Services
D4W3	22	Early Intervention	Childhood Behavioral Health	
D5W1	22	Health and Wellness Promoting Schools	Opportunities for Continued Education	

Workgroup Roles, Responsibilities, and Logistics

Domain Leads were tasked with setting the vision, goals, and objectives for the workgroups. They would also monitor progress and ensure alignment across the priorities.

Workgroup Leads were tasked with leading the planning process for their designated priorities. They also collected and documented input, assigned offline tasks, monitored workgroup progress and provided feedback on draft deliverables.

Workgroup Members were tasked with participating in weekly meetings, completing offline tasks, and providing input and expertise under their assigned priority.

Meetings were held weekly for each domain via Webex, with workgroups breaking out into separate sessions to work on the action plan. Workgroup leads also scheduled additional meetings throughout the process to ensure all action planning items were completed in a timely manner.

Priority Brainstorming Worksheets were developed to allow workgroup members to collaborate on each of the action plan components.

Appendix V: Lessons Learned

The process of planning and drafting the 2025-2030 Prevention Agenda presented unique challenges that the New York State Department of Health and partners have learned from and plan to address in future cycles. In December 2024, at the close of the development process, the Department's Prevention Agenda leadership team sent out a survey (outlined below) to gather feedback on the planning process from those involved. 108 individual respondents provided feedback on their experiences including challenges they faced and suggestions for future planning cycles. In addition to the survey, the leadership team participated in a lessons-learned session to share what worked well, what obstacles and challenges existed, and opportunities to improve the process in the next cycle.

Volunteer Midpoint Survey Questions:

Midpoint Check-in: 2025-2030 Prevention Agenda Planning Workgroups

* First Name

* Last Name

* Organization Name

Office Name

* Your Title

* Email Address

* Are you currently an active participant of a PA workgroup(s)?

- ◯ Yes
- ◯ No

Inactive Participant Feedback

* On which PA workgroup(s) did you participate?

- [ ] Domain 1: Economic Security
- [ ] Domain 2: Social & Community Context
- [ ] Domain 3: Neighborhood & Built Environment
- [ ] Domain 4: Health Care Access & Quality
- [ ] Domain 5: Education Access & Quality

For how long did you participate in your workgroup(s)

* Why did you leave the workgroup(s)? Select all that apply.

- [ ] I could not fulfill the time commitment.
- [ ] I had limited subject matter expertise.
- [ ] I had scheduling conflicts.
- [ ] I dealt with technology issues.
- [ ] Other (please specify)

Meeting Attendance

On which Prevention Agenda workgroup(s) do you participate?

	Domain 1: Economic Stability	Domain 2: Social & Comm
Select Your Workgroup		

* How often have you been able to attend weekly workgroup meetings?

- ◯ I have been able to attend most meetings.
- ◯ I have been able to attend more than half of the meetings.
- ◯ I have been able to attend less than half of the meetings.
- ◯ I have been unable to attend most meetings.

* How much time, on average, have you been able to commit to meetings and offline work?

- ◯ More than 5 hours per week
- ◯ 4-5 hours per week
- ◯ 3-4 hours per week
- ◯ 2-3 hours per week
- ◯ Less than 2 hours per week

Process Feedback

* Do you anticipate a change in your availability for the remainder of the project (through January)?

- ◯ Yes
- ◯ No

The workgroup has so far been effective in achieving its goals.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

The workgroup has improved my understanding of the priority areas.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

Communication within the workgroup has been clear and constructive.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

The workgroup has encouraged open and respectful discussions.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

I feel comfortable sharing my thoughts and ideas in the workgroup.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

The workgroup has been well-organized and structured.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

The workgroup leader has facilitated discussions effectively.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

The workgroup sessions have started and ended on time.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

I have felt engaged and motivated to participate in the workgroup.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

I have been able to contribute my knowledge and skills effectively.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

My input and ideas have been valued by the workgroup members.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

I have gained new insights, skills, or professional contacts from participating in this workgroup.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

The workgroup has provided valuable resources and materials.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

My participation in the workgroup has been a valuable use of my time.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

I am satisfied with my experience in the workgroup.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

I would participate in a similar workgroup in the future.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

I would recommend this experience to my colleagues.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree

◯ Strongly disagree

What challenges, if any, have you faced in attending workgroup meetings?

☐ Scheduling conflicts

☐ Technology issues

☐ Limited availability

☐ Lack of clear agenda

☐ Limited subject matter expertise

☐ None

☐ Other (please specify)

Midpoint Check-in: 2025-2030 Prevention Agenda Planning Workgroups Open-ended Feedback

What could OPH Leadership do to be more helpful in future Prevention Agenda planning cycles?

What could your workgroup lead(s) do to be more helpful in future Prevention Agenda planning cycles?

What could NYSTEC do to be more helpful in future Prevention Agenda planning efforts?

Please provide any other feedback on the Prevention Agenda planning process.

Appendix VI: References

References

1. New York State Department of Health (NYSDOH). Disability Etiquette. NYSDOH, Disability and Health Program online course. Accessed February 13, 2025. nylearnsph.com/Public/Catalog/Description.aspx?u=kM6WW0gCRpl%2b4Z80Vfk4%2bpsWSS6HabZFO1JRZTbmvcrN3NZWPSWJqGeVfdcOUNTpO6AbTweZdfs%3d

2. Ng E, de Colombani P. Framework for Selecting Best Practices in Public Health: A Systematic Literature Review. *J Public Health Res.* 2015;4(3):577. Published 2015 Nov 17. Accessed February 13, 2025. doi:10.4081/jphr.2015.577

3. Race and Ethnicity. American Psychological Association. Updated 2025. Accessed February 13, 2025. apa.org/topics/race-ethnicity

4. What is Racial Equity? Race Forward. Updated 2023. Accessed February 13, 2025. raceforward.org/what-racial-equity-0

5. U.S. Center for Disease Control & Prevention (CDC). Glossary of Terms. CDC, Division for Heart Disease and Stroke Prevention. Updated August 31, 2023. Accessed February 13, 2025 (via WayBack Machine January 26, 2025 archive). web.archive.org/web/20250126163216/https:/www.cdc.gov/dhdsp/health_equity/glossary.htm

6. CDC. Health Disparities. Accessed February 13, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124215102/https:/www.cdc.gov/healthy-youth/health-disparities/l

7. NYSDOH. Health Equity. Updated August 2024. Accessed February 13, 2025. health.ny.gov/community/health_equity

8. World Health Organization (WHO). Health Promotion Glossary of Terms 2021. Published 2021. Accessed February 13, 2025. iris.who.int/bitstream/handle/10665/350161/9789240038349-eng.pdf?sequence=1

9. Sense of Belonging. Cornell University: Diversity and Inclusion. Accessed February 13, 2025. diversity.cornell.edu/belonging/sense-belonging

10. CDC. Writing Effective Objectives. CDC, National Breast and Cervical Cancer Early Detection Program. Accessed February 13, 2025. cdc.gov/cancer/nbccedp/pdf/smartie-objectives-508.pdf

11. Population Health: What Is It and Why Is It Important? University of Minnesota. Accessed February 13, 2025. online.umn.edu/story/population-health-what-it-and-why-it-important#:~:text=Population%20health%20instead%20focuses%20on,location%2C%20or%20health%20care%20provider

12. Standards & Measures for Initial Accreditation: Version 2022. Public Health Accreditation Board (PHAB). Adopted February 2022. Accessed February 13, 2025. phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Version-2022.pdf

13. Bryant BE, Jordan A, Clark US. Race as a Social Construct in Psychiatry Research and Practice. *JAMA Psychiatry.* 2022;79(2):93-94. doi:10.1001/jamapsychiatry.2021.2877

14. Glossary. Planned Parenthood Federation of America. Accessed February 13, 2025. plannedparenthood.org/learn/glossary

15. Office of Disease Prevention and Health Promotion (ODPHP). Social Determinants of Health. ODPHP, Healthy People 2030. Accessed February 13, 2025. odphp.health.gov/healthypeople/priority-areas/social-determinants-health#:~:text=Social%20determinants%20of%20health%20(SDOH,of%2Dlife%20outcomes%20and%20risks.

16. NYSDOH. Prevention Agenda Toward the Healthiest State – 2008-2012. Revised January 2013. Accessed February 13, 2025. health.ny.gov/prevention/prevention_agenda

17. NYSDOH. Health Across All Policies Initiative Launched to Support the Prevention Agenda Goal of Becoming the Healthiest State. Updated August 2021. Accessed February 13, 2025. health.ny.gov/prevention/prevention_agenda/health_across_all_policies

18. Saari C. PHAB Accreditation Requirements for Evidence-Based and Promising Practices. PHAB Seven Directions Fall Forum. Published August 2018. Accessed February 13, 2025. cdn.prod.website-files.com/5d4b3177c03a6439be501a14/5dc0a52c02f22233dbcd58f9_Evidence-Based-Practices-Chelsey-Saari.pdf

19. ODPHP. Health Equity in Healthy People 2030. ODPHP, Healthy People 2030. Accessed February 13, 2025 (via WayBack Machine January 31, 2025 Archive). web.archive.org/web/20250131211404/https:/odphp.health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

20. NYSDOH. New York State Department of Health Health Equity Plan: Year 1 (August 2024 – August 2025). NYSDOH, Office of Health Equity and Human Rights. Published August 2024. Accessed February 13, 2025. health.ny.gov/community/health_equity/docs/health_equity_plan.pdf

21. U.S. Census Bureau. QuickFacts: New York. Accessed February 25, 2025. census.gov/quickfacts/fact/table/NY/IPE120223#IPE120223

22. Shrider EA. Poverty in the United States: 2023. U.S. Census Bureau, Report Number P60-283. Published September 10, 2024. Accessed February 25, 2025. census.gov/library/publications/2024/demo/p60-283.html

23. Magoon V. Screening for Social Determinants of Health in Daily Practice. *Fam Pract Manag*. 2022;29(2):6-11. Accessed February 13, 2025. pubmed.ncbi.nlm.nih.gov/35290006

24. Mobile Food Pantries. Feeding America. Accessed February 13, 2025. feedingamerica.org/our-work/hunger-relief-programs/mobile-food-pantry-program

25. Siegler EL, Lama SD, Knight MG, Laureano E, Reid MC. Community-Based Supports and Services for Older Adults: A Primer for Clinicians. J Geriatr. 2015;2015:678625. doi:10.1155/2015/678625

26. Resources and Support for Older Adults Living Alone: A Comprehensive Guide. National Council on Aging. Published January 2, 2025. Accessed February 13, 2025. ncoa.org/adviser/medical-alert-systems/support-for-older-adults-living-alone

27. Verguet S, Gautam P, Ali I, et al. Investing in school systems: conceptualising returns on investment across the health, education and social protection sectors. *BMJ Glob Health*. 2023;8(12):e012545. doi:10.1136/bmjgh-2023-012545

28. Wan ZH, Jiang Y, Zhan Y. STEM education in early childhood: a review of empirical studies. *Early Education and Development*. 2020;32(7):940-962. doi:10.1080/10409289.2020.1814986

29. STEM for inclusive excellence and equity. In: Developing Culturally and Developmentally Appropriate Early STEM Learning Experiences. Taylor & Francis; 2023:148-171.

30. Jamali SM, Ale Ebrahim N, Jamali F. The role of STEM Education in improving the quality of education: a bibliometric study. *Int J Technol Des Educ.* 2023;33:819–840. doi:10.1007/s10798-022-09762-1

31. Fry R, Kennedy B, Funk C. STEM jobs see uneven progress in increasing gender, racial and ethnic diversity. Pew Research Center. Published April 1, 2021. Accessed February 13, 2025. pewresearch.org/social-trends/2021/04/01/stem-jobs-see-uneven-progress-in-increasing-gender-racial-and-ethnic-diversity

32. Neuberger Z, Hall L. WIC Coordination with Medicaid and SNAP. Center on Budget and Policy Priorities. Updated July 18, 2024. Accessed February 13, 2025. cbpp.org/sites/default/files/7-18-24fa.pdf

33. U.S. Department of Health & Human Services (HHS). Research on the Stability of Child Care Subsidies for Children and Families. HHS, Administration for Children and Families, Office of Planning, Research, and Evaluation. OPRE Report #2023-240. Published August 2023. Accessed February 13, 2025. acf.gov/sites/default/files/documents/opre/OPRE-Research-stability-Sep23.pdf

34. Adams G, Henly JR. Child Care Subsidies: Supporting Work and Child Development For Healthy Families. *Health Affairs Health Policy Brief*. Published April 12, 2020. doi:10.1377/hpb20200327.116465

35. Hayes SL, Mann MK, Morgan FM, et al. Collaboration between local health and local government agencies for health improvement. *Cochrane Database Syst Rev.* 2011;(6):CD007825. Published 2011 Jun 15. doi:10.1002/14651858.CD007825.pub5

36. Hood CM, Gennuso KP, Swain GR, et al. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. *Am J Prev Med*. 2016;50(2):129-135. doi:10.1016/j.amepre.2015.08.024

37. Fornero E, Lo Prete A. Financial education: From better personal finance to improved citizenship. *Journal of Financial Literacy and Wellbeing.* 2023;1(1):12-27. doi:10.1017/flw.2023.7

38. Jappello T, Padula M. Investment in financial literacy and saving decisions. *Journal of Banking & Finance.* 2011;37. doi:10.1016/j.jbankfin.2013.03.019

39. Sumanta Kumar S, Jie Q. Exploring the role of financial inclusion in poverty reduction: An empirical study. *World Development Sustainability.* 2023;3. doi:10.1016/j.wds.2023.100103

40. Billioux A, Verlander K, Anthony S, Alley D. Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. *NAM Perspectives.* Published May 30, 2017. doi:10.31478/201705b

41. About the National Center. National Center for Medical-Legal Partnership. Accessed February 13, 2025. medical-legalpartnership.org/about-us

42. CMS vs TJC Health Equity Requirements. Medisolv, Blog. Published February 24, 2023. Accessed February 13, 2025. blog.medisolv.com/articles/hospital-health-equity-requirements

43. Centers for Medicare & Medicaid Services (CMS). The Accountable Health Communities Health-Related Social Needs Screening Tool. Published September 2021. Accessed February 13, 2025. cms.gov/priorities/innovation/innovation-models/ahcm

44. Screening for Social Determinants of Health: Health System Organizational Self-Assessment and Toolkit. American Cancer Society. Published 2021. Accessed February 13, 2025. hscb.acs4ccc.org/wp-content/uploads/2021/10/Screening-for-SDOH-Toolkit-v03.pdf

45. Pettingell SL, Houseworth J, Tichá R, Kramme JED, Hewitt AS. Incentives, Wages, and Retention Among Direct Support Professionals: National Core Indicators Staff Stability Survey. *Intellect Dev Disabil*. 2022;60(2):113-127. doi:10.1352/1934-9556-60.2.113

46. Medical-Legal Partnerships. Solomon Center for Health and Policy at Yale Law School. Accessed February 13, 2025. law.yale.edu/solomon-center/medical-legal-partnerships

47. U.S. Administration for Children & Families (ACF). TANF-ACF-IM-2016-03 (Strengthening TANF Outcomes By Developing Two-Generation Approaches To Build Economic Security). ACF, Office of Family Assistance. Published April 12, 2016. Updated September 24, 2019. Accessed February 13, 2025. acf.gov/ofa/policy-guidance/tanf-acf-im-2016-03

48. Long T, Cooke FL. Advancing the field of employee assistance programs research and practice: A systematic review of quantitative studies and future research agenda. *Human Resource Management Review*. 2022;33(2):100941. doi:10.1016/j.hrmr.2022.100941

49. Pera MF, Cain MM, Emerick A, et al. Social Determinants of Health Challenges Are Prevalent Among Commercially Insured Populations. *J Prim Care Community Health.* 2021;12:21501327211025162. doi:10.1177/21501327211025162

50. National Academies of Sciences, Engineering, and Medicine. Social Safety Benefits. In: Behavioral Economics: Policy Impact and Future Directions. National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education. Published April 20, 2023. Accessed February 13, 2025. ncbi.nlm.nih.gov/books/NBK593528

51. Bauer L, Schanzenbach DW. The Long-Term Impact of the Head Start Program. Published August 2016. Accessed February 13, 2025. hamiltonproject.org/assets/files/long_term_impact_of_head_start_program.pdf

52. Bailey MJ, Sun S, Timpe B. Prep School for Poor Kids: The Long-Run Impacts of Head Start on Human Capital and Economic Self-Sufficiency. *Am Econ Rev.* 2021;111(12):3963-4001. doi:10.1257/aer.20181801

53. Van Ryzin M, Fishbein D, Biglan A. The Promise of Prevention Science for Addressing Intergenerational Poverty. Psychol Public Policy Law. 2018;24(1):128-143. doi:10.1037/law0000138

54. Nurse-Family Partnership Research Trials and Outcomes. Nurse-Family Partnership. Published 2022. Accessed February 13, 2025. nursefamilypartnership.org/wp-content/uploads/2022/03/NFP-Research-Trials-and-Outcomes.pdf

55. Published Research. Nurse-Family Partnership. Accessed February 13, 2025. nursefamilypartnership.org/about/proven-results/published-research

56. Olds DL, Kitzman H, Anson E, et al. Prenatal and Infancy Nurse Home Visiting Effects on Mothers: 18-Year Follow-up of a Randomized Trial. *Pediatrics.* 2019;144(6):e20183889. doi:10.1542/peds.2018-3889

57. New York Employer Resource Network. Accessed February 13, 2025. ern-nys.com

58. Andermann A; CLEAR Collaboration. Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ*. 2016;188(17-18):E474-E483. doi:10.1503/cmaj.160177

59. Framing Two-Generation Approaches to Supporting Families. FrameWorks Institute. Published 2019. Accessed February 13, 2025. frameworksinstitute.org/app/uploads/2020/06/framing_2gen_playbook_2019-1.pdf

60. Pratap P, Dickson A, Love M, et al. Public Health Impacts of Underemployment and Unemployment in the United States: Exploring Perceptions, Gaps and Opportunities. *Int J Environ Res Public Health.* 2021;18(19):10021. doi:10.3390/ijerph181910021

61. Gany FM, Pan S, Ramirez J, Paolantonio L. Development of a Medically Tailored Hospital-based Food Pantry System. *J Health Care Poor Underserved*. 2020;31(2):595-602. doi:10.1353/hpu.2020.0047

62. Anderson B, Lehto E, Hardin-Fanning F, et al. Establishing a Permanent Food Pantry in a Pediatric Emergency Department. *Pediatrics*. 2023;152(4):e2023061757. doi:10.1542/peds.2023-061757

63. Silver SR, Li J, Quay B. Employment status, unemployment duration, and health-related metrics among US adults of prime working age: Behavioral Risk Factor Surveillance System, 2018-2019. *Am J Ind Med*. 2022;65(1):59-71. doi:10.1002/ajim.23308

64. U.S. Census Bureau. American Community Survey 5-Year Estimates Subject Tables. Employment Status, Table S2301. Published 2024. Accessed February 13, 2025. data.census.gov/table/ACSST5Y2023.S2301?q=unemployment%20rate

65. NYS Department of Labor (NYSDOL). Apprenticeship Trades. Accessed February 13, 2025. dol.ny.gov/apprenticeship/apprenticeship-trades

66. NYSDOL. Hiring Incentives, Tax Credits and Funding Opportunities. Accessed February 13, 2025. dol.ny.gov/hiring-incentives-tax-credits-and-funding-opportunities

67. NYSDOL. Recruit Your Workforce. Accessed February 13, 2025. dol.ny.gov/recruit-your-workforce

68. Kangovi S, Mitra N, Grande D, et al. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. *Health Aff.* 2020;39(2):207-213. doi:10.1377/hlthaff.2019.00981

69. Preparing the Next Generation of the Healthcare Workforce: State Strategies for Recruitment and Retention. National Governors Association. Published July 17, 2023. Accessed February 18, 2025. nga.org/publications/preparing-the-next-generation-of-the-healthcare-workforce-state-strategies-for-recruitment-and-retention

70. U.S. Department of Labor, U.S. Department of Commerce. Skills-First Hiring Starter Kit: A guide for hiring better, faster. Published November 2024. Accessed February 18, 2025 (via WayBack Machine January 22, 2025 archive). web.archive.org/web/20250122000954/dol.gov/sites/dolgov/files/OPA/GoodJobs/Toolkit/skills-first-starter-kit.pdf

71. Oglesby RW. Eliminating Unnecessary Degree Requirements from Public Sector Careers. America First Policy Institute, Issue Brief. Published October 25, 2024. Accessed February 18, 2025. americafirstpolicy.com/issues/eliminating-unnecessary-degree-requirements-from-public-sector-careers#:~:text=Moving%20from%20degree%2Dbased%20hiring,requirements%20for%20public%20sector%20jobs

72. Steffens L, Felix L. Evidence Brief: What is the current evidence on promoting employment for people with intellectual and developmental disabilities? Disability Evidence Portal. Published January 2022. Accessed February 18, 2025. disabilityevidence.org/sites/default/files/content/question_brief/files/2022-02/DEP_EvidenceBrief_IDD_employment_Final.pdf#:~:text=Provide%20training%20on%20inclusive%20employment%20practices%20to%20employers,teach%20strategies%20that%20would%20produce%20positive%20interpersonal%20relationships

73. NYSDOL. Youth Jobs Program for Young New Yorkers. Accessed February 18, 2025. dol.ny.gov/youthjobs

74. Mandsager N, Saccocio J. Employer Resource Networks. *Policy & Practice*. 2016;6. thefreelibrary.com/Employer+resource+networks%3a+improving+job+retention+through...-a0477339726

75. Findeis J, Snyder A, Jayaraman A. The Well-Being of U.S. Farm Workers: Employee Benefits, Public Assistance, and Long-Term Effects. *Review of Agricultural Economics.* 2005;27(3): 361-368. http://www.jstor.org/stable/3700860

76. Arias López MDP, Ong BA, Borrat Frigola X, et al. Digital literacy as a new determinant of health: A scoping review. *PLOS Digit Health.* 2023;2(10):e0000279. doi:10.1371/journal.pdig.0000279

77. Morris ME, Brusco NK, McAleer R, et al. Professional care workforce: a rapid review of evidence supporting methods of recruitment, retention, safety, and education. *Hum Resour Health.* 2023;21(95). doi: 10.1186/s12960-023-00879-5

78. Qu S, Chattopadhyay SK, Hahn RA; Community Preventive Services Task Force. High School Completion Programs: A Community Guide Systematic Economic Review. *J Public Health Manag Pract*. 2016;22(3):E47-E56. doi:10.1097/PHH.0000000000000286

79. Community Preventive Services Task Force. High school completion programs recommended to improve health equity. *Am J Prev Med*. 2015;48(5):609-612. doi:10.1016/j.amepre.2015.01.001

80. ODPHP. High School Graduation. ODPHP, Healthy People 2030. Accessed February 18, 2025. odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/high-school-graduation

81. HHS. Social Determinants of Health: High School Completion Programs. CDC, Community Preventive Services Task Force. Updated June 12, 2024. Accessed February 20, 2025 (via WayBack Machine December 6, 2024 archive).

web.archive.org/web/20241206162609/thecommunityguide.org/media/pdf/SDOH-High-School-Completion-508.pdf

82. Living Well in the Community. Updated 2023. Accessed February 18, 2025. healthycommunityliving.com/hcl/lwc-session/home

83. Our Programs. Broad Futures. Accessed February 18, 2025. broadfutures.org/programs

84. Dave G, Wolfe MK, Corbie-Smith G. Role of hospitals in addressing social determinants of health: A groundwater approach. *Prev Med Rep.* 2021;21:101315. doi:10.1016/j.pmedr.2021.101315

85. Muncan B, Majumder N, Tudose N. From high school to hospital: how early exposure to healthcare affects adolescent career ideas. *Int J Med Educ*. 2016;7:370-371. doi:10.5116/ijme.5801.f2cc

86. Careers. Albany Med Health System. Accessed February 18, 2025. albanymed.org/careers/#

87. Investing in Community Health: A Toolkit for Hospitals. The Center for Community Investment. Published November 2020. Accessed February 18, 2025. centerforcommunityinvestment.org/wp-content/uploads/2022/08/Investing-in-Community-Health_Toolkit.pdf

88. NYSDOH. Food Security, New York States Adults 2021. NYSDOH, Division of Nutrition, Evaluation, Research and Surveillance Unit. BRFSS Brief, No. 2023-12. Published December 2023. Accessed February 13, 2025. health.ny.gov/statistics/brfss/reports/docs/2023-12_brfss_food_securiy.pdf

89. U.S. Department of Agriculture (USDA). Food Security in the U.S. – Key Statistics & Graphics. Updated January 8, 2025. Accessed February 13, 2025. ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics

90. USDA. Nutrition Security. Accessed February 13, 2025. nal.usda.gov/human-nutrition-and-food-safety/nutrition-security

91. ODPHP. Food Insecurity. ODPHP, Healthy People 2030. Accessed February 13, 2025. odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity

92. NYSDOH. 1115 Waiver Demonstration: Conceptual Framework. NYSDOH, Office of Health Insurance Programs. Published August 2021. Accessed February 18, 2025. health.ny.gov/health_care/medicaid/redesign/2021/docs/2021-08_1115_waiver_concept_paper.pdf

93. What Works for Health: Healthy Food in convenience stores. County Health Rankings & Roadmaps. Updated December 10, 2020. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/healthy-food-in-convenience-stores

94. ODPHP. Access to Foods that Support Healthy Dietary Patterns. ODPHP, Healthy People 2030. Accessed February 18, 2025. odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-foods-support-healthy-dietary-patterns

95. Approaches to Increase Access to Foods that Support Healthy Eating Patterns. Rural Health Information Hub. Accessed February 18, 2025. ruralhealthinfo.org/toolkits/sdoh/2/built-environment/food-access

96. Evans A, Banks K, Jennings R, et al. Increasing access to healthful foods: a qualitative study with residents of low-income communities. *Int J Behav Nutr Phys Act.* 2015;12 Suppl 1(Suppl 1):S5. doi:10.1186/1479-5868-12-S1-S5

97. New York State Office of the Governor. During Hunger Action Month, Governor Hochul Launches $10 Million Program to Increase Food Access for New Yorkers. Press Release. Published September 10, 2024. Accessed February 18, 2025. governor.ny.gov/news/during-hunger-action-month-governor-hochul-launches-10-million-program-increase-food-access

98. Promising Strategies to Increase Student Participation in School Meals. Health Eating Research Issue Brief. Published November 2022. Accessed February 18, 2025. healthyeatingresearch.org/wp-content/uploads/2022/11/HER-Meal-Participation-Brief_final.pdf

99. Schools Meals. Hunger Solutions New York. Accessed February 18, 2025. hungersolutionsny.org/federal-nutrition-programs/school-meals

100. ODPHP. Social Determinants of Health: Healthy School Meals for All. ODPHP, Healthy People 2030. Accessed February 18, 2025. odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/social-determinants-health-healthy-school-meals-all

101. What Works for Health: School breakfast programs. County Health Rankings & Roadmaps. Updated September 25, 2019. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/school-breakfast-programs

102. USDA. Provision 2 Guidance National School Lunch and School Breakfast Programs. USDA, Food and Nutrition Service. Updated March 28, 2023. Accessed February 18, 2025. fns.usda.gov/cn/provision-2-guidance-national-school-lunch-and-school-breakfast-programs

103. Ending Hunger Starts at School. Healthy Schools Meals for All. Accessed February 18, 2025. schoolmealsforallny.org

104. Good Food Purchasing Program. Accessed February 18, 2025. goodfoodcities.org/about/

105. NYC Office of the Mayor. Good Food Purchasing. NYC Office of the Mayor, NYC Food Policy. Accessed February 18, 2025. nyc.gov/site/foodpolicy/good-food-purchasing/good-food-purchasing.page

106. CDC. Strategies for Food Service and Nutrition Guidelines. Accessed February 18, 2025. cdc.gov/nutrition/php/public-health-strategy/food-service-and-nutrition-guidelines.html

107. NYC Office of the Mayor. New York City Food Standards. NYC Office of the Mayor, NYC Food Policy. Accessed February 18, 2025. nyc.gov/site/foodpolicy/governance-initiatives/nyc-food-standards.page

108. What Works for Health: Healthy vending machine options. County Health Rankings & Roadmaps. Updated October 26, 2023. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/healthy-vending-machine-options

109. ODPHP. Eliminate very low food security in children – NWS-02. ODPHP, Healthy People 2030. Accessed February 18, 2025. odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating/eliminate-very-low-food-security-children-nws-02

110. ODPHP. Food is Medicine. Accessed February 18, 2025. odphp.health.gov/foodismedicine

111. What Works for Health: Fruit & vegetable incentive programs. County Health Rankings & Roadmaps. Updated December 4, 2020. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/fruit-vegetable-incentive-programs

112. What Works for Health: WIC & Senior Farmers' Market Nutrition Programs. County Health Rankings & Roadmaps. Updated July 13, 2023. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/wic-senior-farmers-market-nutrition-programs

113. CDC. Strategies for Fruit and Vegetable Voucher Incentives and Produce Prescriptions. Accessed February 18, 2025. cdc.gov/nutrition/php/public-health-strategy/voucher-incentives-produce-prescriptions.html?CDC_AAref_Val=cdc.gov/nutrition/state-and-local-strategies/priority-incentives-prescriptions

114. NYC Department of Health and Mental Hygiene (NYC DOHMH). Nutrition Services. Accessed February 18, 2025. nyc.gov/site/doh/health/health-topics/nutrition-services.page

115. NYSDOH. Just Say Yes to Fruits and Vegetables (JSY). NYSDOH, WIC Program. Updated January 2019. health.ny.gov/prevention/nutrition/wic/just_say_yes_fruit_vegs.htm

116. Healthy Eating Research Nutrition Guidelines for the Charitable Food System. Healthy Eating Research. Published March 2020. Accessed February 18, 2025. healthyeatingresearch.org/wp-content/uploads/2020/02/her-food-bank_FINAL.pdf

117. Levi R, Schwartz M, Campbell E, et al. Nutrition standards for the charitable food system: challenges and opportunities. *BMC Public Health*. 2022;22(1):495. doi:10.1186/s12889-022-12906-6

118. Tefft RJ, Waldman MA, D'Amico M, et al. Determining nutrition needs and wants using a community needs assessment model. *Journal of the American Dietetic Association.* 1998;98(9 Supp):A77. doi:10.1016/S0002-8223(98)00581-1

119. Community Nutrition Assessment Tools. Academy of Nutrition and Dietetics, Public Health/Community Nutrition. Accessed February 18, 2025. phcnpg.org/resources/community-nutrition-assessment-tools

120. USDA. ASCEND for Better Health: Data. Nutrition Service. Accessed February 18, 2025. nutrition.gov/topics/ascend-better-health/data

121. USDA. Farm to School. SNAP-Ed Connection. Updated October 26, 2023. Accessed February 18, 2025. snaped.fns.usda.gov/library/intervention/farm-to-school

122. Research Center: New York. United for ALICE. Accessed February 18, 2025. unitedforalice.org/state-overview/new-york

123. New York State Office of the Governor. The New York Housing Compact. Accessed February 18, 2025. governor.ny.gov/programs/new-york-housing-compact

124. Office of the New York State Comptroller. DiNapoli: Housing Cost Burdens for New Yorkers Among Nation's Highest. Published February 14, 2024. Accessed February 18, 2025. osc.ny.gov/press/releases/2024/02/dinapoli-housing-cost-burdens-new-yorkers-among-nations-highest

125. Housing Interventions to Improve Health Outcomes. Healthcare Value Hub, Research Brief No. 36. Published April 2019. Accessed February 18, 2025. healthcarevaluehub.org/advocate-resources/publications/housing-interventions-improve-health-outcomes

126. U.S. Department of Housing and Urban Development (US HUD). Fair Housing and Equal Opportunity. US HUD, Office of Fair Housing and Equal Opportunity. Accessed February 18, 2025. hud.gov/fairhousing

127. State of California Civil Rights Department. Complaint Process. Accessed February 18, 2025. calcivilrights.ca.gov/complaintprocess/

128. U.S. Department of Justice (US DOJ). The Fair Housing Act. US DOJ, Civil Rights Division. Updated June 22, 2023. Accessed February 18, 2025. justice.gov/crt/fair-housing-act-1

129. The National Radon Action Plan 2021-2025: Eliminating Preventable Lung Cancer from Radon in the United States by Expanding Protections for All Communities and Buildings. American Lung Association. Published January 2022. Accessed February 18, 2025. lung.org/getmedia/8be1e569-b2d4-4841-8a70-158e68069041/nrap-2021-2025-action-plan-508.pdf

130. Jacobs DE. Environmental health disparities in housing. *Am J Public Health.* 2011;101 Suppl 1(Suppl 1):S115-S122. doi:10.2105/AJPH.2010.300058

131. Fedorowicz M, Schilling J, Bramhall E, et al. Leveraging the Built Environment for Health Equity: Promising Interventions for Small and Medium-Size Cities. Urban Institute Research Report. Published July 2020. Accessed February 18, 2025. urban.org/sites/default/files/publication/102557/leveraging-the-built-environment-for-health-equity_0.pdf

132. What Works for Health: Healthy home environment assessments. County Health Rankings & Roadmaps. Updated December 9, 2022. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/healthy-home-environment-assessments

133. National Healthy Housing Standard. National Center for Healthy Housing, American Public Health Association. Published May 16, 2014. Accessed February 18, 2025. nchh.org/resource-library/national-healthy-housing-standard.pdf

134. What Works for Health: Community land trusts. County Health Rankings & Roadmaps. Updated May 19, 2022. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/community-land-trusts

135. Rose J, Arikat L, Gusoff G, et al. Mechanisms to Improve Health Through Community Land Trusts. *J Urban Health.* 2023;100(2):389-397. doi:10.1007/s11524-022-00706-7

136. Rural New Yorkers at Risk: Saving Affordable Rental Housing Created Through USDA's Section 515 Program. Regional Plan Association. Published February 2024. Accessed February 18, 2025. rpa.org/about/about-rpa

137. Buss J. The Importance of Community Engagement in Zoning Reform. National Association of Realtors. Published November 8, 2023. Accessed February 18, 2025. nar.realtor/on-common-ground/the-importance-of-community-engagement-in-zoning-reform

138. Gillman A. How Home Affects Health. Robert Wood Johnson Foundation, Blog. Published March 28, 2019. Accessed February 18, 2025. rwjf.org/en/insights/blog/2019/03/how-home-affects-health.html

139. The Solution. National Low Income Housing Coalition. Accessed February 18, 2025. nlihc.org/explore-issues/why-we-care/solution

140. Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs: Findings form the Commonwealth Fund 2024 National Survey of Federally Qualified Health Centers. The Commonwealth Fund, Issue Briefs. Published August 8, 2024. Accessed February 18, 2025. commonwealthfund.org/publications/issue-briefs/2024/aug/community-health-centers-meeting-primary-care-needs-2024-FQHC-survey

141. Moses J. Working in Homeless Services: A Survey of the Field. National Alliance to End Homelessness, Homelessness Research Institute. Published December 5, 2023. Accessed February 18, 2025. endhomelessness.org/wp-content/uploads/2023/12/Working-in-Homeless-Services-A-Survey-of-the-Field_12-5-23_FINAL.pdf

142. 5 Ways to Ease Staffing Shortages Now and into the Future. American Hospital Association. Accessed February 18, 2025. aha.org/aha-center-health-innovation-market-scan/2022-02-15-5-ways-ease-staffing-shortages-now-and-future

143. ODPHP. Safe Drinking Water Information System (SDWIS). ODPHP, Healthy People 2030. Accessed February 18, 2025. odphp.health.gov/healthypeople/objectives-and-data/data-sources-and-methods/data-sources/safe-drinking-water-information-system-sdwis

144. Mouchtouri VA, Goutziana G, Kremastinou J, et al. Legionella species colonization in cooling towers: risk factors and assessment of control measures. *Am J Infect Control.* 2010;38(1):50-55. doi:10.1016/j.ajic.2009.04.285

145. U.S. Office of Public Health Services. Office of the Surgeon General. Mental Health: A Report of the Surgeon General – Executive Summary. HHS, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), National Institutes of Health (NIH), National Institute of Mental Health (NIMH). Published 1999. Accessed February 13, 2025. govinfo.gov/content/pkg/GOVPUB-HE20-PURL-LPS56921/pdf/GOVPUB-HE20-PURL-LPS56921.pdf

146. Wilkinson R, Marmot M. Social determinants of the health: the solid facts, 2nd ed. WHO, Regional Office for Europe. Published 2003. Accessed February 13, 2025. iris.who.int/handle/10665/326568

147. U.S. Office of Public Health Services. Office of the Surgeon General. The U.S. Surgeon General's Framework for Workplace Mental Health & Well-Being. HHS, Office of Public Health Services. Published 2022. Accessed February 13, 2025 hhs.gov/sites/default/files/workplace-mental-health-well-being.pdf

148. NYSDOH. Prevention Agenda Tracking Dashboard. Updated April 2024. Accessed February 13, 2025. apps.health.ny.gov/public/tabvis/PHIG_Public/pa/reports/#state

149. Anxiety Disorders. In: Diagnostic and statistical manual of mental health disorders, 5th ed. American Psychiatric Association. 2022.

150. Integrative Approaches: Healthy Mind, Body, Spirit. Breath-Body-Mind Foundation. Accessed February 18, 2025. breath-body-mind.com

151. NYS Office of Mental Health (NYSOMH). New York State Trauma-Informed Network & Resource Center. Accessed February 18, 2025. traumainformedny.org

152. Joyce S, Shand F, Tighe J, Laurent SJ, Bryant RA, Harvey SB. Road to resilience: a systematic review and meta-analysis of resilience training programmes and interventions. *BMJ Open.* 2018;8(6):e017858.. doi:10.1136/bmjopen-2017-017858

153. Mental Health First Aid: Research and Evidence Base. National Council for Mental Wellbeing. Accessed February 18, 2025. mentalhealthfirstaid.org/about/research

154. No-Cost Youth and Teen Mental Health First Aid Training for Schools and Community Organizations. Mental Health Association in New York State (MHANYS), School Mental Health Resource Training Center. Accessed February 18, 2025. mentalhealthednys.org/ymhfa-tmhfa

155. NYSDOH. Social Care Networks (SCN). Updated February 2025. Accessed February 18, 2025. health.ny.gov/health_care/medicaid/redesign/sdh/scn

156. NYSOMH. Community Mental Health Promotion and Support (COMHPS). Accessed February 18, 2025. omh.ny.gov/comhps-contacts.pdf

157. ENGAGE: Training to Help Bridge the Treatment Gap. Columbia University, Irving Medical Center, Department of Psychiatry. Accessed February 18, 2025. columbiapsychiatry.org/education-and-training/engage

158. NYSDOH. Prevention Agenda 2019-2024. NYSDOH, NYS Public Health and Health Planning Council. Updated June 30, 2023. health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/nys_pa.pdf

159. What Works for Health: School-based social and emotional instruction. County Health Rankings & Roadmaps. Updated November 13, 2018. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/school-based-social-and-emotional-instruction

160. CDC. Adverse Childhood Experiences (ACEs) Prevention: Resource for Action – A Compilation of the Best Available Evidence. CDC, National Center for Injury Prevention and Control, Division of Violence Prevention. Published 2019. Accessed February 18, 2025. cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf

161. A Modern SEL Platform Built on Proven Content for PreK-12 Settings. Positive Action. Accessed February 18, 2025. positiveaction.net

162. Second Step High School. Second Step. Accessed February 18, 2025. secondstep.org

163. Fundamentals of SEL. CASEL. Accessed February 18, 2025. casel.org/fundamentals-of-sel

164. SAMHSA. National Survey on Drug Use and Health (NSDUH). Updated February 19, 2025. Accessed February 25, 2025. samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.

165. CDC. About Provisional Mortality Statistics, 2018 through Last Week. CDC Wide-ranging Online Data for Epidemiologic Research (WONDER). Accessed February 25, 2025. wonder.cdc.gov/mcd-icd10-provisional.html

166. CDC. 2023 Youth Risk Behavior Survey Results. Accessed February 25, 2025. cdc.gov/yrbs/results/2023-yrbs-results.html

167. Hope Squad. Suicide Prevention Resource Center, Best Practices Registry. Accessed February 18, 2025. bpr.sprc.org/program/hope-squad

168. Comunilife Life Is Precious Program (Comunilife, Inc.). Suicide Prevention Resource Center, Best Practices Registry. Accessed February 18, 2025. bpr.sprc.org/program/comunilife-life-is-precious-program

169. Tuda D, Stefancic A, Lam P, et al. Life is precious: A quasi-experimental study of a community-based program to prevent suicide among Latina adolescents in New York City. Suicide *Life Threat Behav.* 2025;55(1):e13027. doi:10.1111/sltb.13027

170. Sources of Strength. Suicide Prevention Resource Center, Best Practices Registry. Accessed February 18, 2025. bpr.sprc.org/program/sources-of-strength

171. NY CARES UP: Strengthening Resiliency & Wellness for Uniformed Personnel. Accessed February 18, 2025. nycaresup.com/

172. Framework. ZERO Suicide. Accessed February 18, 2025. zerosuicide.edc.org/about/framework

173. QPR Pathfinder Training. QPR Institute. Accessed February 18, 2025. qprinstitute.com

174. LivingWorks safeTALK. Suicide Prevention Resource Center, Best Practices Registry. Accessed February 18, 2025. bpr.sprc.org/program/livingworks-safetalk

175. LivingWorks ASIST. Suicide Prevention Resource Center, Best Practices Registry. Accessed February 18, 2025. bpr.sprc.org/program/livingworks-asist

176. Greenberg MT. Evidence for Social and Emotional Learning in Schools. Learning Policy Institute, Research Brief. Published March 2023. Accessed February 18, 2025. learningpolicyinstitute.org/media/3978/download?inline&file=Evidence_for_SEL_BRIEF.pdf

177. Welcome to the Family Acceptance Project. San Francisco State University. Accessed February 19, 2025. familyproject.sfsu.edu

178. Evidence-Based Resources. Family Acceptance Project, National SOGIE Center. Accessed February 19, 2025. lgbtqfamilyacceptance.org/evidence-based-resources

179. If you need to talk, the 988 Lifeline is here. 988 Suicide & Crisis Lifeline. Accessed February 19, 2025. 988lifeline.org

180. Media Resources. 988 Suicide & Crisis Lifeline. Accessed February 19, 2025. 988lifeline.org/media-resources/

181. SAMHSA. 988 Partner Toolkit. Accessed February 19, 2025. samhsa.gov/mental-health/988/partner-toolkit

182. SAMHSA. Suicide Prevention. Updated August 27, 2024. Accessed February 19, 2025 (via WayBack Machine January 31, 2025 archive). web.archive.org/web/20250131085842/samhsa.gov/mental-health/suicidal-behavior/prevention

183. CDC. Suicide Prevention Resource for Action. Accessed February 19, 2025. cdc.gov/suicide/resources/prevention.html

184. Brodsky BS, Spruch-Feiner A, Stanley B. The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care. *Front Psychiatry.* 2018;9:33. doi:10.3389/fpsyt.2018.00033

185. NYSOMH. Suicide Prevention. Accessed February 19, 2025. omh.ny.gov/omhweb/suicide_prevention

186. HHS. National Strategy for Suicide Prevention 2024. Published April 2024. Accessed February 19, 2025. hhs.gov/sites/default/files/national-strategy-suicide-prevention.pdf

187. U.S. Department of Veterans Affairs (VA). Lethal Means Safety and Suicide Prevention. VA, Mental Illness Research Education and Clinical Center/Center of Excellence (MIRECC/CoE). Accessed February 19, 2025. mirecc.va.gov/visn19/lethalmeanssafety

188. NYSDOH. Priority Area: Mental Health/Substance Abuse. NYSDOH, Prevention Agenda Toward the Healthiest State. Updated June 2009. Accessed February 19, 2025. health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse

189. Cultural Responsiveness to Racial Trauma. The National Child Traumatic Stress Network. Published 2020. Accessed February 19, 2025. nctsn.org/print/2417

190. New York Data and Resources. County Health Rankings & Roadmaps. Accessed February 19, 2025. countyhealthrankings.org/health-data/new-york/data-and-resources

191. Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. *Ethn Dis.* 1992;2(3):207-221. pubmncbi.nlm.nih.gov/1467758

192. Njoroge WFM, White LK, Waller R, et al. Association of COVID-19 and Endemic Systemic Racism With Postpartum Anxiety and Depression Among Black Birthing Individuals. *JAMA Psychiatry.* 2022;79(6):600-609. doi:10.1001/jamapsychiatry.2022.0597

193. National Institute of Mental Health (NIMH). Depression. National Institute of Health (NIH), NIMH. Updated February 2025. Accessed February 19, 2025. nimh.nih.gov/health/topics/depression

194. HHS. Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders. HHS, The Community Guide for Preventive Services. Updated November 3, 2018. Accessed February 19, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124090746/thecommunityguide.org/findings/mental-health-and-mental-illness-collaborative-care-management-depressive-disorders.html

195. What Works for Health: Behavioral health primary care integration. County Health Rankings & Roadmaps. Updated May 14, 2018. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/behavioral-health-primary-care-integration

196. Collaborative Care Medicaid Program (CCMP). NYSOMH, University of Washington Psychiatry & Behavioral Sciences, AIMS Center. Accessed February 19, 2025. aims.uw.edu/nyscc/collaborative-care-medicaid-program-ccmp

197. Warren JC, Smalley KB, Barefoot KN. Perceived ease of access to alcohol, tobacco and other substances in rural and urban US students. *Rural Remote Health.* 2015;15(4):3397. pubmed.ncbi.nlm.nih.gov/26518286

198. Schneider DR, Thurow CF, Brown EC, et al. Communities That Care (CTC): Community Prevention Interventions. In: Drugs and Human Behavior. Published 2021. doi.org/10.1007/978-3-030-62855-0_26

199. NYSDOH. State Unintentional Drug Overdose Reporting System (SUDORS): Characteristics of Fatal Drug Overdoses in New York State Deaths that occurred between January and December 2023. NYSDOH, Office of Drug User Health, AIDS Institute. Accessed February 19, 2025. health.ny.gov/diseases/aids/consumers/prevention/oduh/docs/unintentional_od_report2023.pdf

200. Carrol JJ, Green TC, Noonan RK. Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States – An introduction for public health, law enforcement, local organizations, and others striving to serve their community. CDC., National Center for Injury Prevention and Control. Published 2018. Accessed February 19, 2025. cdc.gov/overdose-resources/pdf/2018-evidence-based-strategies_508.pdf

201. Abedi B, Reardon S, Winters KC, et al. Long-Term Outcome of a Brief Intervention to Address Adolescent Drug Abuse in a School Setting. *J Child Adolesc Subst Abuse*. 2019;28(2):132-141. doi:10.1080/1067828X.2019.1623146

202. NYSDOH. Buprenorphine Assistance Program (BUPE-AP). NYSDOH, Office of Drug User Health. Updated January 2025. Accessed February 19, 2025. health.state.ny.us/diseases/aids/consumers/prevention/oduh/buprenorphine_assistance.htm

203. HHS. Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder. Federal Register;86(80):2243. Published April 28, 2021. Accessed February 19, 2025. govinfo.gov/content/pkg/FR-2021-04-28/pdf/2021-08961.pdf

204. NYSDOH. Medication for Opioid Use Disorder (MOUD): Correctional Health Implementation Toolkit. Published August 2022. Accessed February 19, 2025. health.ny.gov/diseases/aids/providers/prevention/harm_reduction/buprenorphine/docs/moud_toolkit.pdf

205. CMS. Substance Use Disorder (SUD) Treatment and Access Policy and Procedure Toolkit for Nursing Homes and Adult Care Facilities. CMS, IPRO QIN-QIO. Published August 23, 2024. docs.google.com/document/d/1-bOlJhyyiaMe3BRQUXQIp4WwTVPQO2O7/edit

206. Connecting the Dots: Linkage to Treatment, Harm Reduction Supplies, and Telemedicine Services. MATTERS Network. Accessed February 19, 2025. mattersnetwork.org/

207. Yörük BK. Can technology help to reduce underage drinking? Evidence from the false ID laws with scanner provision. *J Health Econ*. 2014;36:33-46. doi:10.1016/j.jhealeco.2014.03.004

208. Webb AC, Nichols MH, Shah N, et al. Effect of lock boxes and education on safe storage of medications. *Inj Epidemiol*. 2020;7(Suppl 1):21. doi:10.1186/s40621-020-00257-y

209. Lipari RN. Trends in Adolescent Substance Use and Perception of Risk from Substance Use. In: The CBHSQ Report. SAMHSA. Published January 3, 2013. Accessed February 19, 2025. ncbi.nlm.nih.gov/books/NBK385059

210. Kumpfer KL. Family-based interventions for the prevention of substance abuse and other impulse control disorders in girls. *ISRN Addict.* 2014;2014:308789. doi:10.1155/2014/308789

211. Communities That Care. Blueprints for Healthy Youth Development. Accessed February 19, 2025. blueprintsprograms.org/programs/444999999/communities-that-care/

212. NYS OASAS. NYS OASAS Evidence-Based Programs & Strategies for Prevention. Published September 2024. Accessed February 19, 2025. oasas.ny.gov/system/files/documents/2024/10/approved-evidence-based-prevention-programs.pdf

213. NYS OASAS. SBIRT: Screening, Brief Intervention & Referral to Treatment. Accessed February 19, 2025. oasas.ny.gov/sbirt

214. Fajobi OH, Peluso C. Behavioral Risk Factor Surveillance System Brief: Cigarette Smoking, New York State Adults, 2022. NYSDOH, Division of Chronic Disease Prevention, Bureau of Chronic Disease Evaluation and Research, New York State Behavioral Risk Factor Surveillance System (BRFSS) Brief Number 2024-09. Published April 2024. Accessed February 19, 2025. health.ny.gov/statistics/brfss/reports/docs/2024-09_brfss_cigarette_smoking.pdf

215. NYSDOH. Highlights from the 2022 New York Youth Tobacco Survey: August 2024. RTI International, prepared for NYSDOH. Published August 2024. Accessed February 19, 2025. health.ny.gov/prevention/tobacco_control/reports/docs/2022_youth_tobacco_use.pdf

216. CDC. Clinical Interventions to Treat Tobacco Use and Dependence Among Adults. CDC, Smoking and Tobacco Use. Accessed February 19, 2025. cdc.gov/tobacco/hcp/patient-care-settings/clinical.html

217. Garrett BE, Dube SR, Babb S, et al. Addressing the Social Determinants of Health to Reduce Tobacco-Related Disparities. *Nicotine Tob Res.* 2015;17(8):892-897. doi:10.1093/ntr/ntu266

218. HHS. Eliminating Tobacco-Related Disease and Death: Addressing Disparities—A Report of the Surgeon General. HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Published 2024. Accessed February 19, 2025. hhs.gov/sites/default/files/2024-sgr-tobacco-related-health-disparities-full-report.pdf

219. Robertson L, McGee R, Marsh L, et al. A systematic review on the impact of point-of-sale tobacco promotion on smoking. *Nicotine Tob Res.* 2015;17(1):2-17. doi:10.1093/ntr/ntu168

220. ODPHP. Scientific Evidence Brief: Flavored Tobacco Products, Including Menthol. ODPHP, Healthy People 2030. Updated February 2021. Accessed February 18, 2025. odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/scientific-evidence-brief-flavored-tobacco-products-including-menthol

221. HHS. Tobacco Use: Mass-Reach Health Communication Interventions. HHS, The Community Guide for Preventive Services. Updated June 22, 2015. Accessed February 19, 2025 (via WayBack Machine December 10, 2024 archive). web.archive.org/web/20241210160631/thecommunityguide.org/findings/tobacco-use-mass-reach-health-communication-interventions.html

222. HHS. Monograph 19: The Role of the Media in Promoting and Reducing Tobacco Use. HHS, NIH, National Cancer Institute. Published June 2008. Accessed February 19, 2025. cancercontrol.cancer.gov/brp/tcrb/monographs/monograph-19

223. HHS. Tobacco Use: Smoke Free Policies. HHS, The Community Guide for Preventive Services. Updated November 3, 2018. Accessed February 19, 2025 (via WayBack Machine December 10, 2024 archive). web.archive.org/web/20250131192217/thecommunityguide.org/findings/tobacco-use-smoke-free-policies.html

224. Agency for Healthcare Research and Quality (AHRQ). Five Major Steps to Intervention (The "5 A's"). Updated December 2012. Accessed February 19, 2025. ahrq.gov/prevention/guidelines/tobacco/5steps.html

225. CDC. Clinical Education and Training. Accessed February 19, 2025. CDC, Smoking and Tobacco Use. cdc.gov/tobacco/hcp/patient-care/clinical-education-and-training.html

226. HHS. Tobacco Use: Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products. HHS, The Community Guide for Preventive Services. Updated November 5, 2018. Accessed February 19, 2025 (via WayBack Machine December 19, 2024 archive). web.archive.org/web/20241219092041/thecommunityguide.org/findings/tobacco-use-community-mobilization-additional-interventions.html

227. NYSDOH. Alcohol Use. Accessed February 20, 2025. health.ny.gov/prevention/alcohol_surveillance

228. Balu RK, O'Sullivan G, Haile K, et al. Binge and Heavy Drinking. NYSDOH, New York State BRFSS, 2022, No. 2024-08. Accessed February 20, 2025. health.ny.gov/statistics/brfss/reports/docs/2024-08_brfss_binge_heavy_drinking.pdf.

229. Sacks JJ, Gonzales KR, Bouchery EE, et al. 2010 National and State Costs of Excessive Alcohol Consumption. *Am J Prev Med*. 2015;49(5):e73-e79. doi:10.1016/j.amepre.2015.05.031

230. CDC. Alcohol-Related Disease Impact (ARDI). Accessed February 20, 2025. nccd.cdc.gov/DPH_ARDI/Default/Report.aspx?T=AAM&P=33D8D55A-61AA-4B50-85F2-196E4B171B08&R=E0D4BCF1-210B-4F01-B176-BB912621903A&M=970D71AB-3342-4B99-B82F-3D71211E0CF0&F=&D=

231. HHS. Alcohol Excessive Consumption: Electronic Screening and Brief Interventions (e-SBI). HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124104939/thecommunityguide.org/findings/alcohol-excessive-consumption-electronic-screening-and-brief-interventions-e-sbi.html

232. US Preventive Services Task Force, Curry SJ, Krist AH, et al. Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2018;320(18):1899-1909. doi:10.1001/jama.2018.16789

233. Young B, Lewis S, Katikireddi SV, et al. Effectiveness of Mass Media Campaigns to Reduce Alcohol Consumption and Harm: A Systematic Review. *Alcohol*. 2018;53(3):302-316. doi:10.1093/alcalc/agx094

234. CDC. Alcohol Use: Shareable Graphics. Accessed February 20, 2025. cdc.gov/alcohol/graphics/l

235. HHS. Alcohol Excessive Consumption: Increasing Alcohol Taxes. HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine January 19, 2025 archive). web.archive.org/web/20250119092934/thecommunityguide.org/findings/alcohol-excessive-consumption-increasing-alcohol-taxes.html

236. CDC. About Minimum Pricing Policies. CDC, Alcohol Use. Accessed February 20, 2025. cdc.gov/alcohol/prevention/minimum-pricing-policies.html

237. HHS. Alcohol Excessive Consumption: Maintaining Limits on Days of Sale. HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine January 19, 2025 archive). web.archive.org/web/20250119095030/thecommunityguide.org/findings/alcohol-excessive-consumption-maintaining-limits-days-sale.html

238. HHS. Alcohol Excessive Consumption: Maintaining Limits on Hours of Sale. HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine January 19, 2025 archive). web.archive.org/web/20250119105227/thecommunityguide.org/findings/alcohol-excessive-consumption-maintaining-limits-hours-sale.html

239. HHS. Alcohol Excessive Consumption: Regulation of Alcohol Outlet Density. HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine January 19, 2025 archive). web.archive.org/web/20250119103928/thecommunityguide.org/findings/alcohol-excessive-consumption-regulation-alcohol-outlet-density.html

240. Kelly-Weeder S, Phillips K, Rounseville S. Effectiveness of public health programs for decreasing alcohol consumption. *Patient Intell*. 2011;2011(3):29-38. doi:10.2147/PI.S12431

241. Meisel PL, Sparks A, Eck R, et al. Baltimore City's landmark alcohol and tobacco billboard ban: an implementation case study. *Inj Prev*. 2015;21(1):63-67. doi:10.1136/injuryprev-2014-041244

242. What is “sober curious?” Alcohol and Drug Foundation. Published February 14, 2024. Accessed February 20, 2025. adf.org.au/insights/sober-curious

243. Robert NF. Understanding the “Sober Curious” Movement. Forbes. Published January 10, 2024. Accessed February 20, 2025. forbes.com/sites/nicoleroberts/2024/01/10/understanding-the-sober-curious-movement/

244. National institute on Alcohol Abuse and Alcoholism (NIAAA). CollegeAIM – the College Alcohol Intervention Matrix. NIAAA, College AIM. Accessed February 20, 2025. collegedrinkingprevention.gov/collegeaim

245. HHS. Alcohol Excessive Consumption: Overservice Law Enforcement Initiatives. HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine December 13, 2024 archive). web.archive.org/web/20241213040730/thecommunityguide.org/findings/alcohol-excessive-consumption-overservice-law-enforcement-initiatives.html

246. HHS. Alcohol Excessive Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors. HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine January 19, 2025 archive). web.archive.org/web/20250119100125/thecommunityguide.org/findings/alcohol-excessive-consumption-enhanced-enforcement-laws-prohibiting-sales-minors.html

248. HHS. Substance Use: Family-Based Interventions to Prevent Substance Use Among Youth. HHS, The Community Guide for Preventive Services. Updated October 1, 2018. Accessed February 20, 2025 (via WayBack Machine

January 23, 2025 archive). web.archive.org/web/20250123114232/thecommunityguide.org/findings/substance-use-family-based-interventions-to-prevent-substance-use-among-youth.html

249. HHS. Substance Use: Community Interventions Involving Coalitions or Partnerships to Prevent Substance Use Among Youth. HHS, The Community Guide for Preventive Services. Updated October 28, 2024. Accessed February 20, 2025 (via WayBack Machine January 23, 2025 archive). web.archive.org/web/20250123110949/thecommunityguide.org/findings/substance-use-community-interventions-involving-coalitions-or-partnerships-to-prevent-substance-use-among-youth.html

250. Interactive Data Query: National Survey of Children's Health (2022-Present). Data Resource Center for Child & Adolescent Health. Accessed February 20, 2025. childhealthdata.org/browse/survey/results?q=11266&r=34

251. CDC. About Adverse Childhood Experiences. CDC, Adverse Childhood Experiences (ACEs). Accessed February 20, 2025. cdc.gov/aces/about/l

252. Supporting Children Who Have Experienced Trauma. American Academy of Pediatrics. Updated July 21, 2021. Accessed February 20, 2025. aap.org/en/patient-care/foster-care/supporting-children-who-have-experienced-trauma/?srsltid=AfmBOorIYamb_yqyPlZfzbpSRlQGw_phFZG4a07wBh_QN57cmoHAtLHl#traumatoolbox

253. CDC. Adverse Childhood Experiences Prevention Strategy. CDC, National Center for Injury Prevention and Control. Published September 2020. Accessed February 20, 2025 (via WayBack Machine January 31, 2025 archive). web.archive.org/web/20250131084024/cdc.gov/aces/media/pdfs/ACEs-Strategic-Plan_Final_508.pdf

255. Jones CM, Merrick MT, Houry DE. Identifying and Preventing Adverse Childhood Experiences: Implications for Clinical Practice. *JAMA.* 2020;323(1):25-26. doi:10.1001/jama.2019.18499

256. CDC. Policy Approaches to Preventing ACEs. CDC, Injury Center. Accessed February 20, 2025. cdc.gov/injury/budget-funding/policy-approaches-to-preventing-aces.html

257. Collaborating for Child Well-Being: A Toolkit for Local Health Departments & Early Care and Education. ChildCare Aware of America, National Association of County and City Health Officials (NACCHO), PennState Extension. Published 2024. Accessed February 20, 2025. info.childcareaware.org/hubfs/Collaborating%20for%20Child%20Well-Being%20Toolkit%20Sep2024.pdf

258. SAMHSA. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. SAMHSA Trauma and Justice Strategic Initiative. Published July 2014. Accessed February 20, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124123458/ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

259. Foster Accountable, Trauma-Responsive Local, State, and Federal Governments. Campaign for Trauma-Informed Policy and Practice. Accessed February 20, 2025. ctipp.org/goverment

260. Healing Frameworks: Understanding ACEs in Indigenous Communities. National Indian Health Board. Updated November 1, 2024. Accessed February 20, 2025. legacy.nihb.org/aces-resource-basket

261. NYSDOH. Fruit and Vegetable Consumption: New York State Adults, 2019. BRFSS Brief Number 2021-08. Accessed February 23, 2025. health.ny.gov/statistics/brfss/reports/docs/2021-08_brfss_fruits_and_vegetables.pdf

262. Meek JY, Nobel L. Section on Breastfeeding. Policy Statement: Breastfeeding and the Use of Human Milk. *Pediatrics.* 2022;150(1):e2022057988. doi: 10.1542/peds.2022-057988

263. ODPHP. Healthy People 2030: Building a healthier future for all. Accessed February 23, 2025. odphp.health.gov/healthypeople

264. CDC. Supplemental figures and table for Vaccination Coverage by Age 24 Months Among Children Born in 2017 and 2018 – National Immunization Survey-Child, United States, 2018-2020. CDC, ChildVaxView. Accessed February 23, 2025. cdc.gov/childvaxview/publications-resources/nis-child-2018-2020.html

265. CDC. Food Service Guidelines. CDC, Nutrition. Accessed February 20, 2025. cdc.gov/nutrition/php/food-service-guidelines/l

266. CDC. Strategies for Continuity of Care in Breastfeeding. CDC, Breastfeeding. Accessed February 20, 2025. cdc.gov/breastfeeding/php/strategies/public-health-strategies-for-continuity-of-care-in-breastfeeding.html

267. CDC. High-Impact Obesity Prevention Standards. CDC, Early Care and Education. Accessed February 20, 2025. cdc.gov/early-care-education/php/obesity-prevention-standards/l

268. USDA, HHS. Dietary Guidelines for Americans, 2020-2025, 9th ed. Published December 2020. Accessed February 20, 2025. dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials

269. 4. Actions for Healthy Eating. In: Local Government Actions to Prevent Childhood Obesity. Institute of Medicine (US) and National Research Council (US) Committee on Childhood Obesity Prevention Actions for Local Governments. Published 2009. Accessed February 20, 2025. ncbi.nlm.nih.gov/books/NBK219682

270. Muth ND, Dietz WH, Magge SN, et al. Public Policies to Reduce Sugary Drink Consumption in Children and Adolescents. *Pediatrics*. 2019;143(4):e20190282. doi:10.1542/peds.2019-0282

271. Lobstein T. Reducing consumption of sugar-sweetened beverages to reduce the risk of childhood overweight and obesity. World Obesity Federation, WHO e-Library of Evidence for Nutrition Actions (eLENA). Published September 2014. Accessed February 20, 2025. who.int/tools/elena/bbc/ssbs-childhood-obesity

272. Mishra SK, Khanal AR, Collins WJ. Farm-to-School programmes, benefits, health outcomes and barriers: A structured literature review. *Health Education Journal.* 2022;81(7):781-792. doi:10.1177/00178969221119290

273. Bobronnikov E, Boyle M, Grosz M, et al. Farm to School Literature Review. USDA, Food and Nutrition Service. Published March 2021. Accessed February 20, 2025. fns-prod.azureedge.us/sites/default/files/resource-files/Farm-to-School-LitReview.pdf

274. CDC. Comprehensive Framework for Addressing the School Nutrition Environment and Services. CDC, National Centre for Chronic Disease Prevention and Health Promotion. Published September 2024. Accessed February 20, 2025. cdc.gov/school-nutrition/media/pdfs/2024/09/School_Nutrition_Framework_508tagged.pdf

275. Policy Opportunities for Increasing Access to Healhty Foods in Schools. American Academy of Pediatrics, Institute for Healthy Childhood Weight. Updated March 29, 2022. Accessed February 20, 2025. aap.org/en/patient-care/institute-for-healthy-childhood-weight/obesity-prevention-policy-opportunities-tool/policy-opportunities-for-increasing-access-to-healthy-foods-in-schools/?srsltid=AfmBOorL-sJgfh-rjqh5WRqmWcqGOqkvXKSzH6MF-s3LXVskOJAxwAe

276. HHS. CPSTF Recommends Digital Health Interventions to Increase Healthy Eating and Physical Activity. HHS, The Community Guide for Preventive Services. Updated October 19, 2022. Accessed February 20, 2025 (via WayBack Machine January 22, 2025 archive). web.archive.org/web/20250122144325/thecommunityguide.org/news/cpstf-recommends-digital-health-interventions-increase-healthy-eating-and-physical-activity.html

277. HHS. Social Determinants of Health: Fruit and Vegetable Incentive Programs. HHS, The Community Guide for Preventive Services. Updated January 15, 2025. Accessed February 20, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124122617/thecommunityguide.org/findings/social-determinants-health-fruit-vegetable-incentive-programs.html

278. HHS. Social Determinants of Health: Healthy School Meals for All. HHS, The Community Guide for Preventive Services. Updated January 17, 2025. Accessed February 20, 2025 (via WayBack Machine January 31, 2025 archive). web.archive.org/web/20250131191706/thecommunityguide.org/findings/social-determinants-health-healthy-school-meals-all.html

279. Food Marketing to Kids. Center for Science in the Public Interest. Published April 2024. Accessed February 20, 2025. cspinet.org/sites/default/files/2024-05/FMK%20Fact%20Sheet%20April%202024.pdf

280. WHO. Policies to protect children from the harmful impact of food marketing: WHO guideline. Published July 3, 2023. Accessed February 20, 2025. who.int/publications/i/item/9789240075412

281. Buffalo Public School District. Subject: District Wellness Policy: Making Health Academic. Policy Memo. Updated April 2024. Accessed February 20, 2025. core-docs.s3.us-east-1.amazonaws.com/documents/asset/uploaded_file/3927/BPS/4580979/Wellness_Policy_2024.pdf

282. Elliott C, Truman E, Nelson MR, et al. Food Promotion and Children's Health: Considering Best Practices for Teaching and Evaluating Media Literacy on Food Marketing. *Front Public Health.* 2022;10:929473. doi:10.3389/fpubh.2022.929473

283. Austin EW, Austin B, Kaiser CK, et al. A Media Literacy-Based Nutrition Program Fosters Parent-Child Food Marketing Discussions, Improves Home Food Environment, and Youth Consumption of Fruits and Vegetables. *Child Obes*. 2020;16(S1):S33-S43. doi:10.1089/chi.2019.0240

284. Powel RM, Gross T. Food for Thought: A Novel Media Literacy Intervention on Food Advertising Targeting Young Children and their Parents. *Journal of Media Literacy Education.* 2018;10(3):80-94. files.eric.ed.gov/fulltext/EJ1194055.pdf

285. Naderer B. Advertising Unhealthy Food to Children: on the Importance of Regulations, Parenting Styles, and Media Literacy. *Curr Addict Rep.*2021; 8:12–18. doi:10.1007/s40429-020-00348-2

286. The Salty Truth About Sodium: Why New York Needs Menu Warnings – S2532A(Rivera)/A8860A(Reyes). Center for Science in the Public Interest. Published February 2022. Accessed February 20, 2025. cspinet.org/sites/default/files/2022-03/Fact%20Sheet_NYS_Sodium_FINAL.pdf

287. The Sweet Truth About Added Sugars: Why New York Needs Menu Warnings – S6408A(Rivera)/A6546A(Reyes). Center for Science in the Public Interest. Published March 2024. Accessed February 20, 2025. cspinet.org/sites/default/files/2024-04/Fact%20Sheet_NY%20added%20sugars%20bill_2023.pdf

288. National Heart, Lung, and Blood Institute. Educational Resources for the DASH Eating Plan. Updated June 24, 2024. Accessed February 20, 2025. nhlbi.nih.gov/education/dash/resources

289. NIH. The Faith, Activity and Nutrition (FAN) Program. NIH, National Cancer Institute. Updated March 29, 2023. Accessed February 20, 2025. ebccp.cancercontrol.cancer.gov/programDetails.do?programId=10977999%20

290. CDC. Food Literacy. CDC, Health Literacy. Accessed February 20, 2025. cdc.gov/health-literacy/php/research-summaries/food-literacy.html

291. NYS Office of Temporary and Disability Assistance (NYS OTDA). SNAP-Ed. Accessed February 20, 2025. otda.ny.gov/programs/nutrition

292. USDA. Cooking Matters for Healthcare Partners. USDA, SNAP-Ed Connection. Updated August 23, 2023. Accessed February 20, 2025. snaped.fns.usda.gov/library/intervention/cooking-matters-healthcare-partners

293. Serving Up Plants by Default: Optimizing variety, health, and sustainability of all-you-care-to-eat university dining with plant-based defaults. Better Food Foundation, Food for Climate League. Published May 2023. Accessed February 20, 2025. betterfoodfoundation.org/wp-content/uploads/2023/05/Exec-Summary_Serving-Up-Plants-by-Default.pdf

294. NYC Health + Hospitals. NYC Health + Hospitals Now Serving Culturally Diverse Plant-Based Meals as Primary Dinner Option for Inpatients at All of Its 11 Public Hospitals. NYC Health + Hospitals, Press Releases. Published January 9, 2023. Accessed February 20, 2025. nychealthandhospitals.org/pressrelease/nyc-health-hospitals-now-serving-plant-based-meals-as-primary-dinner-option-for-inpatients-at-all-of-its-11-public-hospitals

295. NYS Food as Medicine Project: Policy and Practice Recommendations. The Food Pantries for the Capital District, The Alliance for a Hunger Free New York, NY Health Foundation, Harvard Law School Center for Health Law and Policy

Innovation. Published October 16, 2023. Accessed February 20, 2025. thefoodpantries.org/wp-content/uploads/2024/04/Final_1115_Recommendations.pdf

296. CDC. National Diabetes Prevention Program. Accessed February 20, 2025. cdc.gov/diabetes-prevention/l

297. Wang L, Lauren BN, Hager K, et al. Health and Economic Impacts of Implementing Produce Prescription Programs for Diabetes in the United States: A Microsimulation Study. *J Am Heart Assoc*. 2023;12(15):e029215. doi:10.1161/JAHA.122.029215

298. ODPHP. Physical Activity Guidelines for Americans. Accessed February 25, 2025. odphp.health.gov/our-work/nutrition-physical-activity/physical-activity-guidelines

299. NYSDOH. Physical Activity. Updated February 2025. Accessed February 25, 2025. health.ny.gov/community/physical_activity/#:~:text=To%20obtain%20the%20most%20health%20benefits%20from%20physical%20activity%2C%20adults,least%20two%20days%20each%20week.

300. CDC. Strategies for Physical Activity Through Community Design. CDC, Physical Activity. Accessed February 20, 2025. cdc.gov/physical-activity/php/strategies/increasing-physical-activity-through-community-design-prevention-strategies.html?CDC_AAref_Val=cdc.gov/physicalactivity/community-strategies/activity-friendly-routes-to-everyday-destinations.html#cdc_public_health_strategy_resources-resources

301. CDC. Action Planning Guide for Physically Active Communities. CDC, Active Communities. Accessed February 20, 2025. cdc.gov/active-communities-tool/php/planning-guide/l

302. CDC. Assessment Modules. CDC, Active Communities. Accessed February 20, 2025. cdc.gov/active-communities-tool/php/assessment-modules/l

303. NYS Department of Transportation (NYSDOT). Complete Streets. Accessed February 20, 2025. dot.ny.gov/programs/completestreets

304. U.S. Department of Transportation (US DOT). Zero Deaths and Safe System. US DOT, Federal Highway Administration. Updated August 2, 2024. Accessed February 20, 2025. highways.dot.gov/safety/zero-deaths

305. HHS. Combined Built Environment Features Help Communities Get Active. HHS, The Community Guide for Preventive Services. Accessed February 20, 2025 (via WayBack Machine November 29, 2024 archive). web.archive.org/web/20241129142113/thecommunityguide.org/news/combined-built-environment-features-help-communities-get-active.html

306. Temperature. New York State Climate Impacts Assessment. Accessed February 25, 2025. nysclimateimpacts.org/explore-the-assessment/new-york-states-changing-climate/nysc-temperature

307. New York State. State Support for Local Climate Action. New York State, Climate Smart Communities. Accessed February 25, 2025. climatesmart.ny.gov

308. New York State. Extreme Heat Action Plan: Adaptation Agenda for 2024-2030. NYS Energy Research & Development Authority (NYSERDA), NYS Department of Environmental Conservation (DEC), NYS Office of the Governor. Published 2024. Accessed February 25, 2025. dec.ny.gov/sites/default/files/2024-06/extremeheatactionplan.pdf

309. Widerynski S, Schramm P, Conlon K, et al. The Use of Cooling Centers to Prevent Health-Related Illness: Summary of Evidence and Strategies for Implementation. CDC, Climate and Health Program, Climate and Health Technical Report Series. Published August 7, 2017. Accessed February 20, 2025. stacks.cdc.gov/view/cdc/47657/cdc_47657_DS1.pdf

310. Choi YJ. Age-Friendly Features in Home and Community and the Self-Reported Health and Functional Limitation of Older Adults: the Role of Supportive Environments. *J Urban Health.* 2020;97(4):471-485. doi:10.1007/s11524-020-00462-6

311. Xu X, Chen C. Energy efficiency and energy justice for U.S. low-income households: An analysis of multifaceted challenges and potential. *Energy Policy.* 2019;128:763-764. doi:10.1016/j.enpol.2019.01.020

312. Balbus JM, Greenblatt JB, Chari R, et al. Erratum to: A wedge-based approach to estimating health co-benefits of climate change mitigation activities in the United States. *Climatic Change*. 2015;129:363–364. doi:10.1007/s10584-015-1336-z

313. Gao J, Kovats S, Vardoulakis S, et al. Public health co-benefits of greenhouse gas emissions reduction: A systematic review. *Sci Total Environ.* 2018;627:388-402. doi:10.1016/j.scitotenv.2018.01.193

314. Tomson C. Reducing the carbon footprint of hospital-based care. *Future Hosp J.* 2015;2(1):57-62. doi:10.7861/futurehosp.2-1-57

315. Bavida J, Ayanoglu H, Pereira CV, et al. Active Aging and Smart Public Parks. *Geriatrics.* 2023;8(5):94. doi:10.3390/geriatrics8050094

316. Foderaro LW, Klein W. The Power of Parks to Promote Health: A Special Report. Trust for Public Land. Published May 2023. Accessed February 20, 2025. e7jecw7o93n.exactdn.com/wp-content/uploads/2023/05/The-Power-of-Parks-to-Promote-Health-A-Trust-for-Public-Land-Special-Report.pdf

317. Schiltz NK, Armstrong GQ, Foradori MA, et al. Evaluation of education initiatives to increase delivery of age-friendly care in retail clinics. *J Am Geriatr Soc.* 2024;72(10):3046-3054. doi:10.1111/jgs.19081

318. National Institute on Aging. Research Highlights: Social isolation, loneliness in older people pose health risks. Published April 23, 2019. Accessed February 20, 2025. nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks

319. CDC. Health Effects of Social Isolation and Loneliness. CDC, Social Connection. Accessed February 20, 2025. cdc.gov/social-connectedness/risk-factors

320. Sen K, Prybutok G, Prybutok V. The use of digital technology for social wellbeing reduces social isolation in older adults: A systematic review. *SSM Popul Health.* 2021;17:101020. doi:10.1016/j.ssmph.2021.101020

321. Fields NL, Anderson KA, Dabelko-Schoeny H. The effectiveness of adult day services for older adults: a review of the literature from 2000 to 2011. *J Appl Gerontol.* 2014;33(2):130-163. doi:10.1177/0733464812443308

322. Lehning AJ, De Biasi A. Creating an Age-Friendly Public Health System: Challenges, Opportunities, and Next Steps. Trust for America's Health. Published March 2018. Accessed February 20, 2025. tfah.org/wp-content/uploads/2018/09/Age_Friendly_Public_Health_Convening_Report_FINAL_1__1_.pdf

323. Age-Friendly Health Systems, New York State Action Community. Healthcare Association of NYS (HANYS). Accessed February 20, 2025. hanys.org/age-friendly

324. Age Friendly Health Systems. Institute for Healthcare Improvement. Accessed February 20, 2025. ihi.org/networks/initiatives/age-friendly-health-systems

325. Advancing Successful Care Transitions to Improve Outcomes. Society of Hospital Medicine. Accessed February 20, 2025. hospitalmedicine.org/clinical-topics/care-transitions

326. Clarke JL, Bourn S, Skoufalos A, et al. An Innovative Approach to Health Care Delivery for Patients with Chronic Conditions. *Popul Health Manag.* 2017;20(1):23-30. doi:10.1089/pop.2016.0076

327. Murphy SC, Severance JJ, Camp K, et al. Lessons Learned from Age-Friendly, Team-Based Training. *Geriatrics.* 2023;8(4):78. doi:10.3390/geriatrics8040078

328. Poverty Simulations. Missouri Community Action Network. Accessed February 20, 2025. communityaction.org/povertysimulations

329. Gomez M, Reddy AL, Dixon SL, et al. A Cost-Benefit Analysis of a State-Funded Healthy Homes Program for Residents With Asthma: Findings From the New York State Healthy Neighborhoods Program. *J Public Health Manag Pract*. 2017;23(2):229-238. doi:10.1097/PHH.0000000000000528

330. NYSDOH. Injury and Violence in New York State. Updated June 2023. Accessed February 25, 2025. health.ny.gov/statistics/prevention/injury_prevention/#:~:text=The%20most%20recent%20data%20available,Research%20Cooperative%20System%20(SPARCS).

331. Nesbit B, Robinson I, Bryan S. A national landscape: Injury and violence prevention health equity scan findings and implications for the field of practice. *J Safety Res*. 2022;80:457-462. doi:10.1016/j.jsr.2021.12.026

332. Mosley EA, Prince JR, McKee GB, et al. Racial Disparities in Sexual Assault Characteristics and Mental Health Care After Sexual Assault Medical Forensic Exams. *J Womens Health*. 2021;30(10):1448-1456. doi:10.1089/jwh.2020.8935

333. Rees CA, Monuteaux MC, Steidley I, et al. Trends and Disparities in Firearm Fatalities in the United States, 1990-2021. *JAMA Netw Open*. 2022;5(11):e2244221. doi:10.1001/jamanetworkopen.2022.44221

334. Deadly Skyline: An Annual Report on Construction Fatalities in New York State. New York Committee for Occupational Safety & Health. Published February 2024. Accessed February 25, 2025. longislandfed.org/system/files/2024-05/nycosh-construction-fatalities-report-2024.pdf

335. Walk Safe Long Island. Accessed February 20, 2025. walksafeli.org/programming

336. The Evidence of Effectiveness. Cure Violence Global. Published August 2021. Updated August 2022. Accessed February 20, 2025. cvg.org/wp-content/uploads/2021/09/Cure-Violence-Evidence-Summary.pdf

337. Klofas J, Duda J, Schreck C, et al. SNUG Evaluation. Center for Public Safety Initiatives, prepared for NYS Division of Criminal Justice Services. Published July 2013. Accessed February 20, 2025. rit.edu/liberalarts/sites/rit.edu.liberalarts/files/documents/our-work/2013-10.pdf

338. Cure Violence. John Jay College of Criminal Justice, Research and Evaluation Center. Accessed February 20, 2025. johnjayrec.nyc/cureviolence

339. Becker MG, Hall JS, Ursic CM, et al. Caught in the Crossfire: the effects of a peer-based intervention program for violently injured youth. *J Adolesc Health*. 2004;34(3):177-183. doi:10.1016/j.jadohealth.2003.04.001

340. NYS Division of Criminal Justice Services. Gun Involved Violence Elimination (GIVE) Initiative. Accessed February 20, 2025. criminaljustice.ny.gov/ops/gunviolencereduction

341. NYSDOH. Prevention Agenda 2019-2024: Promote a Healthy and Safe Environment Action Plan. Updated January 2023. Accessed February 20, 2025. health.ny.gov/prevention/prevention_agenda/2019-2024/env.htm#FA1

342. Evidence-Based Falls Prevention Programs. National Council on Aging. Published December 1, 2023. Accessed February 20, 2025. ncoa.org/article/evidence-based-falls-prevention-programs

343. CDC. What is Safe Routes to School (SRTS)? Accessed February 20, 2025. archive.cdc.gov/www_cdc_gov/policy/hi5/saferoutes/l

344. US DOT. Safe Routes to School. US DOT, National Highway Traffic Safety Administration. Accessed February 20, 2025. nhtsa.gov/book/countermeasures-that-work/bicycle-safety/countermeasures/other-strategies-behavior-change/safe

345. ODPHP. Crime and Violence. ODPHP, Healthy People 2030. Accessed February 18, 2025. odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/crime-and-violence

346. Edgerly A, Gillespie GL, Bhattacharya A, et al. Summarizing Recommendations for the Prevention of Occupational Heat-Related Illness in Outdoor Workers: A Scoping Review. *Workplace Health Saf.* 2025;73(2):63-84. doi:10.1177/21650799241281998

347. Marinucci GD, Luber G, Uejio CK, et al. Building Resilience Against Climate Effects—a novel framework to facilitate climate readiness in public health agencies. *Int J Environ Res Public Health*. 2014;11(6):6433-6458. doi:10.3390/ijerph110606433

348. Santaella-Tenorio J, Cerdá M, Villaveces A, et al. What Do We Know About the Association Between Firearm Legislation and Firearm-Related Injuries? [published correction appears in *Epidemiol Rev.* 2017 Jan 1;39(1):171-172. doi: 10.1093/epirev/mxx011.]. *Epidemiol Rev*. 2016;38(1):140-157. doi:10.1093/epirev/mxv012

349. Rowhani-Rahbar A, Simonetti JA, Rivara FP. Effectiveness of Interventions to Promote Safe Firearm Storage. *Epidemiol Rev*. 2016;38(1):111-124. doi:10.1093/epirev/mxv006

350. Simonetti JA, Rowhani-Rahbar A, King C, et al. Evaluation of a community-based safe firearm and ammunition storage intervention. *Inj Prev*. 2018;24(3):218-223. doi:10.1136/injuryprev-2016-042292

351. Cerdá M, Morenoff JD, Hansen BB, et al. Reducing violence by transforming neighborhoods: a natural experiment in Medellín, Colombia. *Am J Epidemiol*. 2012;175(10):1045-1053. doi:10.1093/aje/kwr428

352. Heinze JE, Krusky-Morey A, Vagi KJ, et al. Busy Streets Theory: The Effects of Community-engaged Greening on Violence. *Am J Community Psychol*. 2018;62(1-2):101-109. doi:10.1002/ajcp.12270

353. US DOT. A Highway Safety Countermeasure Guide for State Highway Safety Offices. US DOT, National Highway Traffic Safety Administration. Accessed February 20, 2025. nhtsa.gov/book/countermeasures/countermeasures-that-work

354. Johnston YA, Bergen G, Bauer M, et al. Implementation of the Stopping Elderly Accidents, Deaths, and Injuries Initiative in Primary Care: An Outcome Evaluation. *Gerontologist.* 2019;59(6):1182-1191. doi:10.1093/geront/gny101

355. NYSDOH. Age-Friendly Planning Grant Recipients Announced. NYSDOH, Office for the Aging. Published November 22, 2019. Accessed February 20, 2025. aging.ny.gov/news/new-york-state-office-aging-department-health-and-department-state-announce-award-recipients

356. van Hoof J, Dikken J, van Staalduinen WH, et al. Towards a Better Understanding of the Sense of Safety and Security of Community-Dwelling Older Adults. The Case of the Age-Friendly City of The Hague. *Int J Environ Res Public Health*. 2022;19(7):3960. Published 2022 Mar 26. doi:10.3390/ijerph19073960

357. Zuo W, Cheng B, Feng X, et al. Relationship between urban green space and mental health in older adults: mediating role of relative deprivation, physical activity, and social trust. *Front Public Health*. 2024;12:1442560. doi:10.3389/fpubh.2024.1442560

358. Won J, Lee C, Forjuoh SN, et al. Neighborhood safety factors associated with older adults' health-related outcomes: A systematic literature review. *Soc Sci Med*. 2016;165:177-186. doi:10.1016/j.socscimed.2016.07.024

359. WHO. WHO recommendations on antenatal care for a positive pregnancy experience. Published November 28, 2016. Updated 2022. Accessed February 23, 2025. who.int/publications/i/item/9789241549912

360. CDC. Infant Mortality Rates by State. CDC, National Center for Health Statistics. Accessed February 23, 2025. cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

361. Peahl AF, Turrentine M, Barfield W, et al. Michigan Plan for Appropriate Tailored Healthcare in Pregnancy Prenatal Care Recommendations: A Practical Guide for Maternity Care Clinicians. *J Womens Health.* 2022;31(7):917-925. doi:10.1089/jwh.2021.0589

362. Herzberg MP, Smyser CD. Prenatal Social Determinants of Health: Narrative review of maternal environments and neonatal brain development. *Pediatr Res*. 2024;96(6):1417-1428. doi:10.1038/s41390-024-03345-7

363. Nolvi S, Merz EC, Kataja EL, et al. Prenatal Stress and the Developing Brain: Postnatal Environments Promoting Resilience. *Biol Psychiatry*. 2023;93(10):942-952. doi:10.1016/j.biopsych.2022.11.023

364. Opioid Use and Opioid Use Disorder in Pregnancy. The American College of Obstetricians and Gynecologists (ACOG), Committee Opinion Number 711. Published August 2017. Accessed February 20, 2025. acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

365. Woman of Color Health Equity Collective. Association of Maternal & Child Health Programs, Innovation Station. Accessed February 20, 2025. amchp.org/wp-content/uploads/2021/05/MotherWoman-MA.pdf

366. NYSDOH. New York State Medicaid Redesign Team (MRT) Waiver Amendment: New York Health Equity Reform (NYHER): Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic. Published September 2, 2022. Accessed February 20, 2025. health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/2022-09-02_final_amend_request.pdf

367. NYSDOH. Spotlight on Perinatal Substance Use Disorder. NYSDOH, Issue Brief from the New York State Maternal Mortality Review Board. Published November 2023. Accessed February 20, 2025. health.ny.gov/community/adults/women/maternal_mortality/docs/2023-11_spotlight.pdf

368. Knocke K, Chappel A, Sugar S, et al. Doula Care and Maternal Health: An Evidence Review. HHS, Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, Issue Brief No. HP-2022-24. Published December 13 2022. Accessed February 20, 2025. aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf

369. Sobczak A, Taylor L, Solomon S, et al. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. *Cureus*. 2023;15(5):e39451. Published 2023 May 24. doi:10.7759/cureus.39451

370. CenteringPregnancy. Centering Healthcare Institute. Accessed February 20, 2025. centeringhealthcare.org/what-we-do/centering-pregnancy

371. Buultjens M, Farouque A, Karimi L, et al. The contribution of group prenatal care to maternal psychological health outcomes: A systematic review. *Women Birth*. 2021;34(6):e631-e642. doi:10.1016/j.wombi.2020.12.004

372. Gennaro S, Melnyk BM, Szalacha LA, et al. Effects of Two Group Prenatal Care Interventions on Mental Health: An RCT. *Am J Prev Med*. 2024;66(5):797-808. doi:10.1016/j.amepre.2024.01.005

373. NYC DOHMH. NYC Nurse-Family Partnership: Personal Nurses for First-Time Parents. Accessed February 20, 2025. nyc.gov/site/doh/health/health-topics/nurse-family-partnership.page

374. Maternal Health. Home Visiting Evidence of Effectiveness (HomVEE). Accessed February 20, 2025. homvee.acf.hhs.gov/outcomes/maternal-health

375. Family Spirit. Title IV-E Prevention Services Clearinghouse. Updated May 2021. Accessed February 20, 2025. preventionservices.acf.hhs.gov/programs/648/show#:~:text=Family%20Spirit%C2%AE%20is%20a%20culturally-tailored%20home%20visiting%20program,behavioral%20and%20emotional%20outcomes%20among%20mothers%20and%20children

376. HRSA. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. Updated January 2025. Accessed February 20, 2025. mchb.hrsa.gov/programs-impact/maternal-infant-early-childhood-home-visiting-miechv-program

377. Madden N, Emeruwa UN, Friedman AM, et al. Telehealth Uptake into Prenatal Care and Provider Attitudes during the COVID-19 Pandemic in New York City: A Quantitative and Qualitative Analysis. *Am J Perinatol*. 2020;37(10):1005-1014. doi:10.1055/s-0040-1712939

378. Combellick JL, Telfer ML, Ibrahim BB, et al. Midwifery care during labor and birth in the United States. *Am J Obstet Gynecol*. 2023;228(5S):S983-S993. doi:10.1016/j.ajog.2022.09.044

379. Midwifery: Evidence-Based Practice – A Summary of Research on Midwifery Practice in the United States. American College of Nurse-Midwives. Updated April 2012. Accessed February 20, 2025. midwife.org/wp-content/uploads/2024/10/Midwifery-Evidence-Based-Practice.pdf

380. Guide for Midwifery Leadership. International Confederation of Midwives. Updated January 4, 2022. Accessed February 20, 2025. internationalmidwives.org/resources/guide-for-midwifery-leadership

381. Ahmadpour P, Moosavi S, Mohammad-Alizadeh-Charandabi S, et al. Effect of implementing a birth plan on maternal and neonatal outcomes: a randomized controlled trial. *BMC Pregnancy Childbirth*. 2022;22(1):862. doi:10.1186/s12884-022-05199-5

382. Lothian J. Does Childbirth Education Make a Difference?. *J Perinat Educ.* 2016;25(3):139-141. doi:10.1891/1058-1243.25.3.139

383. Treating the Perinatal Population in the Collaborative Care Model. American Psychiatric Association. Published 2019. Accessed February 20, 2025. psychiatry.org/getmedia/e2eafc40-965c-4a72-b206-50b458c35e16/APA-Treating-Perinatal-in-the-CoCM-Guide.pdf

384. SAMHSA. National Strategy to Improve Maternal Mental Health Care. SAMHSA, Task Force on Maternal Mental Health. Published May 2024. Accessed February 20, 2025. samhsa.gov/sites/default/files/mmh-strategy.pdf

385. McKinney B. Addressing the Maternal Mental Health Crisis Through a Novel Tech-Enabled Peer-to-Peer Driven Perinatal Collaborative Care Model. *Voices in Bioethics*. 2023;9. philpapers.org/rec/MCKATM-2

386. Rice C, Ingram E, O'Mahen H. A qualitative study of the impact of peer support on women's mental health treatment experiences during the perinatal period. *BMC Pregnancy Childbirth*. 2022;22(1):689. doi:10.1186/s12884-022-04959-7

387. Dennis CL, Hodnett E, Kenton L, et al. Effect of peer support on prevention of postnatal depression among high risk women: multisite randomised controlled trial. *BMJ*. 2009;338:a3064. doi:10.1136/bmj.a3064

388. Chinman M, George P, Dougherty RH, et al. Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatr Serv*. 2014;65(4):429-441. doi:10.1176/appi.ps.201300244

389. Novoa C. Ensuring Healthy Births Through Prenatal Support: Innovations From Three Models. Center for American Progress. Published January 31, 2020. Accessed February 20, 2025. americanprogress.org/article/ensuring-healthy-births-prenatal-support

390. Phillips S, Villalobos AVK, Crawbuck GSN, et al. In their own words: patient navigator roles in culturally sensitive cancer care. *Support Care Cancer*. 2019;27(5):1655-1662. doi:10.1007/s00520-018-4407-7

391. Cultural Navigators to Liaise Between Communities and Public Health. University of Minnesota, National Resource Center for Refugees, Immigrants, and Migrants (NRC-RIM). Accessed February 20, 2025. nrcrim.org/cultural-navigators-liaise-between-communities-and-public-health

392. Connecting to Care: Cultural Navigator Training. The Cross Cultural Health Care Program. Accessed February 20, 2025. xculture.org/cultural-navigator-training

393. Schuster RC, Wachter K, McRae K, et al. “I promised them I would be here”: A qualitative study of the changing roles of cultural health navigators who serve refugees during the COVID-19 pandemic. *Social Sciences & Humanities Open.* 2023;10:101002. doi:10.1016/j.ssaho.2024.101002

394. NYSDOH. Growing Up Healthy Hotline. Updated July 2021. Accessed February 20, 2025. health.ny.gov/community/pregnancy/health_care/prenatal/guh.htm

395. NYSDOH. New York State Perinatal Quality Collaborative (NYSPQC). Updated February 2024. Accessed February 20, 2025. health.ny.gov/community/pregnancy/nyspqc

396. CDC. National Vital Statistics Reports 70(14). Published December 8, 2021. Accessed February 25, 2025. cdc.gov/nchs/data/nvsr/nvsr70/NVSR70-14.pdf

397. Declercq E, Zephyrin LC. Issue Brief & Report: Maternal Mortality in the United States: A Primer. The Commonwealth Fund. Published December 16, 2020. Accessed February 25, 2025. commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer

398. NYSDOH. New York State Report on Pregnancy-Associated Deaths in 2018-2020. NYSDOH, Maternal Mortality Review Board. Published March 2024. Accessed February 20, 2025. health.ny.gov/community/adults/women/maternal_mortality/docs/maternal_mortality_review_2018-2020.pdf

399. Moon RY, Carlin RF, Hand I; Task Force on Sudden Infant Death Syndrome and the Committee on Fetus and Newborn. Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. *Pediatrics*. 2022;150(1):e2022057990. doi:10.1542/peds.2022-057990

400. Giron K, Noe S, Saiki L, et al. Implementation of Postpartum Depression Screening for Women Participating in the WIC Program. *J Am Psychiatr Nurses Assoc*. 2021;27(6):443-449. doi:10.1177/10783903211047889

401. Obstetric Hemorrhage Bundle. ACOG Safe Motherhood Initiative: Obstetric Hemorrhage. Accessed February 20, 2025. acog.org/community/districts-and-sections/district-ii/programs-and-resources/safe-motherhood-initiative/obstetric-hemorrhage

402. Perinatal Mental Health Conditions. Alliance for Innovation on Maternal Health, ACOG. Accessed February 20, 2025. saferbirth.org/psbs/perinatal-mental-health-conditions

403. Care for Pregnant and Postpartum People with Substance Use Disorder. Alliance for Innovation on Maternal Health, ACOG. Accessed February 20, 2025. saferbirth.org/psbs/care-for-pregnant-and-postpartum-people-with-substance-use-disorder/

404. Lee AR, Hollier L, Streeter TE, et al. Hypertension in Pregnancy Change Package. CDC, A Million Hearts Action Guide. Published 2024. Accessed February 20, 2025. millionhearts.hhs.gov/files/Hypertension-in-Pregnancy-508.pdf

405. Our Work: Community Based Doulas. HealthConnectOne. Accessed February 20, 2025. healthconnectone.org/our-work/community-based-doulas

406. Mottl-Santiago J, Dukhovny D, Cabral H, et al. Effectiveness of an Enhanced Community Doula Intervention in a Safety Net Setting: A Randomized Controlled Trial. *Health Equity*. 2023;7(1):466-476. doi:10.1089/heq.2022.0200

407. Walker A. Community-Based Doulas are Improving Maternal Mental Health Outcomes and Expanding the Health Care Safety Net. National Association of Community Health Centers (NACHC), Blog. Published July 13, 2023. Accessed February 20, 2025. nachc.org/community-based-doulas-are-improving-maternal-mental-health-outcomes-and-expanding-the-health-care-safety-net

408. Clapp MA, Ray A, Liang P, et al. Postpartum Primary Care Engagement Using Default Scheduling and Tailored Messaging: A Randomized Clinical Trial. *JAMA Netw Open*. 2024;7(7):e2422500. doi:10.1001/jamanetworkopen.2024.22500

409. Dolin CD, Compher CC, Oh JK, et al. Pregnant and hungry: addressing food insecurity in pregnant women during the COVID-19 pandemic in the United States. *Am J Obstet Gynecol MFM*. 2021;3(4):100378. doi:10.1016/j.ajogmf.2021.100378

410. McKay FH, Spiteri S, Zinga J, et al. Systematic Review of Interventions Addressing Food Insecurity in Pregnant Women and New Mothers. *Curr Nutr Rep*. 2022;11(3):486-499. doi:10.1007/s13668-022-00418-z

411. Nawabi F, Krebs F, Vennedey V, et al. Health Literacy in Pregnant Women: A Systematic Review. *Int J Environ Res Public Health*. 2021;18(7):3847. doi:10.3390/ijerph18073847

412. Pregnancy and Substance Use: A Harm Reduction Toolkit. Academy of Perinatal Harm Reduction. Updated October 2022. Accessed February 20, 2025. perinatalharmreduction.org/toolkit-pregnancy-substance-use

413. SESSION 1, The importance of infant and young child feeding and recommended practices. In: Infant and Young Child Feeding: Model Chapter for Textbooks for Medical Students and Allied Health Professionals. WHO. Published 2009. Accessed February 20, 2025. ncbi.nlm.nih.gov/books/NBK148967

414. The HealthySteps Network. Zero to Three. Accessed February 20, 2025. healthysteps.org/who-we-are/the-healthysteps-network/

415. Racial and Ethnic Inequities in Obstetrics and Gynecology. ACOG, Committee Statement Number 10. Published September 2024. Accessed February 20, 2025. acog.org/clinical/clinical-guidance/committee-statement/articles/2024/09/racial-and-ethnic-inequities-in-obstetrics-and-gynecology

416. Smith MA, Gigot M, Harburn A, et al. Insights into measuring health disparities using electronic health records from a statewide network of health systems: A case study. *J Clin Transl Sci.* 2023;7(1):e54. doi:10.1017/cts.2022.521

417. Maternal Mental Health Resources. Project TEACH. Accessed February 20, 2025. projectteachny.org/about/mmh

418. NYSDOH. Chronic Diseases and Conditions. Updated November 2021. Accessed February 25, 2025. health.ny.gov/diseases/chronic

419. Strom JL, Egede LE. The impact of social support on outcomes in adult patients with type 2 diabetes: a systematic review. *Curr Diab Rep.* 2012;12(6):769-781. doi:10.1007/s11892-012-0317-0

420. Strengthening Partnerships between Public Health and Community-Based Organizations. CDC Foundation. Accessed February 20, 2025. cdcfoundation.org/programs/strengthening-interface-between-public-health-and-community-based-organizations

421. Cook SC, Keesecker NM. Integrating Community Health Workers into Health Care Teams to Improve Equity and Quality of Care. Finding Answers: Disparities Research for Change. Published 2020. Accessed February 20, 2025. nachw.org/wp-content/uploads/2020/07/NACDD/Natl101_Cook%202015%20integrating%20CHW%20in%20teams.pdf

422. Simoni JM, Franks JC, Lehavot K, et al. Peer interventions to promote health: conceptual considerations. *Am J Orthopsychiatry*. 2011;81(3):351-359. doi:10.1111/j.1939-0025.2011.01103.x

423. Chin MH, Clarke AR, Nocon RS, et al. A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *J Gen Intern Med*. 2012;27(8):992-1000. doi:10.1007/s11606-012-2082-9

424. Petiwala A, Lanford D, Landers G, et al. Community voice in cross-sector alignment: concepts and strategies from a scoping review of the health collaboration literature. *BMC Public Health*. 2021;21(1):712. doi:10.1186/s12889-021-10741-9

425. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care. Published May 4, 2021. Accessed February 20, 2025. pubmed.ncbi.nlm.nih.gov/34251766

426. What Works for Health: Health insurance enrollment outreach & support. County Health Rankings & Roadmaps. Updated March 24, 2022. Accessed February 20, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/health-insurance-enrollment-outreach-support

427. What Works for Health: Chronic disease self-management (CDSM) programs. County Health Rankings & Roadmaps. Updated June 6, 2024. Accessed February 18, 2025. countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/chronic-disease-self-management-cdsm-programs

428. Krishnaswami J, Sardana J, Daxini A. Community-Engaged Lifestyle Medicine as a Framework for Health Equity: Principles for Lifestyle Medicine in Low-Resource Settings. *Am J Lifestyle Med*. 2019;13(5):443-450. doi:10.1177/1559827619838469

429. Flack JM, Adekola B. Blood pressure and the new ACC/AHA hypertension guidelines. *Trends Cardiovasc Med*. 2020;30(3):160-164. doi:10.1016/j.tcm.2019.05.003

430. Shimbo D, Artinian NT, Basile JN, et al. Self-Measured Blood Pressure Monitoring at Home: A Joint Policy Statement From the American Heart Association and American Medical Association [published correction appears in *Circulation*. 2020 Jul 28;142(4):e64. doi: 10.1161/CIR.0000000000000906.]. *Circulation*. 2020;142(4):e42-e63. doi:10.1161/CIR.0000000000000803

431. Ursua RA, Aguilar DE, Wyatt LC, et al. A community health worker intervention to improve blood pressure among Filipino Americans with hypertension: A randomized controlled trial. *Prev Med Rep*. 2018;11:42-48. doi:10.1016/j.pmedr.2018.05.002

432. Tan J, Ramazanu S, Liaw SY, et al. Effectiveness of Public Education Campaigns for Stroke Symptom Recognition and Response in Non-Elderly Adults: A Systematic Review and Meta-Analysis. *J Stroke Cerebrovasc Dis*. 2022;31(2):106207. doi:10.1016/j.jstrokecerebrovasdis.2021.106207

433. Bushnell C, Kernan WN, Sharrief AZ, et al. 2024 Guideline for the Primary Prevention of Stroke: A Guideline From the American Heart Association/American Stroke Association [published correction appears in *Stroke.* 2024 Dec;55(12):e439. doi: 10.1161/STR.0000000000000482.] [published correction appears in *Stroke*. 2025 Feb;56(2):e98. doi: 10.1161/STR.0000000000000486.]. *Stroke*. 2024;55(12):e344-e424. doi:10.1161/STR.0000000000000475

434. Volerman A, Chin MH, Press VG. Solutions for Asthma Disparities. *Pediatrics*. 2017;139(3):e20162546. doi:10.1542/peds.2016-2546

435. EXHALE Strategies. Allergy & Asthma Network. Accessed February 23, 2025. exhale.allergyasthmanetwork.org/resources

436. CDC. About the Lifestyle Change Program. CDC, Diabetes Prevention Program. Accessed February 23, 2025. cdc.gov/diabetes-prevention/lifestyle-change-program/lifestyle-change-program-details.html

437. Gunasekaran U. Expanding Diabetes Specialty Care in a Community Primary Care Practice Center. *Clin Diabetes*. 2023;41(4):573-576. doi:10.2337/cd22-0032

438. ODPHP. Cancer Screening: Reducing Client Out-of-Pocket Costs – Breast Cancer. ODPHP, Healthy People 2030. Updated October 2009. Accessed February 23, 2025. odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/cancer-screening-reducing-client-out-pocket-costs-breast-cancer

439. HHS. CPSTF Findings for Cancer Prevention and Control. HHS, The Community Guide for Preventive Services. Updated January 24, 2023. Accessed February 23, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124090327/thecommunityguide.org/pages/task-force-findings-cancer-prevention-and-control.html

440. NYSDOH. Help Uninsured Patients Get Screened for Breast, Cervical, and Colorectal Cancer. Become a Participating Health Care Provider with the New York State Cancer Services Program. NYSDOH, Cancer Services Program. Updated September 2024. Accessed February 23, 2025. health.ny.gov/diseases/cancer/docs/csp_provider_fact_sheet.pdf

441. Medications and Obesity: Exploring the Landscape and Advancing Comprehensive Care: Proceedings of a Workshop. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Food and Nutrition Board; Roundtable on Obesity Solutions. Published October 1, 2024. Accessed February 23, 2025. pubmed.ncbi.nlm.nih.gov/39591481

442. CDC. All Continuous NHANES. National Health and Nutrition Examination Survey. Accessed February 25, 2025. wwwn.cdc.gov/nchs/nhanes/continuousnhanes/default.aspx?BeginYear=2017

443. CDC. Community Water Fluoridation. CDC, Fluoridation. Accessed February 23, 2025. cdc.gov/fluoridation/l

444. ODPHP. Increase the proportion of people whose water systems have the recommended amount of fluoride – OH-11: Evidence-Based Resources. ODPHP, Healthy People 2030. Accessed February 23, 2025. odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-policy/increase-proportion-people-whose-water-systems-have-recommended-amount-fluoride-oh-11/evidence-based-resources

445. Head Start. Improving Oral Health Literacy. Head Start, Brush Up on Oral Health. Updated April 25, 2023. Accessed February 23, 2025. headstart.gov/oral-health/brush-oral-health/improving-oral-health-literacy?redirect=eclkc

446. ODPHP. Health Literacy in Healthy People 2030. ODPHP, Healthy People 2030. Accessed February 23, 2025. odphp.health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030

447. Guo Y, Logan HL, Dodd VJ, et al. Health literacy: a pathway to better oral health. *Am J Public Health*. 2014;104(7):e85-e91. doi:10.2105/AJPH.2014.301930

448. U.S. Preventive Services Taskforce. A & B Recommendations. Accessed February 23, 2025. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

449. Albougami A. Oral Health Literacy Levels of Nursing Professionals and Effectiveness of Integrating Oral Health Training into Nursing Curricula: A Systematic Review*. Appl. Sci.* 2023;13(18):10403. doi: 10.3390/app131810403

450. Learn from Academic Experts. Smiles for Life. Accessed February 23, 2025. smilesforlifeoralhealth.org

451. Wilson K. Minimally-Invasive Care: Policy Opportunities to Improve Dental Care Access and Affordability. Community Catalyst: Coverage and Care. Published October 2024. Accessed February 23, 2025. communitycatalyst.org/wp-content/uploads/2024/10/MIC-Policy-Opportunities-Brief.pdf

452. Outreach and Education Model. Rural Health Information Hub. Accessed February 23, 2025. ruralhealthinfo.org/toolkits/oral-health/2/outreach-and-education-model

453. CDC. Oral Health in Healthcare Settings to Prevent Pneumonia Toolkit. CDC, HAIs. Accessed February 23, 2025. cdc.gov/healthcare-associated-infections/hcp/prevention-healthcare/oral-health-pneumonia-toolkit.html#:~:text=Develop%20written%20protocols%20and%20standard,%2C%20desensitizing%2C%20non%2Dfoaming

454. Boyle CA, Perrin JM, Moyer VA. Use of clinical preventive services in infants, children, and adolescents. *JAMA*. 2014;312(15):1509-1510. doi:10.1001/jama.2014.12890

455. Decade of Vaccine Economics (DOVE). Immunization Economics. Accessed February 25, 2025. immunizationeconomics.org/dove-home

456. NYS Education Department (NYSED). Immunizations. NYSED, Student Support Services. Accessed February 25, 2025. nysed.gov/student-support-services/immunizations

457. Council on Environmental Health. Prevention of Childhood Lead Toxicity [published correction appears in *Pediatrics.* 2017 Aug;140(2):e20171490. doi: 10.1542/peds.2017-1490.] [published correction appears in *Pediatrics.* 2020 Jun;145(6):e20201014. doi: 10.1542/peds.2020-1014.]. *Pediatrics*. 2016;138(1):e20161493. doi:10.1542/peds.2016-1493

458. HHS. CPSTF Findings for Increasing Vaccination. HHS, The Community Guide for Preventive Services. Updated April 16, 2019. Accessed February 23, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124094656/thecommunityguide.org/pages/task-force-findings-increasing-vaccination.html

459. HPV Vaccination Starting at Age 9. Taylor & Francis Online, Human Vaccines & Immunotherapeutics. Published February 17, 2023. Updated December 19, 2023. Accessed February 23, 2025. tandfonline.com/journals/khvi20/collections/HPV-vaccination-starting-age-9

460. WHO. New WHO Global Evidence Review on Health and Migration underscores how the implementation of inclusive immunization plans is critical for Member States to achieve universal health coverage. Published July 12, 2022. Accessed February 23, 2025. who.int/news/item/12-07-2022-new-who-global-evidence-review-on-health-and-migration-underscores-how-the-implementation-of-inclusive-immunization-plans-is-critical-for-member-states-to-achieve-universal-health-coverage

461. Schaffer DeRoo S, Limaye RJ. Culturally Aware Vaccine Promotion to Prevent Outbreaks. *JAMA Netw Open*. 2024;7(8):e2429612. doi:10.1001/jamanetworkopen.2024.29612

462. HRSA, CDC, Agency for Toxic Substances and Disease Registry (ATSDR). HRS-CDC Letter on Childhood Lead Poisoning Prevention and Blood Lead Testing. Published January 10, 2023. Accessed February 23, 2025. stacks.cdc.gov/view/cdc/135295

463. CDC. Testing for Lead Poisoning in Children. CDC, Childhood Lead Poisoning Prevention. Accessed February 23, 2025. cdc.gov/lead-prevention/testing/l

464. Polivka BJ, Chaudry RV, Sharrock T. Using mixed methods to evaluate the Pediatric Lead Assessment Network Education Training Program (PLANET). *Eval Health Prof*. 2009;32(1):23-37. doi:10.1177/0163278708328741

465. CDC. Recommended Actions Based on Blood Lead Level. CDC, Childhood Lead Poisoning Prevention. Accessed February 23, 2025. cdc.gov/lead-prevention/hcp/clinical-guidance/l

466. HHS, HRSA. Enhancing Communication: Improving Care for Infants with Hearing Loss. Published April 2009. Accessed February 23, 2025. nichq.org/wp-content/uploads/2024/09/Enhancing-Communication-Newborn-Hearing.pdf

467. APTR-CDC Cooperative Agreement. Association for Prevention Teaching and Research. Accessed February 23, 2025. aptrweb.org/page/cdc_ca

468. Stories of Impact: The Power of Academic Partnerships in Public Health. Public Health Accreditation Board. Published July 24, 2022. Accessed February 23, 2025. phaboard.org/stories-of-impact/the-power-of-academic-partnerships-in-public-health

469. NYSDOH. Information for Families. NYSDOH, Early Intervention Program. Updated January 2024. Accessed February 25, 2025. health.ny.gov/community/infants_children/early_intervention/families.htm

470. Office of the New York State Comptroller. Oversight of the Early Intervention Program. Published February 28, 2023. Accessed February 25, 2025. osc.ny.gov/state-agencies/audits/2023/02/28/oversight-early-intervention-program

471. NYS Council on Children and Families. Early Childhood Comprehensive Systems. Accessed February 23, 2025. ccf.ny.gov/eccs-impact

472. NYSDOH. Early Intervention Program. Updated January 2024. Accessed February 23, 2025. health.ny.gov/community/infants_children/early_intervention

473. CEC Recommended Practices Interactive Glossary. Division for Early Childhood of the Council for Exception Children. Published April 18, 2015. Accessed February 23, 2025. dec-sped.org/_files/ugd/95f212_26fd2a7b804c40ea908fe5f58a65ec52.pdf

474. Flower KB, Massie S, Janies K, et al. Increasing Early Childhood Screening in Primary Care Through a Quality Improvement Collaborative. *Pediatrics*. 2020;146(3):e20192328. doi:10.1542/peds.2019-2328

475. Zubler JM, Wiggins LD, Macias MM, et al. Evidence-Informed Milestones for Developmental Surveillance Tools. *Pediatrics*. 2022;149(3):e2021052138. doi:10.1542/peds.2021-052138

476. Bright Futures Guidelines and Pocket Guide. American Academy of Pediatrics. Updated April 26, 2022. Accessed February 23, 2025. aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide

477. Chen J, Wang Y. Social Media Use for Health Purposes: Systematic Review. *J Med Internet Res*. 2021;23(5):e17917. doi:10.2196/17917

478. McLellan SE, Mann MY, Scott JA, et al. A Blueprint for Change: Guiding Principles for a System of Services for Children and Youth With Special Health Care Needs and Their Families. *Pediatrics*. 2022;149(Suppl 7):e2021056150C. doi:10.1542/peds.2021-056150C

479. CDC. Behavior or conduct programs in children. CDC, Children's Mental Health. Accessed February 25, 2025. cdc.gov/children-mental-health/about/about-behavior-or-conduct-problems-in-children.html

480. Disconnected Youth. County Health Rankings & Roadmaps. Accessed February 25, 2025. countyhealthrankings.org/health-data/health-factors/social-economic-factors/education/disconnected-youth?year=2024

481. NYSDOH. NYS Maternal and Child Health State Dashboard. April 2024. apps.health.ny.gov/public/tabvis/PHIG_Public/mch/reports/#state

482. Child and Adolescent Mental and Behavioral Health Resolution. American Psychological Association. Published June 2019. Accessed February 25, 2025. apa.org/about/policy/child-adolescent-mental-behavioral-health

483. Fiorillo A, de Girolamo G, Simunovic IF, et al. The relationship between physical and mental health: an update from the WPA Working Group on Managing Comorbidity of Mental and Physical Health. *World Psychiatry*. 2023;22(1):169-170. doi:10.1002/wps.21055

484. AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health. American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association. Updated October 19, 2021. Accessed February 25, 2025. aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health

485. NYSOMH. HealthySteps August 2024 Expansion. Accessed February 23, 2025. omh.ny.gov/omhweb/rfp/2024/healthysteps/l

486. Best Practice: Nurse-Family Partnership. Association of Maternal and Child Health Programs. Accessed February 23, 2025. amchp.org/database_entry/nurse-family-partnership

487. CDC. Promote Social, Emotional, and Behavioral Learning. CDC, Mental Health Action Guide. Accessed February 23, 2025 (via WayBack Machine January 24, 2025 archive). web.archive.org/web/20250124175209/cdc.gov/mental-health-action-guide/strategies/social-emotional-behavioral-learning.html

488. ODPHP. Increase the proportion of children and adolescents who get preventive mental health care in school – EMC-D06. ODPHP, Healthy People 2030. Accessed February 23, 2025. odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/children/increase-proportion-children-and-adolescents-who-get-preventive-mental-health-care-school-emc-d06

489. CDC. Schools Connectedness Helps Students Thrive. CDC, Reducing Health Risks Among Youth. Accessed February 23, 2025. cdc.gov/youth-behavior/school-connectedness/l

490. Chen E, Brody GH, Miller GE. Childhood close family relationships and health. *Am Psychol*. 2017;72(6):555-566. doi:10.1037/amp0000067

491. Abrams Z. Kids' mental health is in crisis. Here's what psychologists are doing to help. *American Psychological Association Monitor on Psychology.* 2023;54(1):63. apa.org/monitor/2023/01/trends-improving-youth-mental-health

492. Gopalkrishnan N. Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Front Public Health*. 2018;6:179. doi:10.3389/fpubh.2018.00179

493. Smith S, Granja MR, Nguyen US, et al. How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results of a 50-State Survey (2018 Update). National Center for Children in Poverty. Published November 2018. Accessed February 23, 2025. nccp.org/wp-content/uploads/2018/11/text_1211.pdf

494. Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools. American Academy of Pediatrics. Published February 26, 2024. Accessed February 23, 2025. publications.aap.org/toolkits/resources/15625/Bright-Futures-Toolkit-Links-to-Commonly-Used?autologincheck=redirected;%20and%20Weitzman,%20C.,%20Wegner,%20L.,%20the%20Section%20on%20Developmental%20and%20Behavioral%20Pediatrics,%20Committee%20on%20Psychosocial%20Aspects%20of%20Child%20and%20Family%20Health,%20Council%20on%20Early%20Childhood,%20&%20Society%20for%20Developmental%20and%20Behavioral%20Pediatrics.%20(2015).%20Promoting%20optimal%20development:%20Screening%20for%20behavioral%20and%20emotional%20problems.%20Pediatrics,%20135(2),%20384-395

495. Tyler ET, Hulkower RL, Kaminski JW. Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers. Milbank Memorial Fund. Published March 2017. Accessed February 23, 2025. milbank.org/wp-content/uploads/2017/03/MMF_BHI_REPORT_FINAL.pdf

496. Pediatric Behavioral Health Integration in Primary Care: Understanding One Critical Component of Pediatric Mental Health Care. Children's Hospital Association. Accessed February 23, 2025. childrenshospitals.org/-/media/files/quality/pediatric-behavioral-health-integration-in-primary-care.pdf

497. Lines MM. Pediatric Integrated Primary Care: A Population Health Approach to Meeting the Behavioral Health Needs of Children and Families. *Dela J Public Health*. 2022;8(2):6-9. doi:10.32481/djph.2022.05.002

498. Walter HJ, Vernacchio L, Trudell EK, et al. Five-Year Outcomes of Behavioral Health Integration in Pediatric Primary Care. *Pediatrics*. 2019;144(1):e20183243. doi:10.1542/peds.2018-3243

499. Office of the New York State Comptroller. Missing School: New York's Stubbornly High Rates of Chronic Absenteeism. Published October 2024. Accessed February 25, 2025. osc.ny.gov/files/reports/pdf/missing-school-ny-chronic-absenteeism.pdf

500. Gottfried MA. Chronic absenteeism and its effects on students' academic and socioemotional outcomes. *Journal of Education for Students Placed at Risk (JESPAR)*. 2014;19(2):53-75. doi:10.1080/10824669.2014.962696

501. Gottfried MA. Chronic absenteeism in the classroom context: Effects on achievement. *Urban Education.* 2019;54(1):3-34. doi:10.1177/0042085915618709

502. Johnson GM. Student alienation, academic achievement, and WebCT use. *Journal of Educational Technology & Society.* 2005;8(2):179-189.

503. Schoeneberger JA. Longitudinal attendance patterns: Developing high school dropouts. *The clearing house: a journal of educational strategies, issues and ideas.* 2012;85(1):7-14. doi:10.1080/00098655.2011.603766

504. U.S. Department of Education. Chronic Absenteeism. Updated January 20, 2025. Accessed February 25, 2025. ed.gov/teaching-and-administration/supporting-students/chronic-absenteeism#:~:text=Chronic%20absenteeism%20%E2%80%94%20defined%20as%20students,the%202022%2D23%20school%20year.

505. Using chronic absence to map interrupted schooling, instructional loss and educational inequity: Insights from school year 2017–18 data. Attendance Works, Everyone Graduates Center. Published February 2021. Accessed February 25, 2025. attendanceworks.org/using-chronic-absence-to-map-interrupted-schooling-instructional-loss-and-educational-inequity

506. Balfanz R, Byrnes V. Chronic absenteeism: Summarizing what We know from nationally available data. Johns Hopkins University. Published 2012. Accessed February 25, 2025. hub.jhu.edu/2023/10/12/chronic-absenteeism-challenges-schools/#:~:text=The%20analysis%2C%20conducted%20in%20partnership,almost%20four%20weeks%20throughout%20the

507. National Center for Health Statistics (US). Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Published May 2012. Accessed February 25, 2025. pubmed.ncbi.nlm.nih.gov/22812021

508. Weisz S. Addressing the Health-Related Causes of Chronic Absenteeism: A Toolkit for Action. Healthy Schools Campaign. Published 2022. Accessed February 25, 2025. healthyschoolscampaign.org/wp-content/uploads/2017/02/Addressing_Health-Related_Chronic_Absenteeism_Toolkit_for_Action_Full.pdf

509. U.S. Department of Education. In School Every Day: Addressing Chronic Absenteeism Among Students Experiencing Homelessness. U.S. Department of Education, National Center for Homeless Education. Published 2018. Accessed February 25, 2025. nche.ed.gov/wp-content/uploads/2018/10/chron-absent.pdf

510. The NAEP Glossary of Terms. The Nation's Report Card. Accessed February 25, 2025. nationsreportcard.gov/glossary.aspx?ispopup=false

511. Jefferson MD. The Effect of Poverty on School Attendance and Academic Achievement in Urban Areas. 2017. Accessed February 25, 2025. touroscholar.touro.edu/tucgsoe/49

512. USDA. Local School Wellness Policy. USDA, Food and Nutrition Service. Updated February 6, 2025. Accessed February 23, 2025. fns.usda.gov/cn/local-school-wellness-policy

513. School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students. Rural Health Information Hub. Accessed February 23, 2025. ruralhealthinfo.org/funding/5725

514. Events. School Mental Health Resource & Training Center. Accessed February 23, 2025. mentalhealthednys.org/events

515. Teacher and Staff Well-being. Kaiser Permanente, Thriving Schools. Accessed February 23, 2025. thrivingschools.kaiserpermanente.org/priorities/teacher-and-staff-well-being

516. Mental Health Screening Tools for Grades K-12. National Center on Safe Supportive Learning Environments. Accessed February 23, 2025. safesupportivelearning.ed.gov/sites/default/files/10-MntlHlthScrnTlsGrK-12-508.pdf

517. Peetz C. A Mental Health Screening Saved Students' Lives in this District. Education Week. Published February 23, 2024. Accessed February 23, 2025. edweek.org/leadership/a-mental-health-screening-saved-students-lives-in-this-district/2024/02

518. RULER: The Power of Emotional Intelligence to Achieve Well-being and Success in School and Life. New York State Systems of Care. Accessed February 23, 2025. nyssoc.com/wp-content/uploads/2023/06/Updated-WGIOS-Workshop-3-RULER-May-31st.pdf

519. Pulimeno M, Piscitelli P, Colazzo S, et al. School as ideal setting to promote health and wellbeing among young people. *Health Promot Perspect*. 2020;10(4):316-324. doi:10.34172/hpp.2020.50

520. CDC. Health Education Curriculum Analysis Tool (HECAT) Overview. Accessed February 23, 2025. wwwn.cdc.gov/hecatonline/UserDownloads/overview.pdf

521. CDC. Routine Immunizations on Schedule for Everyone (RISE). CDC, Vaccines & Immunizations. Accessed February 25, 2025. cdc.gov/vaccines/php/rise/l

522. NYSDOH. New York State School Environmental Health Program. Accessed February 25, 2025. health.state.ny.us/environmental/indoors/healthy_schools

523. Kallapiran K, Suetani S, Cobham V, et al. Impact of Positive Childhood Experiences (PCEs): A Systematic Review of Longitudinal Studies. *Child Psychiatry Hum Dev.* Published January 6, 2025. doi:10.1007/s10578-024-01807-x

524. CDC. Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders. CDC, Division of Adolescent and School Health (DASH). Published December 2023. Accessed February 23, 2025 (via WayBack Machine December 18, 2024 archive). web.archive.org/web/20241218165559/cdc.gov/healthyyouth/mental-health-action-guide/pdf/DASH_MH_Action_Guide_508.pdf

525. Missing Persons: Minorities in the Health Professions: A Report of the Sullivan Commission on Diversity in the Healthcare Workforce. The Sullivan Commission. Published 2016. Accessed February 23, 2025. campaignforaction.org/wp-content/uploads/2016/04/SullivanReport-Diversity-in-Healthcare-Workforce1.pdf

526. CDC. Parents for Healthy Schools: A Guide for Getting Parents Involved from K-12. Published October 2019. Accessed February 23, 2025. stacks.cdc.gov/view/cdc/157649

527. Agricultural Literacy Curriculum Matrix. New York Agriculture in the Classroom. Accessed February 23, 2025. newyork.agclassroom.org

528. Sawyer SM, Raniti M, Aston R. Making every school a health-promoting school. *Lancet Child Adolesc Health*. 2021;5(8):539-540. doi:10.1016/S2352-4642(21)00190-5

529. Educator Grants. Seed Your Future. Accessed February 23, 2025. seedyourfuture.org/educator_grants

530. Impact Schools Grant Program. Society of Health and Physical Educators (SHAPE) America. Accessed February 23, 2025. shapeamerica.org/MemberPortal/grants/SHAPE_America_Impact_Schools_Application.aspx#:~:text=SHAPE%20America%27s%20Impact%20Schools%20grant,expertise%20that%20improves%20student%20outcomes.

531. Mindfulness Trainings & Social Emotional Courses. Calming Kids. Accessed February 23, 2025. calmingkids.org/ck-mindfulness-courses

532. Strengthening Families: Increasing positive outcomes for children and families. Center for the Study of Social Policy. Accessed February 23, 2025. cssp.org/our-work/project/strengthening-families

533. Strengthening Families Protective Factors. Children's Trust Fund: Missouri's Foundation for Child Abuse Prevention. Accessed February 23, 2025. ctf4kids.org/strengthening-families-protective-factors

534. CDC. Reminder Systems and Strategies for Increasing Childhood Vaccination Rates. CDC, Vaccines & Immunizations. Accessed February 23, 2025. cdc.gov/vaccines/hcp/admin/reminder-sys.html#:~:text=CDC%20Sources&text=Many%20recordkeeping%20tasks%2C%20as%20well,known%20as%20an%20immunization%20registry

535. Brach C, Keller D, Hernandez L, et al. Ten Attributes of health Literate Health Care Organizations. Institute of Medicine of the National Academies. Published June 2012. Accessed February 23, 2025. nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf

536. Oregon Department of Education. School Attendance, Absenteeism, and Student Success. Accessed February 23, 2025. ode.state.or.us/wma/researchschool-attendance--final-version.pdf

537. Office of the New York State Comptroller. DiNapoli: Nearly 1 in 3 Students Were Chronically Absent from School. Published October 4, 2024. Accessed February 23, 2025. osc.ny.gov/press/releases/2024/10/dinapoli-nearly-1-3-students-were-chronically-absent-school

538. U.S. Department of Education. Chronic Absenteeism. U.S. Department of Education, Institute of Education Sciences. Accessed February 23, 2025. ies.ed.gov/use-work/supporting-recovery-with-evidence-based-practices/chronic-absenteeism

539. NYS Education Department. Student Support Services: Health Screenings. Accessed February 23, 2025. nysed.gov/student-support-services/health-screenings#:~:text=To%20ensure%20that%20all%20children,documented%20on%20a%20health%20exam

540. Status and Trends of Physical Activity Behaviors and Related School Policies. In: Educating the Student Body: Taking Physical Activity and Physical Education to School. Institute of Medicine, Committee on Physical Activity and Physical Education in the School Environment, Food and Nutrition Board. Published October 30, 2013. Accessed February 25, 2025. ncbi.nlm.nih.gov/books/NBK201496

541. U.S. Environmental Protection Agency. Take Action to Improve Indoor Air Quality in Schools. Accessed February 23, 2025. epa.gov/iaq-schools/take-action-improve-indoor-air-quality-schools

542. Murthy N, Rodgers L, Pabst L, et al. Progress in Childhood Vaccination Data in Immunization Information Systems - United States, 2013-2016. *MMWR Morb Mortal Wkly Rep*. 2017;66(43):1178-1181. doi:10.15585/mmwr.mm6643a4

543. Jensen C. Report on Active Schools Survey of Physical Education Teachers' Knowledge, Attitudes and Behaviors Related to Serving as a School Physical Activity Leader – September 2019. Active Schools. Published September 2019. Accessed February 25, 2025. activeschoolsus.org/news-and-resources/pal-survey

544. State University of New York (SUNY). Press Release: You're Accepted! Governor Hochul Launches New Initiative to Help New York Students Enroll at Public Colleges and Universities. Published October 24, 2024. Accessed February 25, 2025. suny.edu/suny-news/press-releases/10-24/10-24-24/top10promise.html

545. New York State. Tuition-Free Degree Program: The Excelsior Scholarship. Accessed February 25, 2025. ny.gov/programs/tuition-free-degree-program-excelsior-scholarship#:~:text=Leading%20the%20Way%20to%20College%20Affordability&text=Under%20this%20groundbreaking%20program%2C%20more,colleges%20in%20New%20York%20State.

546. NYSDOL. Why go to School? Accessed February 25, 2025. dol.ny.gov/why-go-school

547. Haseltine W. A college Degree Contributes In a Major Way to a Healthier Longer Life. Forbes. Published April 26, 2024. Accessed February 25, 2025. forbes.com/sites/williamhaseltine/2024/04/26/a-college-degree-contributes-in-a-major-way-to-a-healthier-longer-life

548. Moore K. Some students in top 10% of class to get auto-admit to SUNY. Times Union. Published October 26, 2024. Accessed February 23, 2025. timesunion.com/education/article/students-top-10-class-get-auto-admit-suny-19857905.php

549. Work-Based Learning Policy: For Out-Of-School Youth and Disadvantaged Adults. WorkforceGPS. Updated November 24, 2021. Accessed February 23, 2025. strategies.workforcegps.org/resources/2018/04/11/18/54/Work-Based-Learning-Policy-For-Out-Of-School-Youth-and-Disadvantaged-Adults

550. CDC. Find Training. CDC, Health Literacy. Accessed February 23, 2025. cdc.gov/health-literacy/php/find-training/get-training.html

551. Maynard BR, Farina A, Dell NA, Kelly MS. Effects of trauma-informed approaches in schools: A systematic review. *Campbell Syst Rev*. 2019;15(1-2):e1018. doi:10.1002/cl2.1018

552. Professional Development for Educators & Public Health Leaders. Coordinated Approach to Child Health (CATCH). Accessed February 23, 2025. catch.org/professional-development

553. New York State Center for School Health. NYSCSH e-Learning and Learning Management System (LMS) Overview. Accessed February 23, 2025. schoolhealthny.com/domain/142

554. Professional Development. New York State Association for Health, Physical Education, Recreation and Dance. Accessed February 23, 2025. nysahperd.org/professional-development

555. Tools for Providing Teachers with Professional Development. OPEN. Accessed February 23, 2025. openphysed.org/professionaldevelopment

556. Luaces MA, Cearley M, Chang K, et al. Envisioning Career Technical Education as a Platform for Student Empowerment. *CTE J*. 2018;6(2):2-14. pubmed.ncbi.nlm.nih.gov/31304182

557. U.S. Department of Education. Integrated Education and Training: A Career Pathways Policy & Practice. U.S. Department of Education, LINCS. Accessed February 23, 2025. lincs.ed.gov/professional-development/resource-collections/profile-1003

558. Bergson-Shilcock A. Foundational Skills in the Service Sector: Understanding and addressing the impact of limited math, reading, and technology proficiency on workers and employers. National Skills Coalition. Published February 2017. Accessed February 23, 2025. nationalskillscoalition.org/wp-content/uploads/2020/12/NSC-foundational-skills-FINAL.pdf

559. Mortrude J. Integrated Education and Training: A Career Pathways Policy & Practice. U.S. Department of Education, ERIC. Published April 2017. Accessed February 23, 2025. eric.ed.gov/?id=ED582917

560. Defining On-Ramps to Adult Career Pathways. Center for Postsecondary and Economic Success. Accessed February 23, 2025. clasp.org/sites/default/files/public/resources-and-publications/publication-1/Minnesota-Career-Pathways-On-Ramps.pdf

561. U.S. Department of Education. Young Adults Neither Enrolled in School nor Working. U.S. Department of Education, National Center for Education Statistics. Published 2024. Accessed February 23, 2025. nces.ed.gov/programs/coe/indicator/col/not-in-school-not-working-neet#suggested-citation