Prevention Agenda 2025-2030:
New York State Department of Health's
Recommendation
Ad Hoc Committee to Support the NYS Prevention Agenda

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Introduction

Common Acronyms

LHDs: Local Health Departments.

SHA: State Health Assessment.

SHIP: State Health Improvement Plan.

CHA: Community Health Assessment.

CHIP: Community Health Improvement Plan.

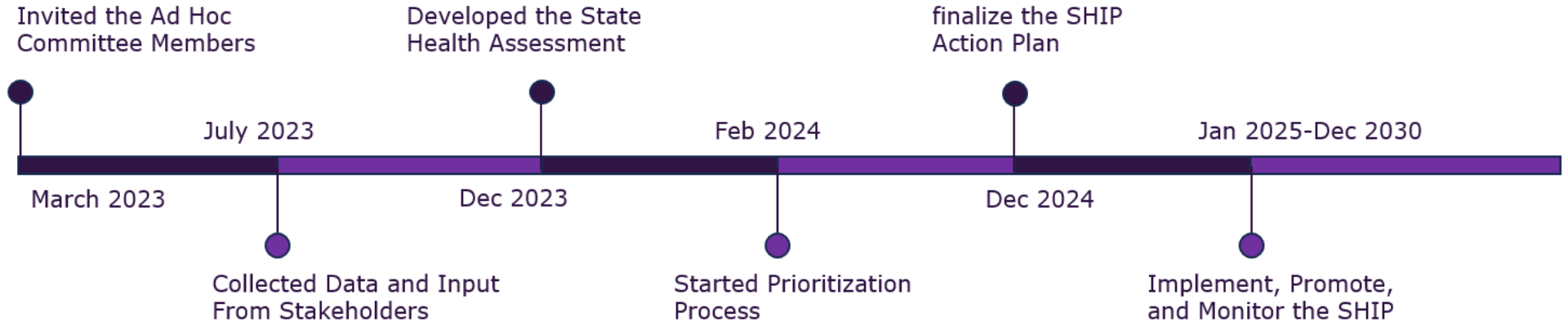
CSP: Community Service Plan.

PHAB: Public Health Accreditation Board.

IRS: Internal Revenue Service.

SDOH: Social Determinants of Health.

2025-2030 Prevention Agenda Timeline



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How Was the 2025-2030 Prevention Agenda Developed?

State Health Assessment

- New York State Data Profiles (e.g., birth, death, hospital records, program statistics, U.S. Census, and national survey)
- 2019-2024 Prevention Agenda progress
- Local Health Departments and Hospitals Plans (112 plans from 58 LHDs and 185 hospitals)

Stakeholder Engagement

- Steering Committee made up of subject matter experts from over 38 centers, divisions, and programs across NYSDOH
- Ad Hoc Committee Includes 120+ representatives from 48 agencies across various sectors beyond health
  - Local Health Departments and NYS Association of County Health Officials
  - Non-profit Hospitals and Hospital Associations
  - State Agencies (e.g.; OMH, OASAS, DOS, NYSOFA and others)
  - Local agencies and community-based organizations

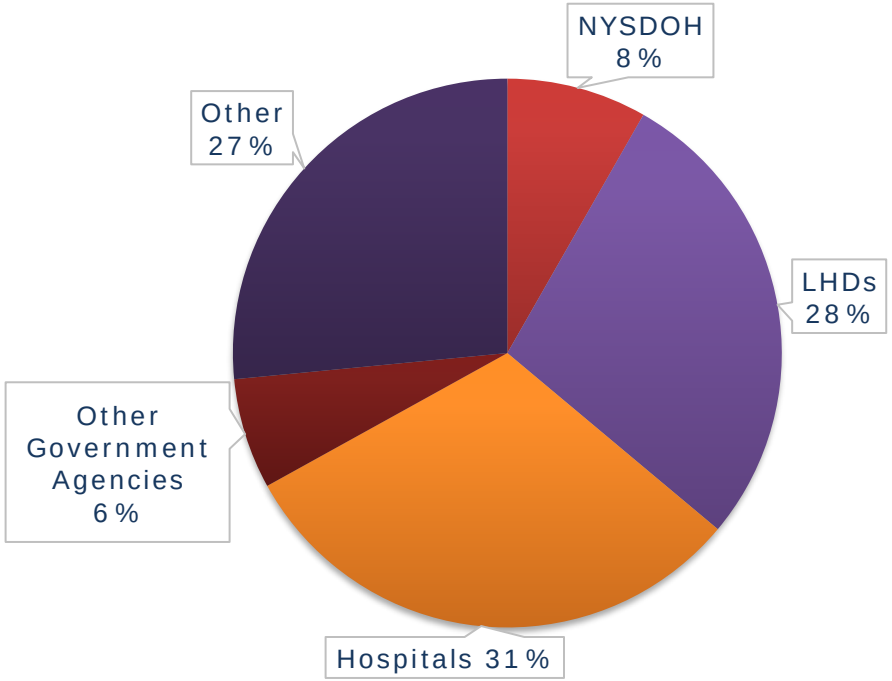
Prioritization

- Online survey completed in Feb 2023 (230 participants)
- Collected stakeholders feedback on selected priorities

Priorities Survey Findings

Weighted Voting Survey

Responses by Organization Type



Response Rate 57%

- NYSDOH
- Local Health Department
- Hospital or Healthcare System
- Other Government Agency
- Other

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Key Findings

Key Findings

- Top Health Concerns: The top priority list encompasses a range of issues, from socioeconomic factors to specific health conditions
  - Economic Wellbeing
  - Mental Wellbeing and Substance Use
  - Safe and Healthy Communities
  - Maternal and Child Health
  - Healthcare Insurance Coverage and Access to Care
  - Education Access and Quality

Weighted Voting Survey

Top Selected Health Issues									
Rank	Health Issue	Severity	Size	Disproportionate Effects	Cost	Life-span Effect	Feasibility	Evidence-based Availability	Total Score
1	Poverty	4.28	4.12	4.73	4.59	4.67	2.87	2.8	28.06
2	Prenatal Care and Maternal Mortality	4.12	3.62	4.43	4.1	4.04	3.94	3.77	28.02
3	Nutrition Security	3.96	3.81	4.6	3.92	4.13	3.67	3.71	27.8
4	Drug Overdose Death	4.59	3.56	3.67	4.13	4.38	3.65	3.67	27.65
5	Health Insurance Access	3.84	3.55	4.3	4.12	4.05	3.88	3.59	27.33
6	Housing Stability and Affordability	4.04	3.94	4.67	4.4	4.26	2.99	2.97	27.27
7	Infant Mortality	4.17	3.36	4.23	3.97	4.02	3.8	3.7	27.25

Weighted Voting Survey

Top Selected Health Issues									
Rank	Health Issue	Severity	Size	Disproportionate Effects	Cost	Life-span Effect	Feasibility	Evidence-based Availability	Total Score
8	Healthy Eating	3.69	3.94	4.17	3.77	4.03	3.8	3.84	27.24
9	Suicide	4.57	3.43	3.2	3.99	4.43	3.59	3.66	26.87
10	Children Receive Appropriate Screening and Services	3.6	3.57	4.07	3.75	3.84	4.15	3.83	26.81
11	Depression	3.99	3.93	3.17	3.92	4.17	3.53	3.69	26.4
12	Early Intervention	3.51	3.37	3.87	3.88	3.83	3.82	3.72	26
13	Unemployment	3.78	3.54	4.57	4.31	4.03	2.89	2.87	25.99
14	Healthy Aging (i.e., preventive services for chronic disease and associated risk factors)	3.69	3.75	3.57	3.82	3.73	3.82	3.56	25.94
15	Physical Access and Proximity to Health Services	3.73	3.57	4.17	3.79	3.86	3.42	3.35	25.89

Weighted Voting Survey

Top Selected Health Issues									
Rank	Health Issue	Severity	Size	Disproportionate Effects	Cost	Life-span Effect	Feasibility	Evidence-based Availability	Total Score
16	Anxiety and Stress	3.84	3.93	3.07	3.79	4.06	3.55	3.6	25.84
17	Adverse Childhood Experiences	3.75	3.63	3.7	3.9	4.27	3.12	3.29	25.66
18	Oral Health	3.34	3.45	4.03	3.49	3.74	3.83	3.74	25.62
19	Injuries and Violence	3.93	3.43	4	3.89	3.97	3.18	3.19	25.59
20	Education Access	3.43	3.55	4.03	3.84	3.96	3.31	3.38	25.5
21	Safe Communities	3.52	3.56	4.1	3.72	3.81	3.22	3.15	25.08
22	Tobacco/ E-cigarette Use	3.79	3.44	3.07	3.66	3.8	3.53	3.77	25.06
23	Lead Poisoning	3.49	2.8	4.1	3.29	3.58	3.85	3.88	24.99

Weighted Voting Survey

Least 10 Selected Health Issues									
Rank	Health Issue	Severity	Size	Disproportionate Effects	Cost	Life-span Effect	Feasibility	Evidence-based Availability	Total Score
44	Tickborne Diseases	3.02	2.63	1.63	2.86	2.94	3.21	3.3	19.59
43	Compulsive Gambling	2.83	2.45	2.33	2.91	3.2	2.9	3.24	19.86
42	Foodborne Illness	2.82	2.56	1.8	2.75	2.59	3.59	3.76	19.87
41	Cannabis Use	2.85	2.97	2.6	3.03	3.18	3.23	3.23	21.09
40	Indoor Radon	3.14	2.44	2.7	2.85	3.24	3.46	3.63	21.46
39	End of Life Care and Planning	3.02	3.11	2.5	3.12	2.83	3.56	3.39	21.53
38	Healthcare Associated Infections	3.23	2.7	2.03	3.17	2.92	3.78	3.76	21.59
37	Outdoor Air Quality	3.25	3.21	2.43	3.36	3.52	2.88	3.04	21.69
36	Climate Change	3.3	3.61	2.2	3.69	3.86	2.68	2.89	22.23
35	Social Cohesion	3.19	3.44	3	3.39	3.61	2.9	2.97	22.5

Recommendations

- The Social Determinants of Health (SDOH) are critical areas of need in New York

Integrate SDOH into the 2025-2030 Prevention Agenda priorities to:

- Address direct and indirect factors influencing health, and
- Reflect needs of the community
- Consistent with approach of Healthy People 2030

NYS DOH Proposal…

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

2019-2024 Prevention Agenda

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

2025-2030 Prevention Agenda

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Why Frame the State Health Improvement Plan Around the Social Determinants of Health?

America's Health Ranking

New York

State Health Department Website: health.ny.gov

Overall Rank

27

Summary

Strengths

- Low premature death rate
- Low prevalence of multiple chronic conditions
- Low occupational fatality rate

Challenges

- Low prevalence of high school completion
- High income inequality
- High percentage of housing with lead risk

Measures

		State Rank	State Value	U.S. Value
Social & Economic Factors		**38**	**-0.280**	
Community and Family Safety	Homicide (Deaths per 100,000 population)	18	4.6	7.7
	Occupational Fatalities (Deaths per 100,000 workers)	1	2.8	3.9
	Public Health Funding (Dollars per person)	11	$232	$183
Economic Resources	Economic Hardship Index (Index from 1-100)	38	70	—
	Food Insecurity (% of households)	31	11.3%	11.2%
	Income Inequality (80-20 Ratio)	50	5.95	4.92
Education	Fourth Grade Reading Proficiency (% of public school students)	39	29.6%	32.1%
	High School Completion (% of adults ages 25+)	45	87.9%	89.6%
Social Support and Engagement	Adverse Childhood Experiences (% of children ages 0-17)	1	9.8%	14.0%
	High-Speed Internet (% of households)	36	92.0%	92.9%
	Residential Segregation - Black/White (Index from 0-100)	47	77	—
	Volunteerism (% of population ages 16+)	38	21.7%	23.2%
	Voter Participation (% of U.S. citizens ages 18+)	36	56.9%	59.5%
Physical Environment		**41**	**-0.105**	
Air and Water Quality	Air Pollution (Micrograms of fine particles per cubic meter)	14	6.7	8.6
	Drinking Water Violations (Average number of violations per community water system)	26	2.0	2.7
	Water Fluoridation (% of population served)	30	71.5%	72.7%
Climate and	Climate Policies (Number of four policies)	1	4	—

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Income, Poverty, and Unemployment by Race/Ethnicity, NYS 2017-2021

Health Indicator	Non-Hispanic			Hispanic	Total
	White	Black	Asian/Pacific Islander		
Median annual household income in US dollars (2017-2021)~	85,520	53,697	83,399	55,621	75,157
Percentage of families below poverty (2017-2021)~	5.7%	16.5%	11.3%	17.6%	9.8%
Percentage of children under age 18 below poverty (2017-2021)~	12.1%	28.0%	16.7%	25.9%	18.4%
Percentage unemployed among the civilian labor force (2017-2021)~	4.9%	9.2%	5.7%	8.3%	6.2%

~White non-Hispanic, Black (including Hispanic), Asian (including Hispanic, excluding Pacific Islanders), and Hispanic (of any race).
Data Source: New York State County Health Indicators by Race/Ethnicity

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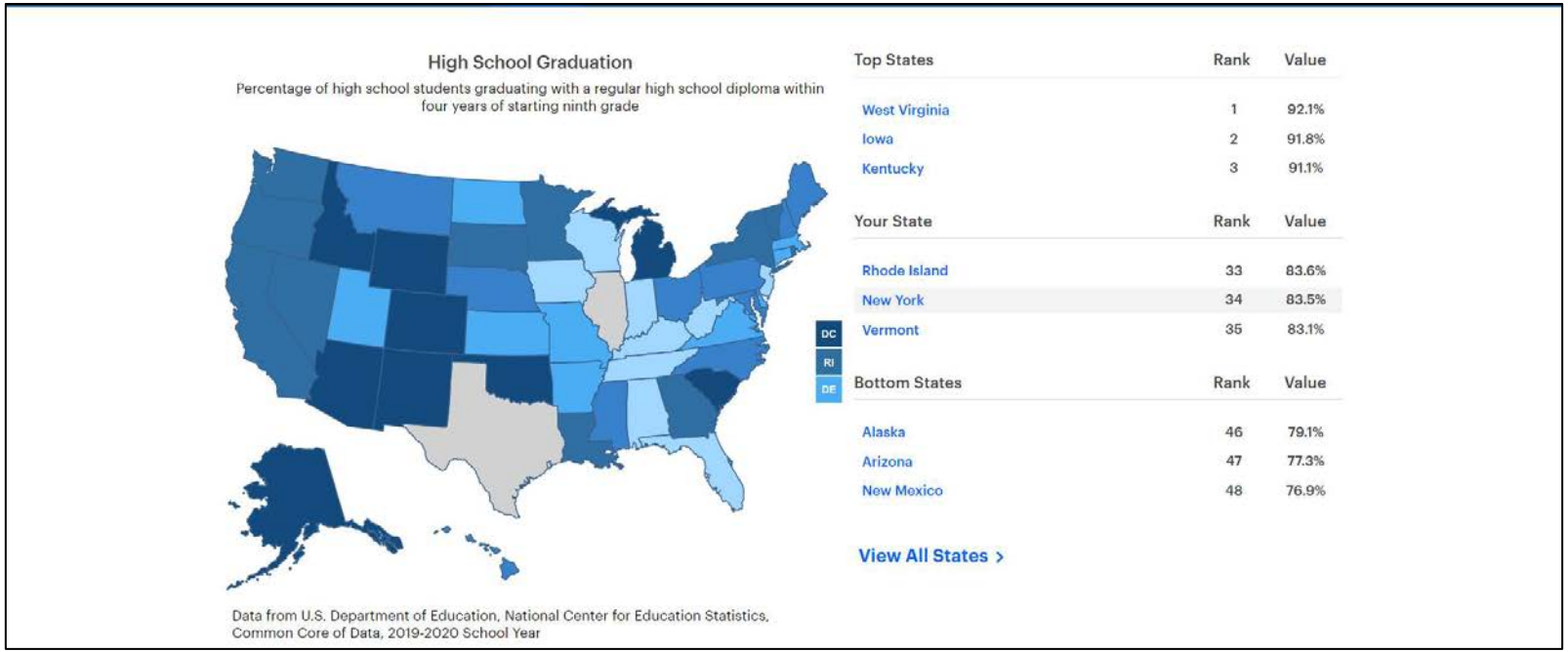
America's Health Rankings



https://www.americashealthrankings.org/explore/measures/Graduation_A/NY

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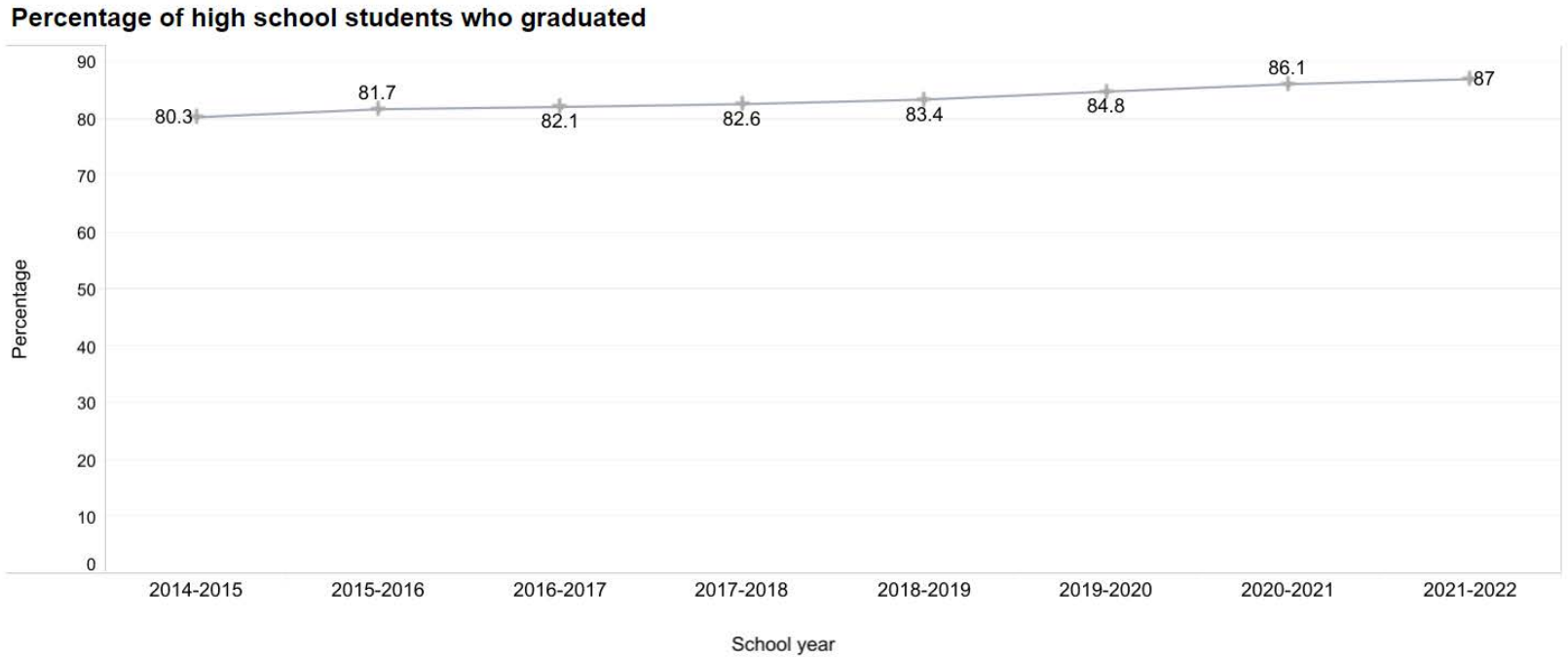
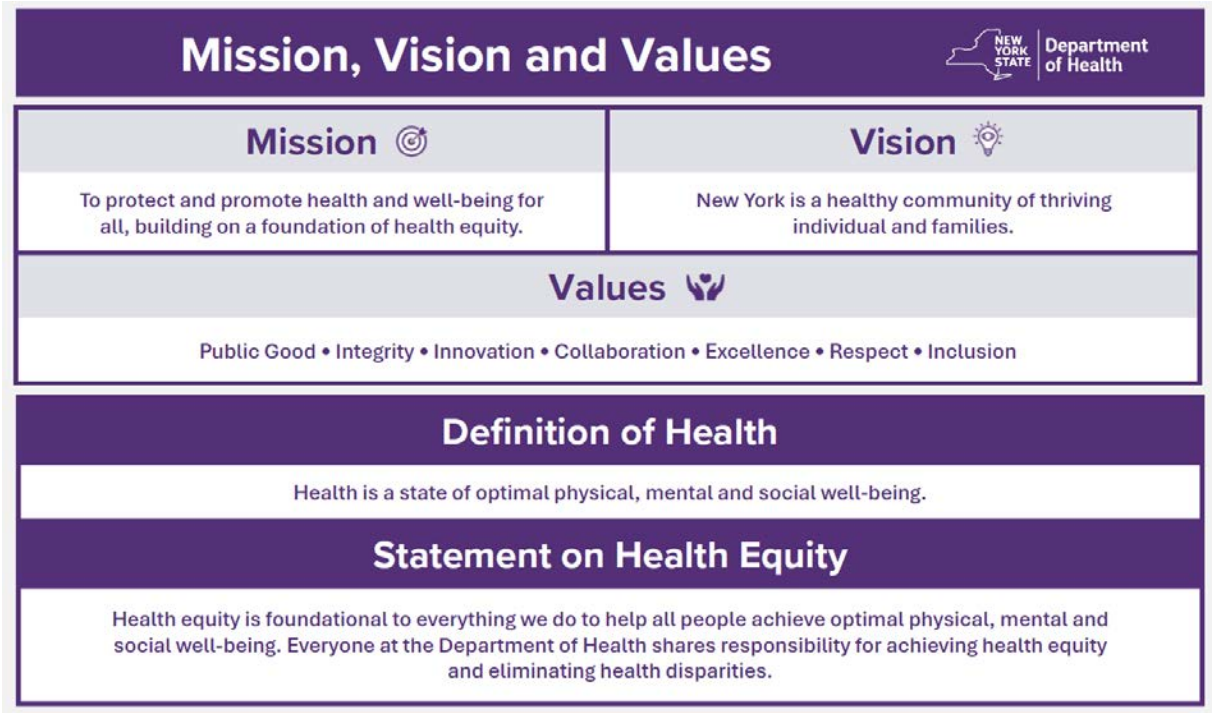
High School Graduation



A SDOH Framework Supports...

- Holistic Approach
- Addressing Root Causes
- Health Equity
- Intersectoral Collaboration
- Preventive Approach
- Community Empowerment

NYSDOH's Updated Mission, Vision, and Values



Prevention Agenda 2025- 2030

2025-2030 Prevention Agenda Framework

Vision

Every individual in New York State has the opportunity, regardless of background or circumstances, to attain their highest level of health across the lifespan

Foundations

- Health Equity
- Prevention Across the Lifespan
- Health Across All Policies
- Local Collaboration-Building

Domain	Priorities
Economic Stability	**Economic Wellbeing** • Poverty • Unemployment • Nutrition Security • Housing Stability and Affordability
Social and Community Context	**Mental Wellbeing** • Anxiety and Stress • Suicide • Depression • Drug Overdose • Tobacco/ E-cigarette Use • Adverse Childhood Experiences • Healthy Eating
Neighborhood and Built Environment	**Safe and Healthy Communities** • Opportunities For Active Transportation and Physical Activity • Access to Community Services and Support • Injuries and Violence
Health Care Access and Quality	**Health Insurance Coverage and Access to Care** • Access to and Use of Prenatal Care • Prevention of Infant and Maternal Mortality • Preventive Services for Chronic Disease Prevention and Control • Oral Health Care (e.g., routine preventive care, community water fluoridation, dental sealants, and access to dental services for Medicaid covered population) **Healthy Children** • Preventive service (e.g.; immunization, hearing screening and follow up, and lead screening) • Early Intervention
Education Access and Quality	**K-12 Student Success And Educational Attainment** • Health and Wellness Promoting Schools (e.g.; timely immunization, healthy school meals, and counselling and mentoring) • Opportunities for Continued Education (e.g.; high school completion programs, transitional and vocational programs, literacy initiatives, and reskilling and retraining programs)

Includes the Top 23 Selected Health Issues

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Foundations

Health Equity: Focus on structural racism and implicit bias as social drivers of health.

Prevention Across the Lifespan: Promote health and prevent disease through evidence-based interventions, addressing social determinants and health inequities at every stage of life.

Health in All Policies: Promote an interdisciplinary, multi-sector collaboration.

Local Collaboration-Building: Work collaboratively with stakeholders and community members to achieve SHIP goals.

Overarching Goals

Domain	Overarching Goal
Economic Stability	All people in New York have the financial security and support needed to thrive
Social and Community Context	All people in New York live in communities that foster and support optimal physical, mental, and social well-being
Neighborhood and Built Environment	All people in New York have equitable access to healthy, and safe neighborhoods
Health Care Access and Quality	All people in New York have access to timely, affordable, and high-quality health care services
Education Access and Quality	All people in New York have equitable access to quality education in an environment that supports physical and mental health

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Prevention Agenda 2025-2030

Each of the 5 domains will include:

- One overarching goal
- 1-3 objectives for each of the priorities
- Indicators to track progress
- Evidence-based interventions
  - For hospitals, health departments, and other organizations
  - Resources for implementation
  - Identification of populations/age groups affected
  - Partners/organizations that play leading or supporting roles

Domain Workgroups

Purpose

Identify the goals, objectives, indicators, and interventions for each domain.

Who?

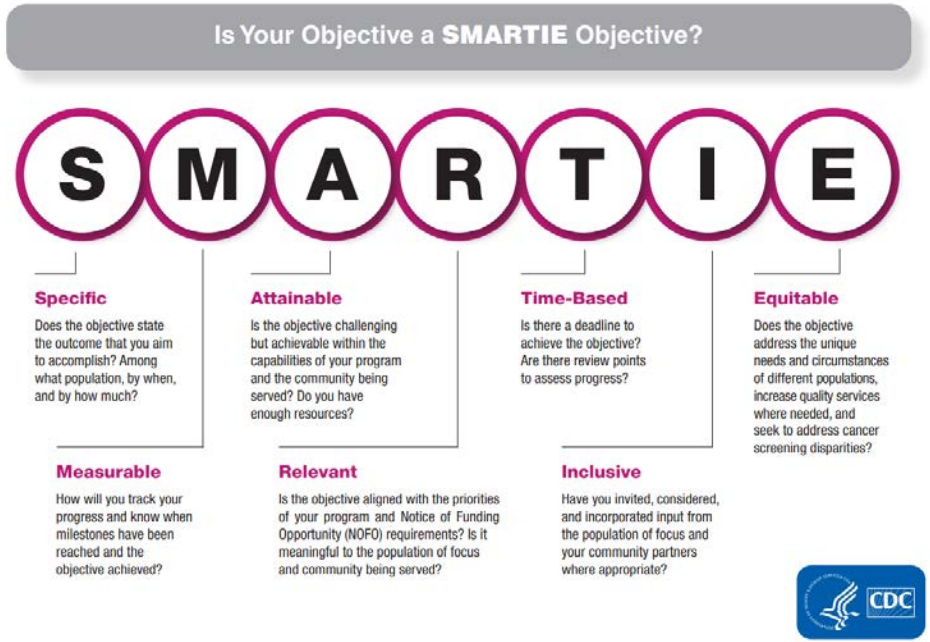
Workgroups are comprised of organizations and members from the Ad Hoc Committee, including NYSDOH programs, LHDs, hospitals, subject-matter experts, and community members.

When?

July- October 2024.

SMARTIE Objectives

The SMARTIE Objectives Framework will be used to ensure that objectives are precise:



CDC

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Questions Raised…

- How can health care organizations effectively address the core issues of social determinants of health?
- Are there examples of successful collaborations between local health departments, hospitals, and other local partners?
- How will other sectors, state agencies, and stakeholder organizations be engaged to ensure the success of the 2025-2030 Prevention Agenda?
- How will consumers be given a voice in the Prevention Agenda going forward?
- How can collaborations between local health departments and hospitals be strengthened or formalized?

Examples of Hospitals and Partners Addressing SDOHs

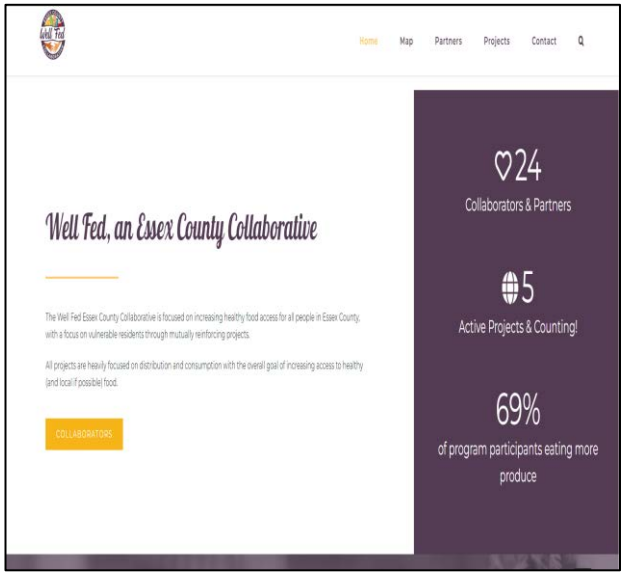
Food Insecurity

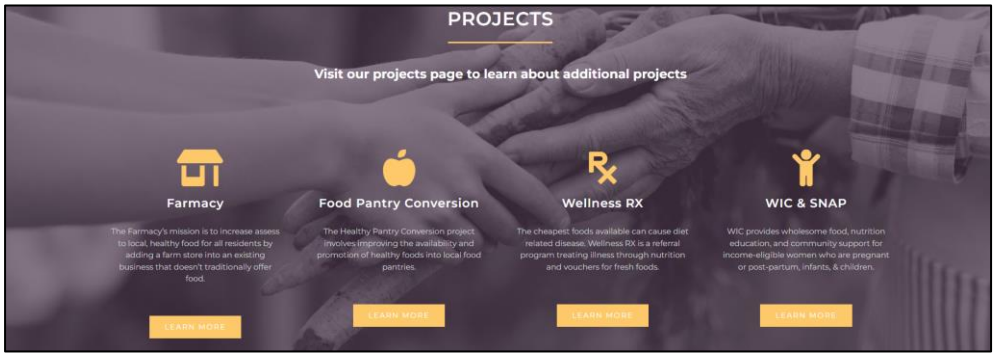
Essex County

The Well Fed Essex County Collaborative

Location: Essex County

- Partnership with Essex County Health Department, Cornell Cooperative Extension, ADK Action, University of Vermont Health Network, Local Farms, and others
- Focus on increasing healthy food access for all people in Essex County, with a focus on vulnerable residents through mutually reinforcing projects.





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SDOHs

NYC Department of Health and Mental Hygiene

NYC Neighborhood Health Atlas

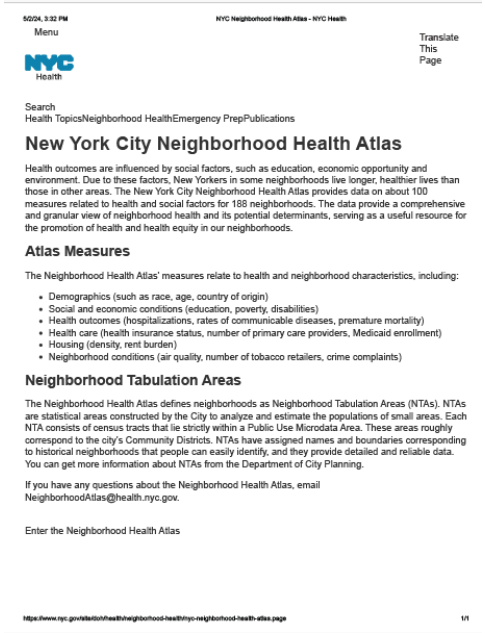
Location: NYC.

Focus on providing data on about 100 measures related to health and social factors for 188 neighborhoods.

Goal: Promotion of health and health equity in NYC neighborhoods.

Data:

1. Demographics (such as race, age, country of origin)
2. Social and economic conditions (education, poverty, disabilities)
3. Health outcomes (hospitalizations, rates of communicable diseases, premature mortality)
4. Health care (health insurance status, number of primary care providers, Medicaid enrollment)
5. Housing (density, rent burden)
6. Neighborhood conditions (air quality, number of tobacco retailers, crime complaints)



5/2/24, 3:32 PM NYC Neighborhood Health Atlas - NYC Health

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New York City Neighborhood Health Atlas

Health outcomes are influenced by social factors, such as education, economic opportunity and environment. Due to these factors, New Yorkers in some neighborhoods live longer, healthier lives than those in other areas. The New York City Neighborhood Health Atlas provides data on about 100 measures related to health and social factors for 188 neighborhoods. The data provide a comprehensive and granular view of neighborhood health and its potential determinants, serving as a useful resource for the promotion of health and health equity in our neighborhoods.

Atlas Measures

The Neighborhood Health Atlas' measures relate to health and neighborhood characteristics, including:

- Demographics (such as race, age, country of origin)
- Social and economic conditions (education, poverty, disabilities)
- Health outcomes (hospitalizations, rates of communicable diseases, premature mortality)
- Health care (health insurance status, number of primary care providers, Medicaid enrollment)
- Housing (density, rent burden)
- Neighborhood conditions (air quality, number of tobacco retailers, crime complaints)

Neighborhood Tabulation Areas

The Neighborhood Health Atlas defines neighborhoods as Neighborhood Tabulation Areas (NTAs). NTAs are statistical areas constructed by the City to analyze and estimate the populations of small areas. Each NTA consists of census tracts that lie strictly within a Public Use Microdata Area. These areas roughly correspond to the city's Community Districts. NTAs have assigned names and boundaries corresponding to historical neighborhoods that people can easily identify, and they provide detailed and reliable data. You can get more information about NTAs from the Department of City Planning.

If you have any questions about the Neighborhood Health Atlas, email NeighborhoodAtlas@health.nyc.gov.

Enter the Neighborhood Health Atlas

https://www.nyc.gov/site/doh/health/neighborhood-health/nyc-neighborhood-health-atlas.page 1/1

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SDOHs

Erie County Health and Human Service Departments

The Live Well Erie Initiative

Location: Erie County.

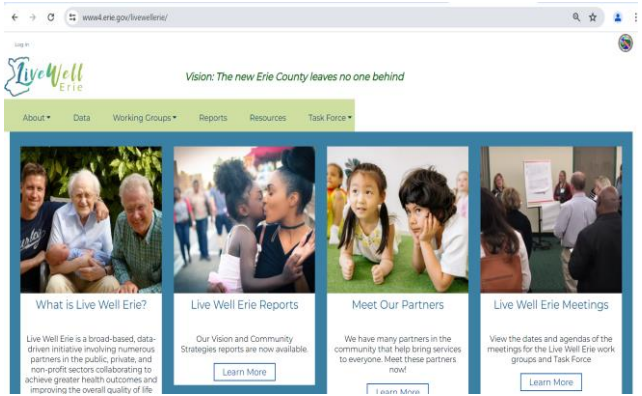
Partnership with community-based organizations, private, non-profit, academic, and philanthropic sectors.

Focus on: Children, Working Families, Seniors.

Goal: Improving the quality of life for Erie County residents.

Five Guiding Principals:

1. A clear focus on the social determinants of health;
2. An integration of the Racial Equity Impact Analysis;
3. An invitation for innovative thinking;
4. An opportunity for the modernization of service delivery;
5. An expectation of partnership and collaboration.



Meaningful improvements in the SDOHs

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SDOHs

Seven Valleys Health Coalition

Location: Cortland County.

Partnership with Cortland County Health Department, Guthrie Cortland Medical Center, and Family Health Network of Central New York.

Goal: Identify unmet needs and addressing local health issues at a local level.

Services:

- Helping people access healthcare services
- Providing counseling and education (e.g., prevention and management of chronic health conditions, food waste, oral health, breastfeeding, and others).
- 2-1-1 CORTLAND

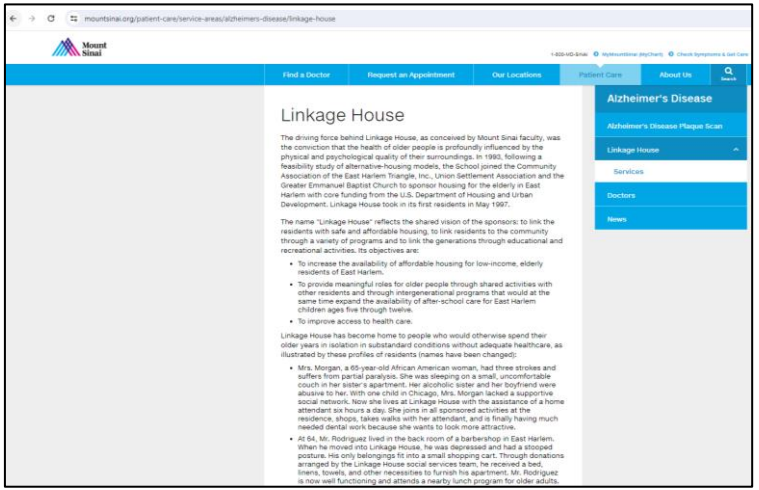
Housing

Mount Sinai

Linkage House

Location: East Harlem.

- Partnership with the Community Association of the East Harlem Triangle, Inc., Union Settlement Association, and the Greater Emmanuel Baptist Church.
- Focus: low-income, elderly, and people with Alzheimer in East Harlem.
- Services:
  - Link the residents with safe and affordable housing.
  - Provide access to quality health care, educational programs, and recreational activities.



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Current Vs New Prevention Agenda

How Will the 2025 -2030 SHIP Be Implemented?

The SHIP menu of objectives, strategies and approaches provides flexible options for all communities to improve outcomes for New Yorkers of all ages.

State and Local Partners:

Many partners at the state and local level contribute to achieving the vision of the Prevention Agenda, including:

- Local health departments
- Hospitals
- State agencies
- Statewide organizations
- Healthcare Providers
- Community behavioral health providers
- Housing organizations
- Medicaid managed care plans
- Philanthropy
- Schools
- Local agencies and community-based organizations

Public and private partners must work together to achieve Prevention Agenda goals

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How Will the 2025 -2030 SHIP Be Implemented?

- SHIP strategies will be implemented as part of:
  - Community health improvement efforts led by local health departments
  - Hospital activities, investments and community benefit expenditures
  - Actions and investments by other community partners.
  - New York's Certificate of Need (CON)

- Strengthen collaboration between hospitals and local health departments
  - Ensure stronger alignment of hospital community investments and local health department priorities.

- Establishing cross-sector partnerships:
  - Implement strategies and interventions to advance the Prevention Agenda and improve the health of individuals of all ages
  - Identify assets, resources, and evidence-based or best-practice interventions

Cycle	2019-2024	2025-2030
Time	6years	6 years
Focus	Major public health areas with a focus on addressing disparities and promoting health equity	Health Equity
Objectives	SMART	SMARTIE
Submission Cycle	Every three years for both LHDs and hospitals	LHDS every 6 years Hospitals every 3 years (per federal requirement)
Priority Selection	• Two Prevention Agenda priorities with one focus area each, or one priority with two focus areas • One priority must address a disparity and promote health equity	• Three priorities under one or more SDOH domain
Collaboration	• Hospitals must align priorities with the county LHD • Encouraged joint CHAs/CHIPs/CSPs	• Hospitals must align priorities with the county LHD • Encouraged joint CHAs/CHIPs/CSPs • Involvement of local communities in assessment, selection, design, prioritization, and implementation
Interagency Collaboration	• Ad Hoc (interagency workgroup)- Planning the Prevention Agenda	• Ad Hoc (interagency workgroup)- Planning the Prevention Agenda • Developing interagency workgroup to address SDOHs

Priorities Selection Example

Domain	Priorities
Economic Stability	**Economic Wellbeing** ❑ Poverty ❑ Unemployment ❑ Nutrition Security ❑ Housing Stability and Affordability
Social and Community Context	**Mental Wellbeing** ❑ Anxiety and Stress ❑ Suicide ❑ Depression ❑ Drug Overdose ❑ Tobacco/ E-cigarette Use ❑ Adverse Childhood Experiences ❑ Healthy Eating
Neighborhood and Built Environment	**Safe and Healthy Communities** ❑ Opportunities For Active Transportation and Physical Activity ❑ Access to Community Services and Support ❑ Injuries and Violence
Health Care Access and Quality	**Health Insurance Coverage and Access to Care** ❑ Access to and Use of Prenatal Care ❑ Prevention of Infant and Maternal Mortality ❑ Preventive Services for Chronic Disease Prevention and Control ❑ Oral Health Care (e.g., routine preventive care, community water fluoridation, dental sealants, and access to dental services for Medicaid covered population) **Healthy Children** ❑ Preventive service (e.g.; immunization, hearing screening and follow up, and lead screening) ❑ Early Intervention
Education Access and Quality	**K-12 Student Success And Educational Attainment** ❑ Health and Wellness Promoting Schools (e.g.; timely immunization, healthy school meals, and counselling and mentoring) ❑ Opportunities for Continued Education (e.g.; high school completion programs, transitional and vocational programs, literacy initiatives, and reskilling and retraining programs)

Three priorities under one SDOH domain

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Priorities Selection Example

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Social and Community Context	**Mental Wellbeing** ❑ Anxiety and Stress ❑ Suicide ❑ Depression ❑ Drug Overdose ❑ Tobacco/ E-cigarette Use ❑ Adverse Childhood Experiences ❑ Healthy Eating
Neighborhood and Built Environment	**Safe and Healthy Communities** ❑ Opportunities For Active Transportation and Physical Activity ❑ Access to Community Services and Support ❑ Injuries and Violence
Health Care Access and Quality	**Health Insurance Coverage and Access to Care** ❑ Access to and Use of Prenatal Care ❑ Prevention of Infant and Maternal Mortality ❑ Preventive Services for Chronic Disease Prevention and Control ❑ Oral Health Care (e.g., routine preventive care, community water fluoridation, dental sealants, and access to dental services for Medicaid covered population) **Healthy Children** ❑ Preventive service (e.g.; immunization, hearing screening and follow up, and lead screening) ❑ Early Intervention
Education Access and Quality	**K-12 Student Success And Educational Attainment** ❑ Health and Wellness Promoting Schools (e.g.; timely immunization, healthy school meals, and counselling and mentoring) ❑ Opportunities for Continued Education (e.g.; high school completion programs, transitional and vocational programs, literacy initiatives, and reskilling and retraining programs)

Three priorities under different SDOH domains

NEW YORK STATE | Department of Health

SDOH Interagency Workgroup

SDOH Interagency Workgroup

Establishment and Proposed Timeline

Purpose

- Promote a government culture that prioritizes health and equity for New Yorkers across policy areas.
- Incorporate health and equity into state agency practices.
- Provide a forum for agencies to identify shared goals and opportunities to enhance performance through collaboration.

Who?

- Explore opportunities for existing interagency councils to create a working group to perform this function.

SDOH Interagency Workgroup

Establishment and Proposed Timeline

NEW YORK STATE | Department of Health

Questions?

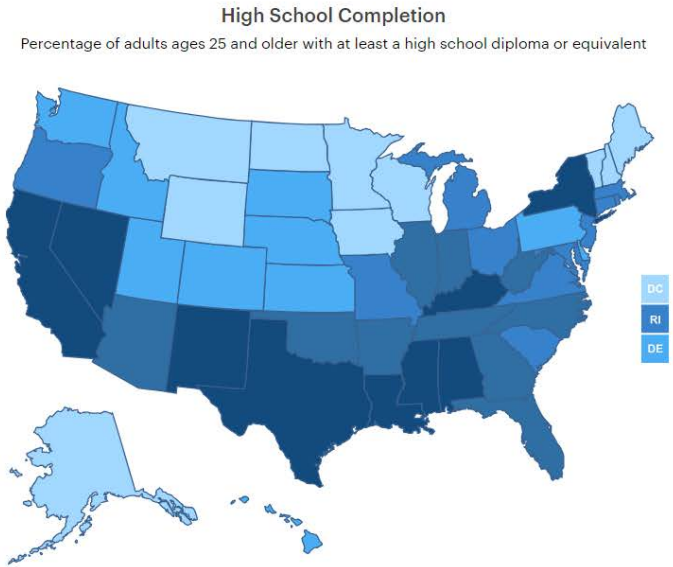
Please contact us at prevention@health.ny.gov

Appendix

America's Health Rankings

High School Completion by State

Percentage of adults ages 25 and older with at least a high school diploma or equivalent



Top States	Rank	Value
Vermont	1	95.0%
Maine	2	94.6%
New Hampshire	3	94.5%
Minnesota, Montana	4	94.0%
North Dakota	6	93.9%

Bottom States	Rank	Value
Mississippi	46	87.6%
Nevada	47	87.4%
Louisiana	48	87.3%
Texas	49	86.1%
California	50	84.7%

View All States >

https://www.americashealthrankings.org/explore/measures/hs_completion/NY

NEW YORK STATE Department of Health

Selected Education Access and Quality Metrics, By Race and Ethnicity, NYS

Health Indicator	Non-Hispanic			Hispanic	Total
	White	Black	Asian/Pacific Islander		
Percentage of high school students who dropped out (2021-2022)	4.0%	9.8%	4.0%	12.2%	7.3%
Percentage of population aged 25 years or older with a bachelor's degree or higher (2017-2021)~	44.7%	25.2%	48.3%	21.0%	38.1%
Percentage of population who speak English less than very well (2017-2021)~	4.5%	6.2%	41.3%	32.9%	6.7%

Data Source: NYS County Health Indicators by Race and Ethnicity

Weighted Voting Survey

Purpose: To help prioritize the 44 public health issues proposed for inclusion in the 2025-2030 Prevention Agenda.

Method:

- Weighted Voting Survey based on seven criteria.
- Weights allow to examine data in a way that includes the responses of every single person who answered a question.

Weighted Voting Survey

Criterion 1: Severity of the Problem

Refers to whether the identified issue can reduce life quality, limit opportunities, or cause serious health outcomes such as disability or death.

Criterion 2: Size of The Problem

Refers to whether the identified issue affects a large number of individuals and has the potential for a significant impact on the health of the community.

Criterion 3: Disproportionate Effects Among Subgroups

Refers to worse health outcomes caused by the issue in specific subgroups, defined by age, race, ethnicity, income, gender, or geography, compared to others.

Criterion 4: Economic and Social Cost

Refers to the consequences of not addressing the issue, which include increased monetary costs (i.e., healthcare and social service expenses) and social costs (i.e., loss of productivity, reduced quality of life, etc.)

Weighted Voting Survey

Criterion 5: Life-span Effect

Refers to a health issue arising at a certain life stage having the potential for lasting impacts and/or serving as a proxy for other related behavioral or social problems.

Criterion 6: Feasibility

Refers to the practicality and adequacy of logistics, including the cost, resources, and interventions needed for the state to effectively address the issue.

Criterion 7: Availability of Evidence-Based Interventions

Refers to whether evidence-based interventions or strategies to prevent or manage the health issue are available and can be implemented with relative ease.

Weighted Voting Survey

How to Calculate the Total weighted Average Score?

Criterion 1	No Impact $X_1 W_1$	Mild $X_2 W_2$	Moderate $X_3 W_3$	Severe $X_4 W_4$	Extreme $X_5 W_5$	Total Participants	Weighted Average
Poverty	2x1= 2	4x2=8	22x3=66	65x4=260	86x5=430	179	(2+8+66+260+430)/179= 4.28

The rating average is calculated as follows, where:

($x1w1$ + $x2w2$ + $x3w3$ ... $xnwn$) / Total number of Responses

w = weight of answer choice
x = response count for answer choice

NEW YORK STATE | Department of Health

Survey Results- Rank of All Health Issues

Rank	Issue	Rank	Issue	Rank	Issue
1	Poverty	16	Anxiety and Stress	31	Hepatitis C
2	Prenatal Care and Maternal Mortality	17	Adverse Childhood Experiences	32	Sexually Transmitted Infections (STIs)
3	Nutrition Security	18	Oral Health	33	HPV Vaccine for Adolescents
4	Drug Overdose Death	19	Injuries and Violence	34	Built and Indoor Environments
5	Health Insurance Access	20	Education Access	35	Social Cohesion
6	Housing Stability and Affordability	21	Safe Community	36	Climate Change
7	Infant Mortality	22	Tobacco/ E-cigarette Use	37	Outdoor Air Quality
8	Healthy Eating	23	Lead Poisoning	38	Healthcare Associated Infections
9	Suicide	24	Language Access	39	End of Life Care and Planning
10	Children Receive Appropriate Screening and Services	25	Human Immunodeficiency Virus (HIV)	40	Indoor Radon
11	Depression	26	Teen Pregnancy	41	Cannabis Use
12	Early Intervention	27	Alcohol Consumption	42	Foodborne Illness
13	Unemployment	28	Water Quality	43	Compulsive Gambling
14	Healthy Aging Ecosystem (i.e., preventive services for chronic disease and associated risk factors)	29	Healthy Schools' Environment	44	Tickborne Diseases
15	Physical Access and Proximity to Health Services	30	Access to Exercise Opportunities		

Weighted Voting Survey

Limitations

- Response Rate
- Subjectivity in Weight Assignment
- Non-response Bias

Poverty

Interventions/ Strategies

Hospitals

1. Partner with local nonprofits to integrate economic services such as financial coaching, tax preparation, and economic bundles into the medical home and clinics.

2. Incorporate strategies to screen patients for resource insecurities and social needs and connect patients to community resources.

3. Use Data to Identify disparities across patient groups.

Health Departments

Other Organization

Poverty

Interventions/ Strategies

Hospitals

Health Departments

1. Increase access to and utilization of financial aid programs for low-income families (i.e., child care subsidies and tax credits).

2. Collaborate with local nonprofits and financial institutions to develop strategies that encourage long-term savings and investment account usage (i.e., Children's Savings Accounts and baby bonds).

3. Maintain, sustain, expand policies and systems that address income security with respect to key living expenses (e.g., housing, taxes, childcare, health care).

Other Organization

Poverty

Interventions/ Strategies
Hospitals
Health Departments
Other Organization

1. Collaborate with local, state, and national governments to integrate health into all policy-making.

2. Partner with healthcare providers to deliver home- and community-based services and other evidence-based services for older adults.

3. Increase the capacity of CBO staff members to use evidence-based programs (EBPs) in communities experiencing health disparities. The intervention included a workshop, ongoing capacity-building supports like a customized web portal, resources, networking events, mini-grants, and technical assistance.

Unemployment

Interventions/ Strategies

Hospitals

1. Incorporate strategies to screen patients for resource insecurities and social needs and connect patients to community resources. [1]
2. Connect volunteer services to patients needing employment resources. [1]
3. Develop relationships and ongoing communication with local employment specialists and organizations. [1]
4. Use Data to identify disparities across patient groups.[2]
5. Create pathways utilizing existing resources to link patients seeking employment to obtain assistance from external agencies. [1]

Health Departments

Other Organization

Unemployment

Interventions/ Strategies

Hospitals

Health Departments

1. Develop relationships with community-based organizations that connect those facing unemployment with state and local resources or benefits. [1]

2. Facilitate relationships between healthcare organizations and employment services organizations. [1]

3. Engage with and maintain policies that align with equitable employment legislation. [2]

Other Organization

Unemployment

Interventions/ Strategies
Hospitals
Health Departments
Other Organization

1. Collaborate with local, state, and national governments to integrate health into all policy-making. [1]

2. Partner with health departments and healthcare settings to develop advocacy and service programs that improve access to employment. [2]

3. Build relationships with other local organizations that advocate for equitable and accessible employment for community members. [2]

Housing Stability and Affordability

Interventions/ Strategies

Hospitals

1. Partner with local organizations to create pathways for referrals to permanent supportive housing and other alternative housing sources.[1]

2. Incorporate strategies to screen patients for resource insecurities and social needs, and connect patients to community resources such as permanent supportive housing or other alternative housing services.[1,2]

3. Offer trauma-informed care training for staff to effectively provide referrals/interventions for patient populations experiencing homelessness.[3]

4. Use Data to Identify disparities across patient groups.[4]

Health Departments

Other Organization

Housing Stability and Affordability

Interventions/ Strategies
Hospitals
Health Departments

1. Develop relationships with community-based organizations that facilitate permanent supportive housing to those dealing with housing instability. [1]

2. Collaborate with state Medicaid agency to reduce housing instability and increase access to healthcare services. [2]

3. Partner with healthcare facilities to foster accessible programs and appropriate resources for people experiencing housing instability. [1]

Other Organization

Housing Stability and Affordability

Interventions/ Strategies
Hospitals
Health Departments
Other Organization

1. Collaborate with local, state, and national governments to integrate health into all policy-making. [1]

2. Increase staff capacity to utilize trauma-informed models of care when working with patients/clients experiencing housing instability. [2]

3. Build relationships with healthcare facilities, health departments, and other local organizations to increase access to resources for people experiencing housing instability. [3]

SDOHs

NYC Department of Health and Mental Hygiene

HealthyNYC Campaign

Location: NYC.

Partner with City agencies, health care institutions, private and nonprofit businesses, community- and faith-based organizations, state and federal leadership, and other.

HealthyNYC Goals

Goals across all drivers

Priority Strategies

To achieve the goals:

- Increase access to and quality of health care, mental health supports and health insurance options.
- Increase access to employment options.
- Address racial disparities in the way care is provided.
- Support community-led programming on health literacy, and increase community health worker presence in communities.
- Promote economic development.
- Improve access to affordable housing.
- Foster community investment in achieving HealthyNYC goals.

NEW YORK STATE | Department of Health

Poverty Intervention

NYC Health + Hospitals

Department of Consumer and Worker **Protection's (DCWP)** NYC Free Tax Prep initiative

- Location: Multiple Locations in Bronx, Brooklyn, Manhattan, and Queens.
- Partnership with BronxWorks, Grow Brooklyn, Urban Upbound, and Code for America's GetYourRefund initiative
- Focus on: New Yorkers who earned <$56,000 or less and are filing on their own or families who earned $80,000 or less.
- Service: virtual and In-person tax preparation.

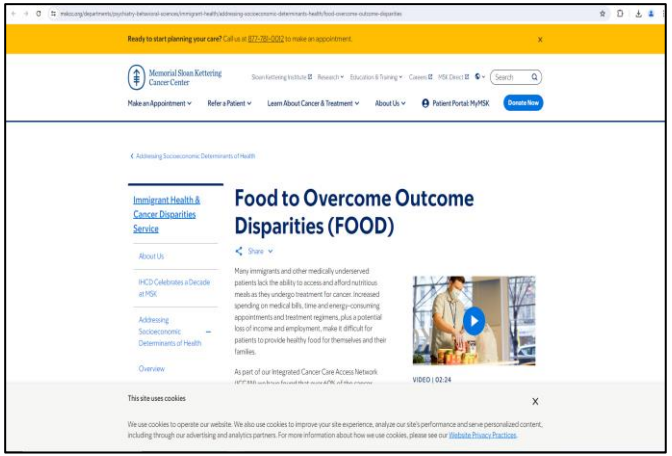
NEW YORK STATE | Department of Health

Food Insecurity

Memorial Sloan Kettering Cancer Center New York

Food to Overcome Outcome Disparities (FOOD)

- Location: *13 pantries co-located in cancer clinics serving patients in Manhattan, Queens, Brooklyn, the Bronx, and Long Island*.
- Partnership with NYC Food Bank, New York Common Pantry, Green Bronx Machine, and others.
- Focus on: Patients with Cancer.
- Services:
  - Free Food Distribution: Offers fresh fruits, vegetables, and healthy options low in sodium and sugar to help patients manage chronic conditions.
  - Provider Training Course: Educates healthcare providers on the importance of addressing food insecurity in clinical interactions with patients.



NEW YORK STATE Department of Health

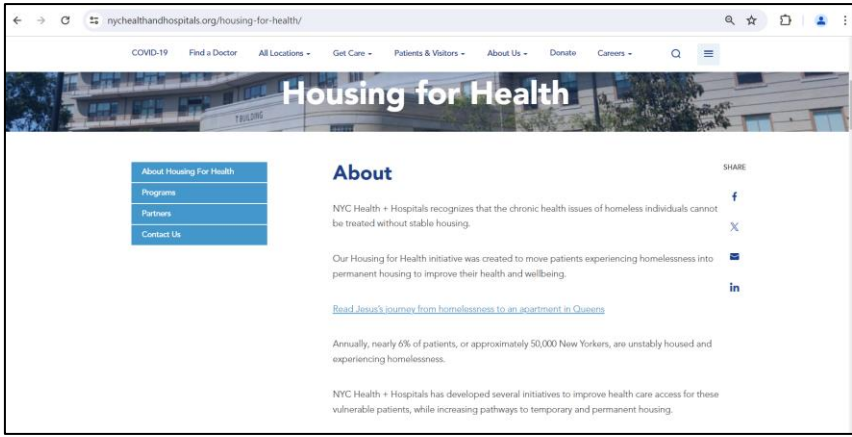
Housing

NYC Health + Hospitals

Housing for Health

Location: East Harlem.

- Partnership with community-based organizations, City and State housing and homelessness agencies, NYC Housing Development Corporation, NYC Department of Social Services, and others.
- Focus on: Patients experiencing homelessness.
- Services:
  - Offer temporary housing for patients experiencing homelessness who have been discharged from an acute care facility but still need specialized care not available in shelters.
  - Provide personalized support to assist patients in finding and applying for permanent housing that meets their specific needs.



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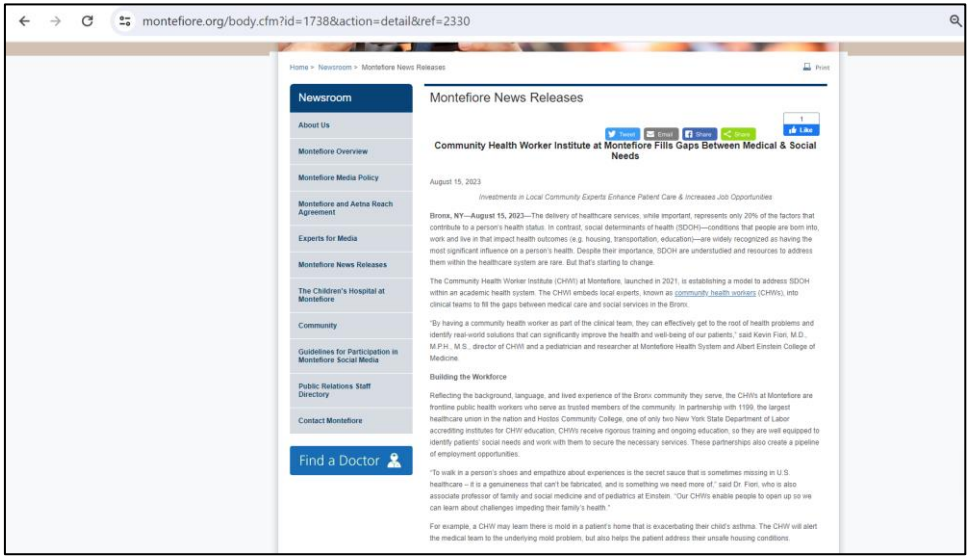
Employment/Education

Montefiore Medical Center

Community Health Worker Institute (CHWI)

Location: Bronx.

- Partnership with 1199 healthcare union and Hostos Community College
- Services:
  - Provide training and education to CHWs
  - Conducts research on SDOH and the impact of CHWs
    - Gather and analyze data on SDOH and health status.
- CHWI enhances Patient Care & Increases Job Opportunities



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