New York State Public Health Corps (NYSPHC) Fellowship Program

Educational Series

PREVENTION AGENDA 2019-2024: NEW YORK STATE'S HEALTH IMPROVEMENT PLAN

January 10th, 2024

Welcome!

Agenda

- Welcome and Agenda
- Learning Objectives
- Presentation
- Questions
- Closing/Evaluation/Program Updates

Welcome! Zahra Alaali & Salman Khan

Prevention Agenda 2019-2024: An Overview

NYSPHC Educational Series

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January 10, 2024

Objectives

- Recognize the Prevention Agenda purpose.
- Describe the role of stakeholders' engagement.
- Identify key findings, successes, and challenges of the 2019-2024 Prevention Agenda cycle.

The Prevention Agenda

The Prevention Agenda = New York State's Health Improvement Plan

- It is the blueprint for state and local action to improve the health and well-being of all New Yorkers and promote health equity across populations who experience disparities.

Vision: New York is the Healthiest State in the Nation for People of All Ages.

Goal: Improve health status of New Yorkers and reduce health disparities through an increased emphasis on prevention.

Common Acronyms

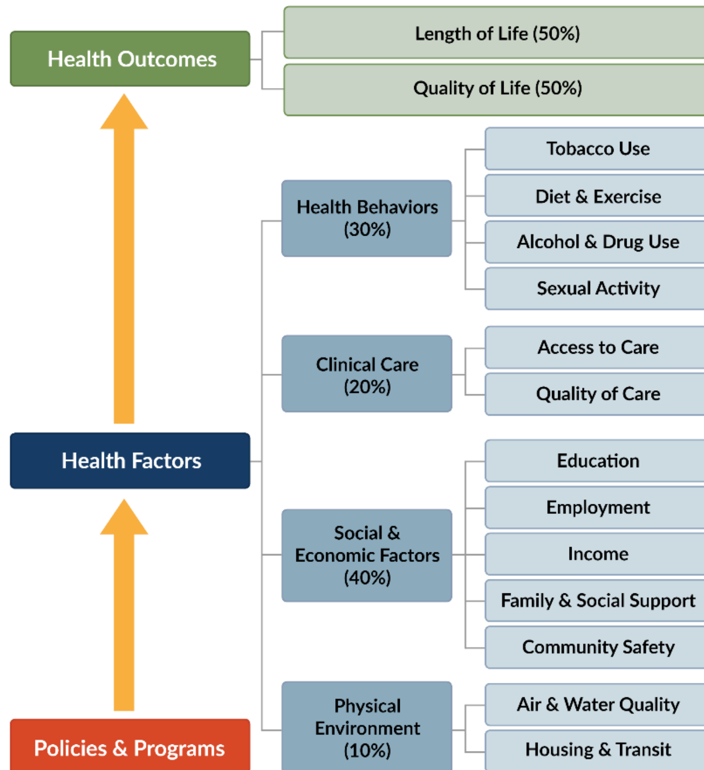
- **DOH:** Department of Health.
- **NYSDOH:** New York State Department of Health.
- **LHDs:** Local Health Departments.
- **SHA:** State Health Assessment.
- **SHIP:** State Health Improvement Plan.
- **CHA:** Community Health Assessment.
- **CHIP:** Community Health Improvement Plan.
- **CSP:** Community Service Plan.
- **DSRIP:** Delivery System Reform Incentive Payment.
- **PHAB:** Public Health Accreditation Board.

SHIP Process

PHAB describes the State Health Improvement Plan (SHIP) as follows:

- It is a systematic plan to address issues identified in the SHA.
  - Addresses the needs of all citizens in the state.
- Describes how DOH and the community it serves will work together to improve the health of the population.
- The plan development must include participation of broad set of community stakeholders and partners.
  - The planning and implementation process is community-driven.
- The plan reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.
- Can be used by the community, stakeholders, and partners to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.

County Health Rankings Model



- A guiding framework of the current Prevention Agenda.
- County Health Rankings' model of health explores the measures that influence how long and how well we live.
- Health Outcomes tell us how long people live on average within a community, and how much physical and mental health people experience in a community while they are alive.
- Health Factors represent those things we can improve to live longer and healthier lives. They are indicators of the future health of our communities.

History of the New York State Prevention Agenda

Prevention Agenda 2008 - 2012	Prevention Agenda 2013-2018	Prevention Agenda 2019 - 2024
• 10 Priorities including access to care. • NYS was the 28th healthiest state. • LHDs and Hospitals were asked to complete collaborative assessments and implementation plans aligned with Prevention Agenda. • Development and implementation of community health improvement efforts proved challenging.	• 5 priorities focused on prevention. • NY was the 15th healthiest state. • LHDs and hospitals strongly urged to collaborate and co-develop shared assessments and implementation plans. • NYSDOH provided feedback and required annual updates to monitor progress. • Hospitals asked to report community benefit spending and to link community benefit spending with implementation of Prevention Agenda interventions and with DSRIP investments.	•5 priorities focused on prevention. •NY was ranked 23rd healthiest state. •Health Across All Policies and Age-Friendly New York were implemented as underpinning frameworks for the Prevention Agenda. •Local health departments priorities were drastically altered by the COVID-19 pandemic.

Priorities Identified for the 2019-2024 Prevention Agenda

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders
- Prevent Communicable Diseases

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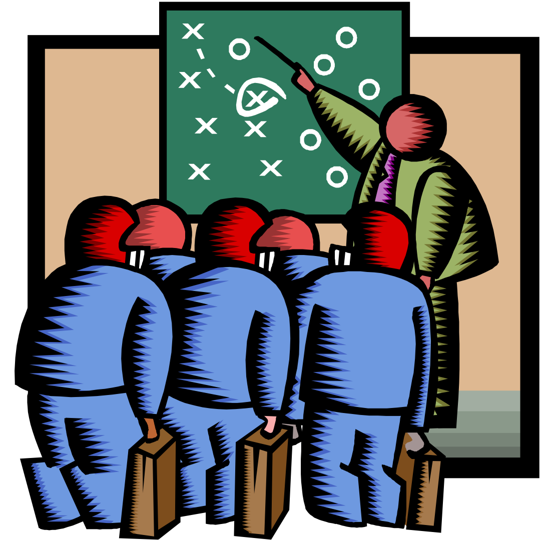
Focus Areas, Goals, Objectives, and Interventions

- **Focus Areas**
  - Goals
    - Measurable Objective(s)
    - Evidence Based Interventions
    - Resources for Implementation
    - Identification of populations/age groups affected
    - Identification of organizations that play leading or supporting roles



Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 1. Promote Well-Being
Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan
Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages
Focus Area 2. Mental and Substance Use Disorders Prevention
Goal 2.1 Prevent underage drinking and excessive alcohol consumption by adults
Goal 2.2 Prevent opioid and other substance misuse and deaths
Goal 2.3 Prevent and address adverse childhood experiences (ACES)
Goal 2.4 Reduce the prevalence of major depressive disorders
Goal 2.5 Prevent suicides
Goal 2.6 Reduce the mortality gap between those living with serious mental illness and the general population

Goal 2.2 Prevent opioid and other substance misuse and deaths

By December 31, 2024

Objective 2.2.1 reduce the age-adjusted rate of **overdose deaths** involving any opioids by 7% to 14.3 per 100,000 population.

Objective 2.2.2 increase the age-adjusted rate of patients who received at least one **Buprenorphine prescription** for opioid use disorder by 20% to 415.6 per 100,000 population. Baseline: 346.3 per 100,000 population.

Objective 2.2.3 reduce the **opioid analgesics prescription** for pain, age-adjusted rate, by 5% to 350.0 per 1,000 population.

Objective 2.2.4 reduce all **emergency department visits** (including outpatients and admitted patients) **involving any opioid overdose**, age adjusted rate by 5% to 53.3 per 100,000 population.

Promote Well-Being and Prevent Mental and Substance Use Disorders Interventions

Focus Area 2. Mental and Substance Use Disorders Prevention

Goal 2.1 Prevent underage drinking and excessive alcohol consumption by adults

+ **Objectives: By December 31, 2024**

+ **Interventions**

Goal 2.2 Prevent opioid and other substance misuse and deaths

+ **Objectives: By December 31, 2024**

- **Interventions**

  + 2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine
  + 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers
  + 2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations
  + 2.2.4 Build support systems to care for opioid users or at risk of an overdose
  + 2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days
  + 2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy

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Stakeholders Engagement

Stakeholders

Public Health and Health Planning Council (PHHPC)

- The Prevention Agenda is updated by the PHHPC at the request of the Department of Health.

Ad hoc committee

- More than 100 organizations across the state.
- Support the Prevention Agenda and recommend updates.
- Provide feedback on the overall approach and cross-cutting principles.
- Advises on how its members can strengthen local action and increase collaborative participation in Prevention Agenda efforts.

Core Partners

Core partners

- The New York State Office of Mental Health (OMH).
- The New York State Office of Alcoholism and Substance Abuse Services (OASAS).
- The New York State Office of Aging (NYSOFA)
- The New York State Department of State (NYSDOS)

The cross-sector partnership helps with identifying:

- Assets and resources.
- Evidence-based or best-practice interventions.
- Strategies/interventions that they will implement to advance the Prevention Agenda in improving the health of individuals of all ages.

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Local Health Departments and hospitals

Community Health Assessment (CHA)

- The health assessment conducted to identify key health needs and issues through systematic, comprehensive data collection and analysis.
- Also known as community health needs assessment (sometimes called a CHNA).

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

- A long-term, systematic effort to address public health problems based on the results of the CHA.
- Helps LHDs and hospitals move from data to action to address health priorities identified in the CHA.
- Updated every three years in New York State.
- The NYSDOH asks hospitals and LHDs to work together with their community partners to address the public health priorities identified in the Prevention Agenda.

2022-2024 CHAs/CHIPs

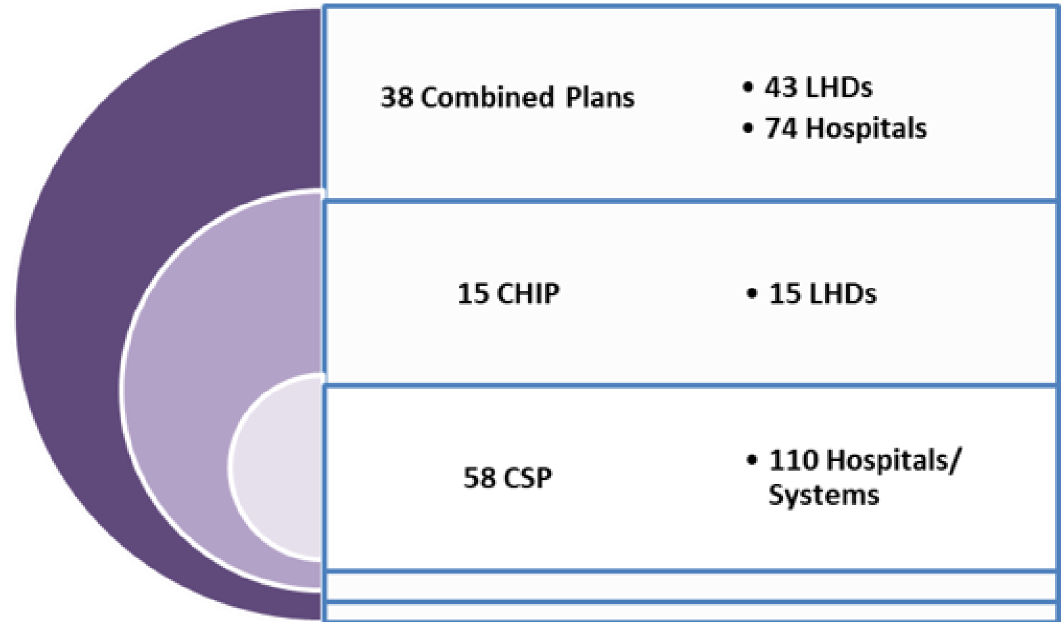
2022–2024 CHAs/CHIPs/CSPs

- The third cycle of the Prevention Agenda required Local Health Departments (LHDs) and Hospitals to select one of the following options:
  - Two Prevention Agenda Priorities and a minimum of one focus area for each priority; Or
  - One Prevention Agenda Priority and at least two focus areas; and
  - At least one of these priorities must address a disparity and promote health equity.
- LHDs and Hospitals within their county were encouraged to submit a combined plan to reflect the needs of the population they serve.

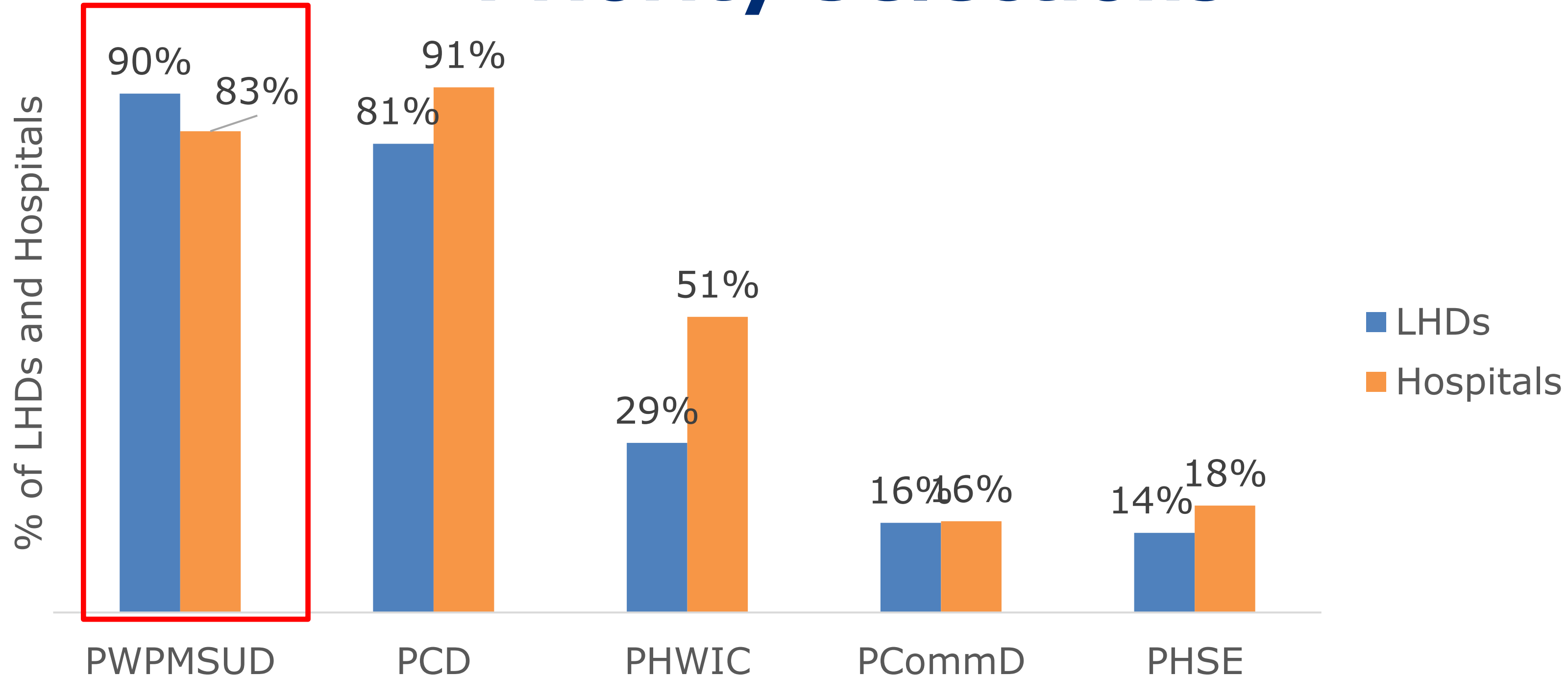
2022–2024 CHAs/CHIPs/CSPs

- A total of 111 plans were submitted by:
  - 58 LHDs.
  - 184 Hospitals.
- 74% of LHDs submitted combined plans with hospitals.
- 40% of hospitals submitted combined plans.

Figure 1: Community Health Plans for 2022-2024 Period.



Priority Selections



PHSE – Promote Healthy and Safe Environment
PCommD – Prevent Communicable Diseases
PHWIC – Promote Healthy Women, Infant and Children
PCD – Prevent Chronic Diseases
PWPMSUD – Promote wellbeing and Prevent Mental and Substance Use Disorders

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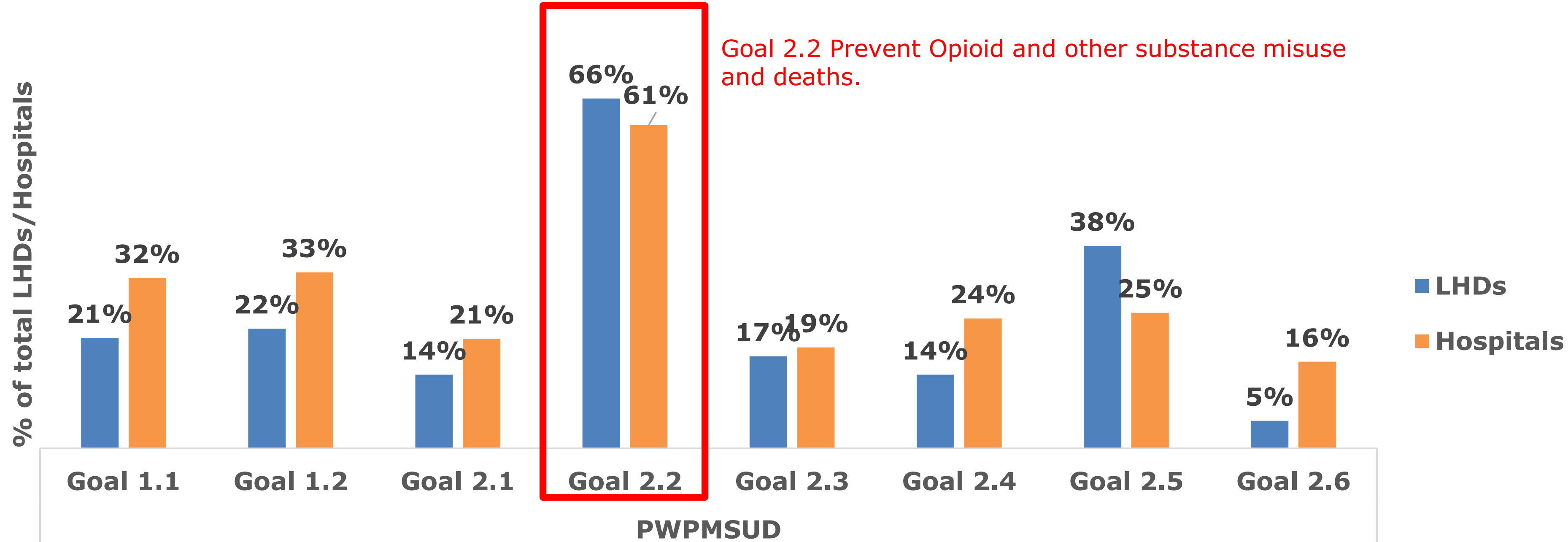
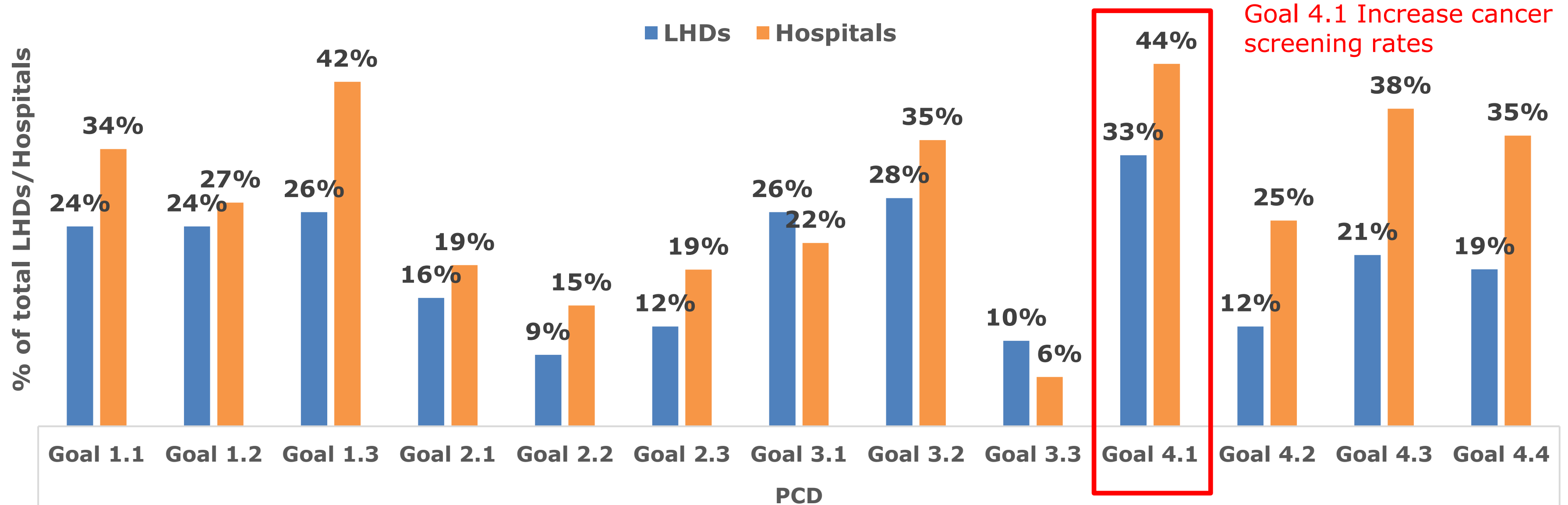
Promote Well-being and Prevent Mental and Substance Use Disorders (PWPMSUD) selected by 52 LHDs and 153 Hospitals

Goal 1.1 Build well-being and resilience
Goal 1.2 Supportive environments
Goal 2.1 Underage drinking
Goal 2.2 Opioid misuse and death
Goal 2.3 ACES
Goal 2.4 Major depressive disorders
Goal 2.5 Prevent suicides
Goal 2.6 Reduce mortality gap



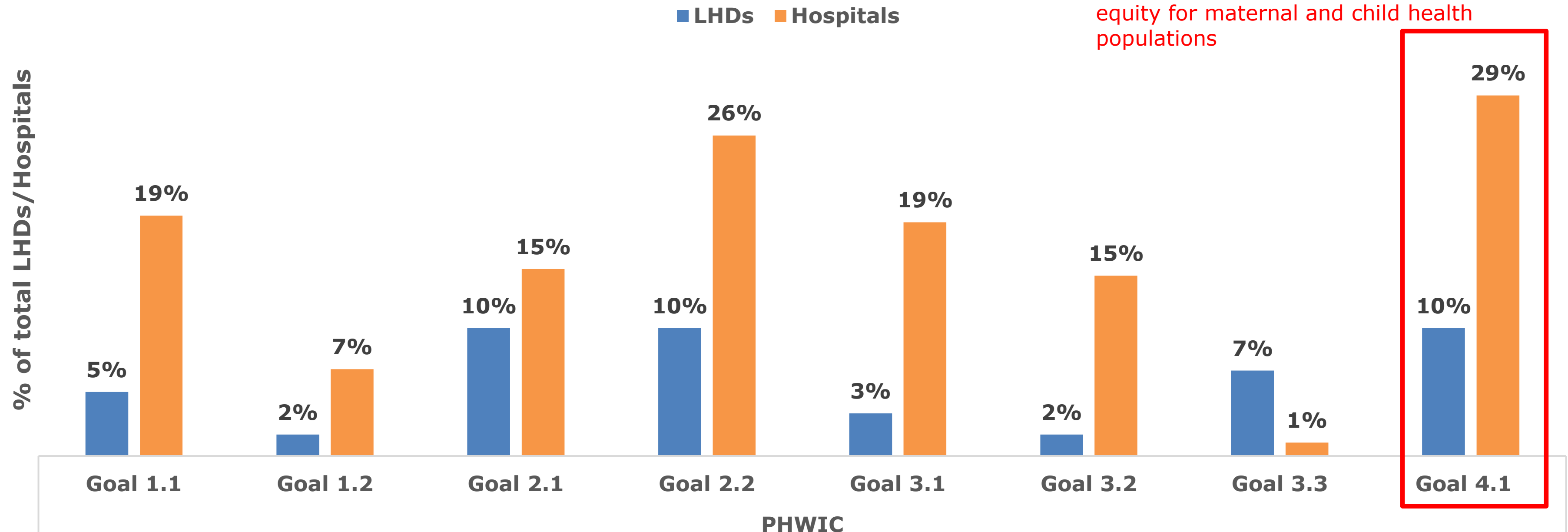
Prevent Chronic Diseases (PCD) selected by 47 LHDs and 167 Hospitals

Goal 1.1 Access to healthy foods
Goal 1.2 Increase skills and knowledge
Goal 1.3 Increase food security
Goal 2.1 Improve community environments
Goal 2.2 Promote schools, childcare and worksites
Goal 2.3 Access to indoor/outdoor places
Goal 3.1 Prevent initiation
Goal 3.2 Promote cessation
Goal 3.3 Secondhand smoke exposure
Goal 4.1 Cancer screening
Goal 4.2 Early detection
Goal 4.3 Evidence-based care
Goal 4.4 Self-management skills



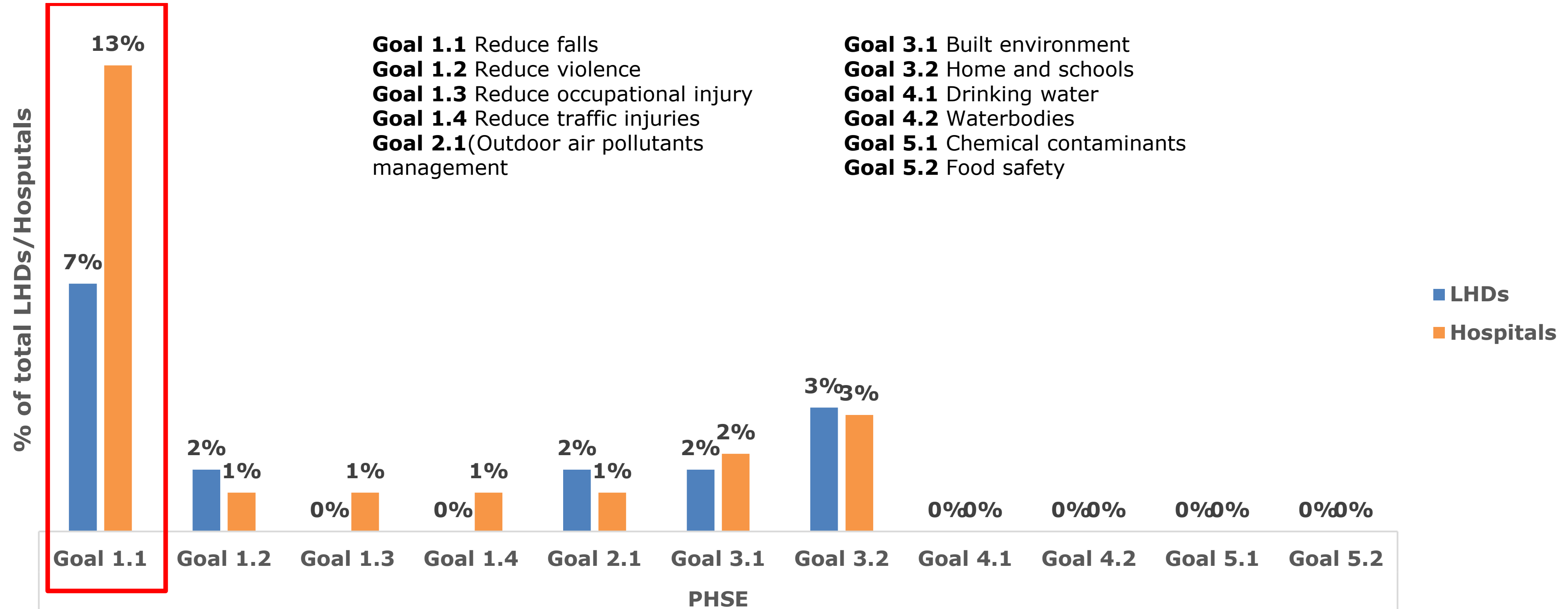
Promote a Healthy Women Infants and Children (PHWIC) selected by 17 LHDs and 94 Hospitals

Goal 1.1 Primary and preventing care
Goal 1.2 Maternal mortality & morbidity
Goal 2.1 Infant mortality & morbidity
Goal 2.2 Breastfeeding
Goal 3.1 Social-emotional development
Goal 3.2 Special health care needs
Goal 3.3 Dental caries
Goal 4.1 Health equity



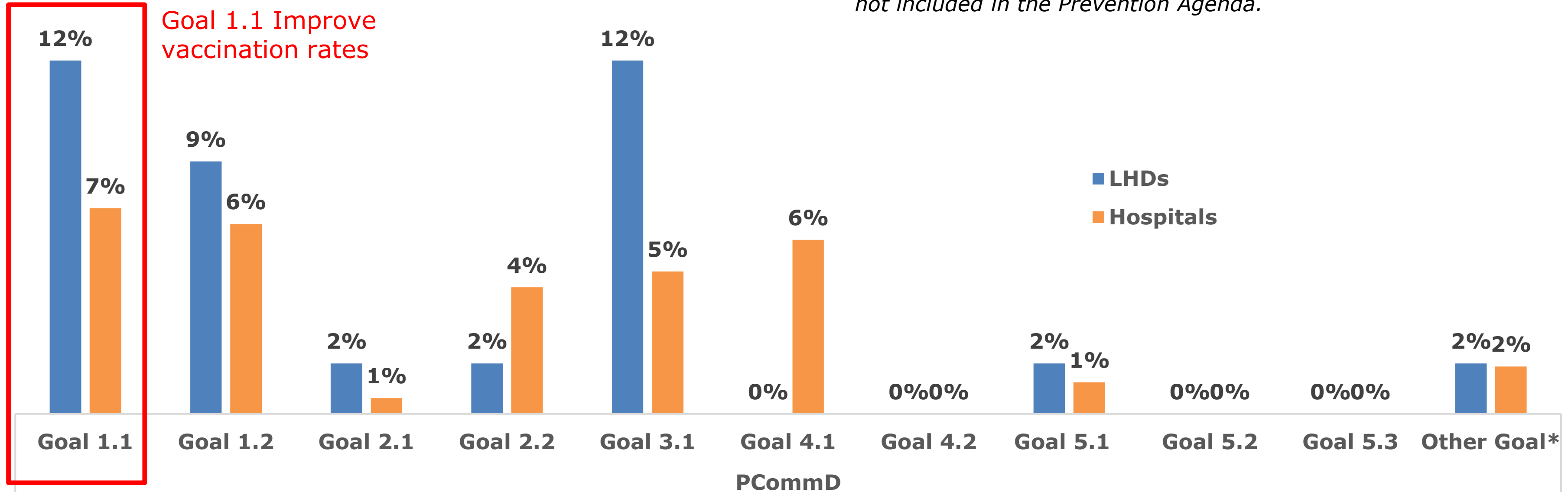
Promote a Healthy and Safe Environment (PHSE) selected by 8 LHDs and 34 Hospitals

Goal 1.1 Reduce falls among vulnerable populations



Prevent Communicable Diseases (PCommD) selected by 9 LHDs and 29 Hospitals

Goal 1.1 Vaccination rates
Goal 1.2 Vaccination disparities
Goal 2.1 HIV morbidity
Goal 2.2 Viral suppression
Goal 3.1 STIs
Goal 4.1 HCV treatment
Goal 4.2 HCV cases
Goal 5.1 Infection control)
Goal 5.2 Multidrug resistant organisms and C. difficile
Goal 5.3 Inappropriate antibiotic use
** Other Goal refer to goals identified as priority health issues by county's that were not included in the Prevention Agenda.*



Health Equity

- Most plans report an intent to address disparities
- Equity issues identified:
  - Socioeconomic status.
  - Race/ethnicity.
  - Health care access.
  - Geography.
  - Disabilities (e.g. social emotional behavioral).
  - Age and gender.
- Urban counties more likely to identify race/ethnicity.
- Rural/suburban more likely to identify socioeconomic status as a disparity.
- Most workplans not clear on how to measure impact on equity.

Summary of the Analysis – MOST Selected Goals

Promote well-being and Prevent Mental and Substance Use Disorders

Focus Area 1. Promote Wellbeing.

- Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages.

Focus Area 2. Mental and Substance Use Disorders.

- Goal 2.2 Prevent opioid and other substance misuse and deaths.

Prevent Chronic Diseases

Focus Area 4. Chronic Disease Preventive Care and Management.

- Goal 4.1 Increase Cancer Screening Rates.
- Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.

Focus Area 1. Healthy Eating and Food Security.

- Goal 1.3 Increase food security.

Summary of the Analysis – Goals NOT Selected

Prevent Communicable Diseases

Focus Area 4. Hepatitis C Virus (HCV).

- Goal 4.2 Reduce the number of new HCV cases among people who inject drugs.

Focus Area 5. Antibiotic Resistance and Healthcare-Associated Infections.

- Goal 5.2 Reduce infections caused by multidrug resistant organisms and C. difficile.
- Goal 5.3 Reduce inappropriate antibiotic use.

Promote a Healthy and Safe Environment

Focus Area 4. Water Quality.

- Goal 4.1 Protect water sources and ensure quality drinking water.
- Goal 4.2 Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water.

Focus Area 5. Food and Consumer Products.

- Goal 5.1 Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure.
- Goal 5.2 Improve food safety management.

Progress Update

2019–2024 Prevention Agenda Progress

Number of Indicators

99

Indicator Status

Met 29.3%

Unmet 70.7%

Indicator Performance

Worsened n=24 24.2%

N/A n=1 1.0%

Improved n=33 33.3%

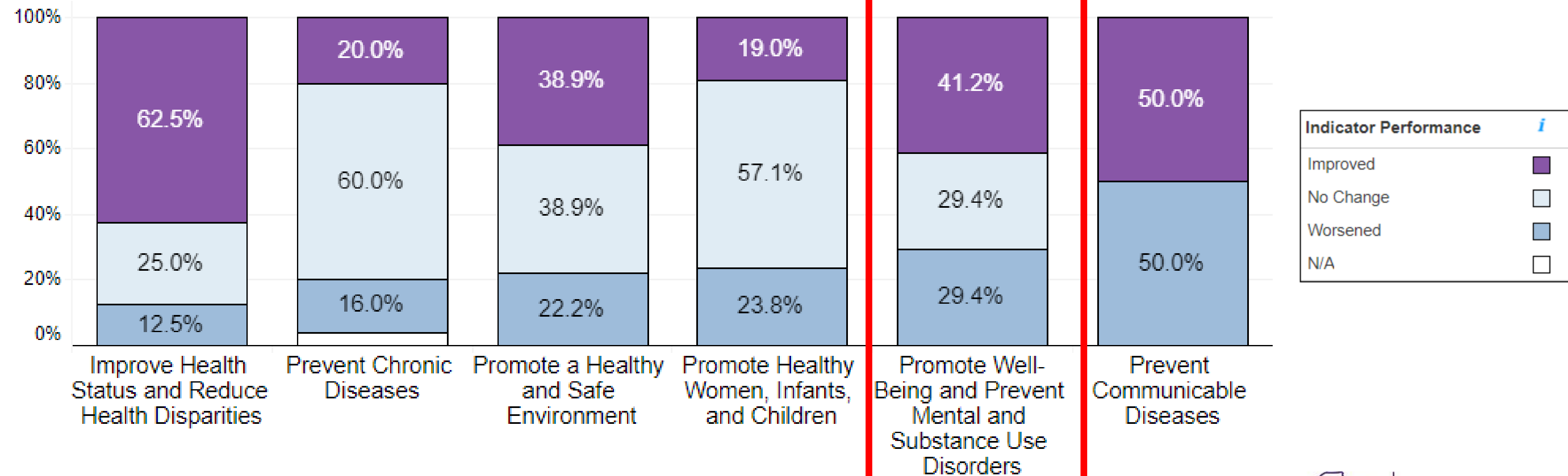
No Change n=41 41.4%

Indicator Performance	
Improved	
No Change	
Worsened	
N/A	

As of November 2023

[New York State Prevention Agenda Dashboard (ny.gov)](#)

2019–2024 Prevention Agenda Progress



As of November 2023

[New York State Prevention Agenda Dashboard (ny.gov)]

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Indicators that have been met

Improve Health Status and Reduce Health Disparities

- Premature deaths (before age 65 years), difference in percentages between Black non-Hispanics and White non-Hispanics.
- Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000.

Prevent Chronic Diseases

- Percentage of adults with an annual household income less than $25,000 who consume one or more sugary drinks per day.
- Prevalence of combustible cigarette use by high school age students.
- Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines, aged 50-64 years.
- Asthma emergency department visits, rate per 10,000, aged 0-17 years.

Indicators that have been met

Promote a Healthy and Safe Environment

- Assault-related hospitalizations, ratio of rates between Black non-Hispanics and White non-Hispanics.
- Assault-related hospitalizations, ratio of rates between Hispanics and White non-Hispanics.
- Firearm assault-related hospitalizations, rate per 10,000 population.
- Percentage of population living in a certified Climate Smart Community.
- Percentage of people who commute to work using alternate modes of transportation (e.g., public transportation, carpool, bike/walk) or who telecommute.
- Number of homes tested per year for radon, three-year average.
- Number of homes mitigated per year for radon, three-year average.
- Number of public water systems per year that were awarded infrastructure improvement assistance, three-year average.

Indicators that have been met

Promote Health Women, Infants, and Children

- Percentage of women with a preventive medical visit in the past year, aged 45+ years.
- Percentage of women who report that a health care provider asked them about depression symptoms at a postpartum visit.
- Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges.
- Percentage of children who received a developmental screening using a parent-completed screening tool in the past year, aged 9-35 months.
- Percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale.

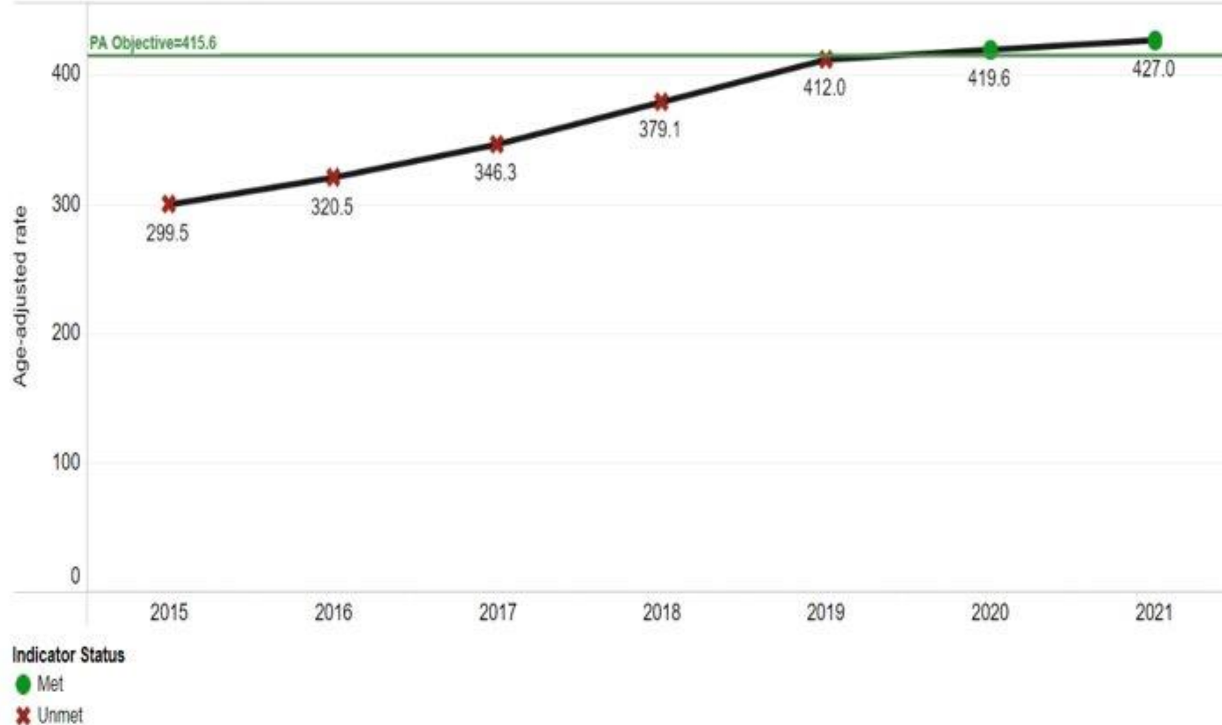
Indicators that have been met

Prevent Communicable Diseases

- Percentage of 13-year-old adolescents with a complete HPV vaccine series.
- Gonorrhea diagnoses, age-adjusted rate per 100,000 population.
- Chlamydia diagnoses, age-adjusted rate per 100,000 population.
- Early syphilis diagnoses, age-adjusted rate per 100,000 population.
- Number of individuals with a syringe transaction at an AIDS Institute-registered syringe exchange program.

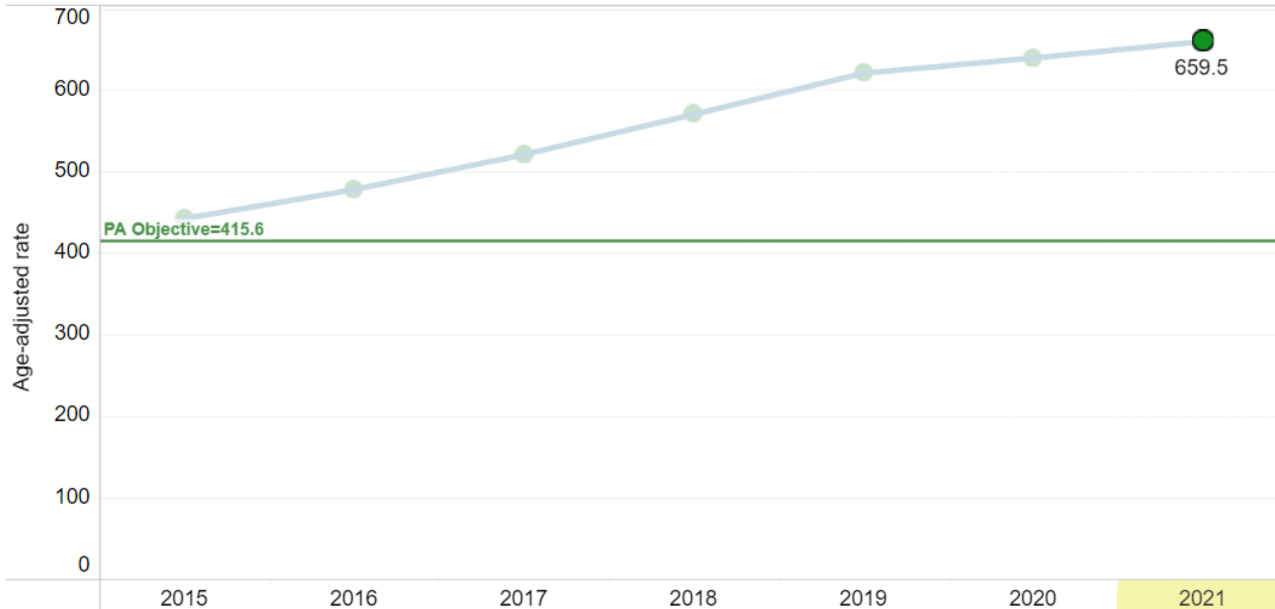
Promote Well-Being and Prevent Mental and Substance Use Disorders

- Binge drinking during the past month among adults, age-adjusted percentage.
- Patients who received at least one buprenorphine prescription for opioid use disorder, age-adjusted rate per 100,000 population.
- Opioid analgesic prescription, age-adjusted rate per 1,000 population.
- Indicated reports of abuse/maltreatment, rate per 1,000 children - aged 0-17 years.
- Percentage of high school students who attempted suicide one or more times during the past year.



Data source: New York State Prescription Monitoring Program Registry

- More patients with opioid use disorder received buprenorphine treatment, although prevalence of opioid use and dependence likely decreased for NYS.
- Despite the impact of COVID pandemic, NYS continues to make progress with increasing the rate for patients with OUD to receive this treatment.
- In response to disruption in care during the pandemic, telehealth efforts were expanded to allow for initiating and continued prescribing of buprenorphine.



- For NYS outside of NYC, the age-adjusted rates of patients with at least one buprenorphine prescription have continued to increase through 2021.

Data source: New York State Prescription Monitoring Program

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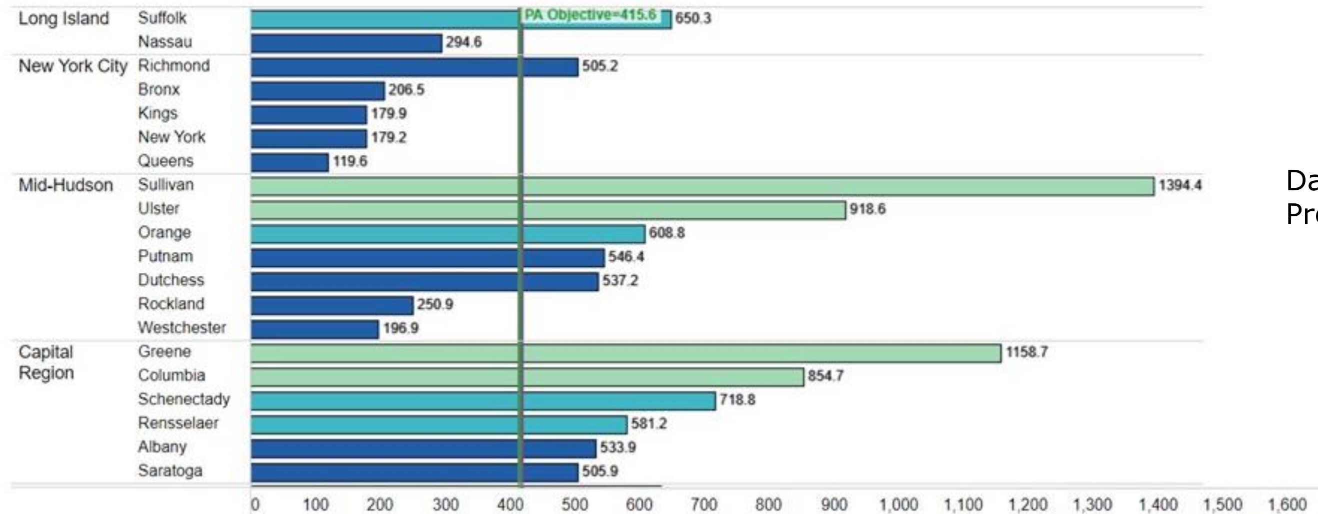


Data source: New York State Prescription Monitoring Program

- Counties in NYC, Long Island, and the Mid-Hudson Valley were among those with the lowest age-adjusted rates for patients who received a buprenorphine prescription.
- NYC has historically had more availability of methadone treatment for OUD as compared with the rest of the state which may be a factor in the lower rates of buprenorphine prescriptions among NYC residents.

Indicators that have not been met and are worsening

Improve Health Status and Reduce Health Disparities

- Percentage of premature deaths (before age 65 years)

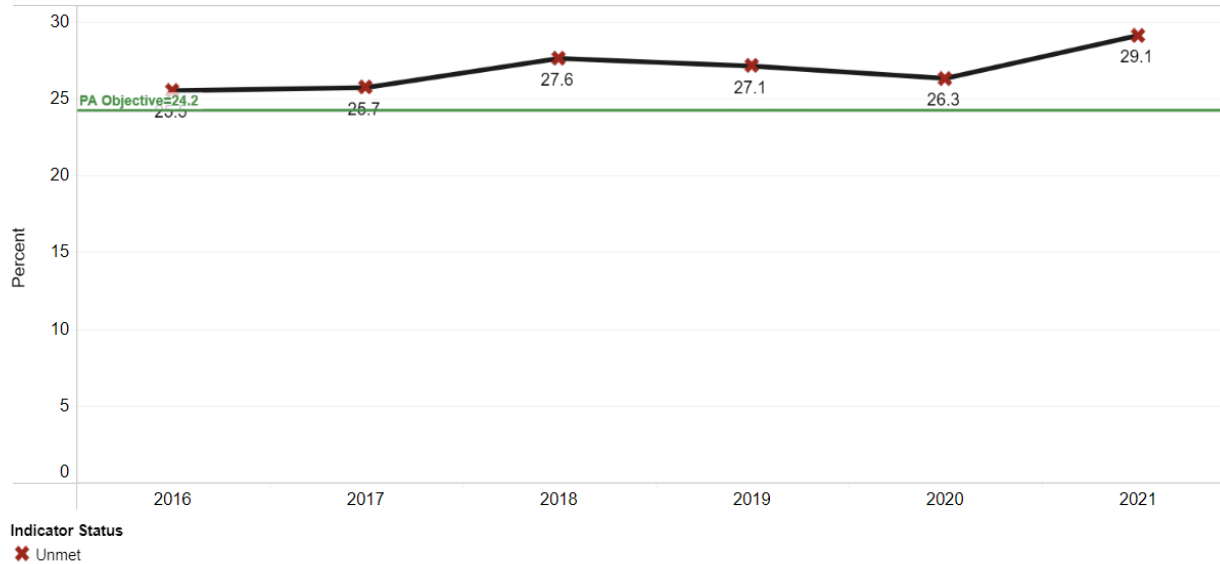
Prevent Chronic Diseases

- Percentage of children with obesity, among children aged 2-4 years participating in the WIC program
- Percentage of adults with obesity
- Percentage of adults with an annual household income less than $25,000 with perceived food security
- Percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition

Promote a Healthy and Safe Environment

- Crash-related pedestrian fatalities, rate per 100,000 population
- Percentage of registered cooling towers in compliance with 10 NYCRR Subpart 4-1
- Number of homes inspected for lead and other health hazards

Percentage of adults with obesity, New York State



Data Source: NYS Behavioral Risk Factor Surveillance System

- The percentage of adults with obesity has not met the 2024 Prevention Agenda objective of 24.2%.
- Most recently, the performance of this indicator worsened with an increase from 26.3% in 2020 to 29.1% in 2021.

Indicators that have not been met and are worsening

Promote Healthy Women, Infants, and Children

- Percentage of women who report ever talking with a health care provider about ways to prepare for a healthy pregnancy, aged 18-44 years.
- Percentage of very low birthweight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU).
- Percentage of infants who received diagnostic hearing test after failing most recent hearing screening.

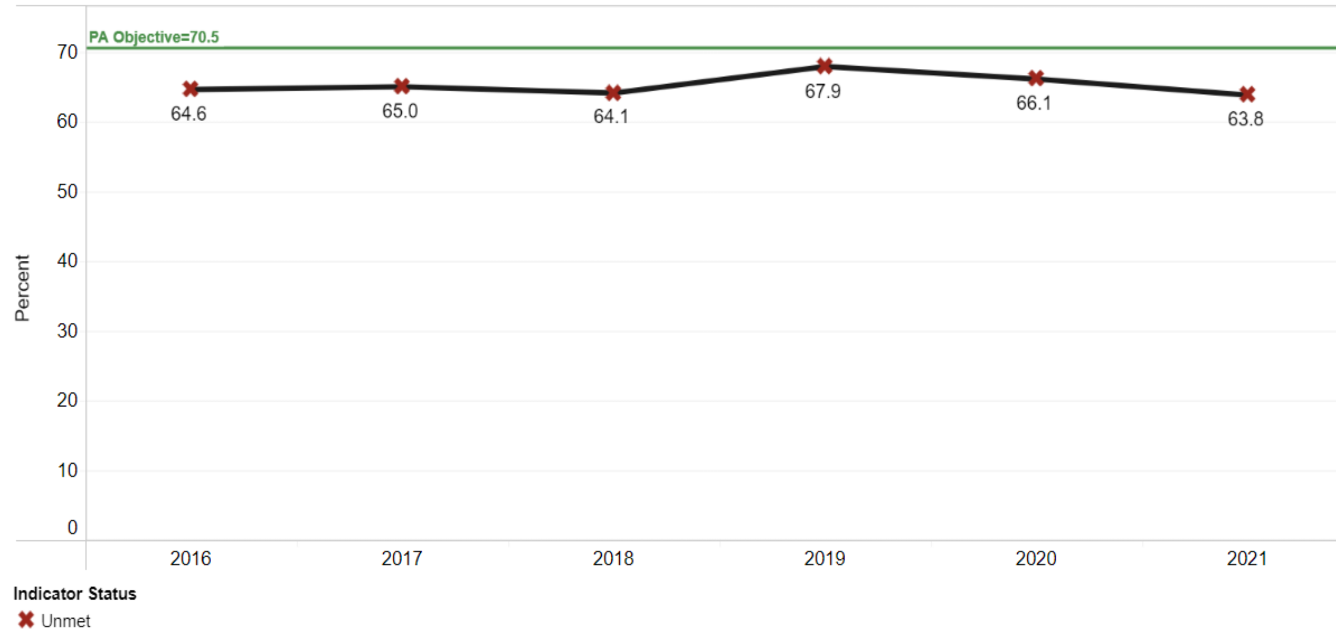
Promote Well-Being and Prevent Mental and Substance Use Disorders

- Overdose deaths involving any opioids, age-adjusted rate per 100,000 population.
- Emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate per 100,000 population.
- Percentage of adults who have experienced two or more adverse childhood experiences (ACEs).
- Percentage of adolescents with major depressive episodes during the past year - aged 12-17 years.
- Percentage of adults with major depressive episodes during the past year

Indicators that have not been met and are worsening

Prevent Communicable Diseases

- Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series.
- Difference in the 4:3:1:3:3:1:4 immunization series coverage by federal poverty level.
- Percentage of all persons living with diagnosed HIV who receive care with suppressed viral load.



- In 2019, percentage of children 24-35-months with completed series was 67.9%, nearing the 2024 Prevention Agenda Objective of 70.5%.
- Dropped to 63.8% by 2021.

Data Source: New York State Immunization Information System (NYSIIS) and Citywide Immunization Registry (CIR)

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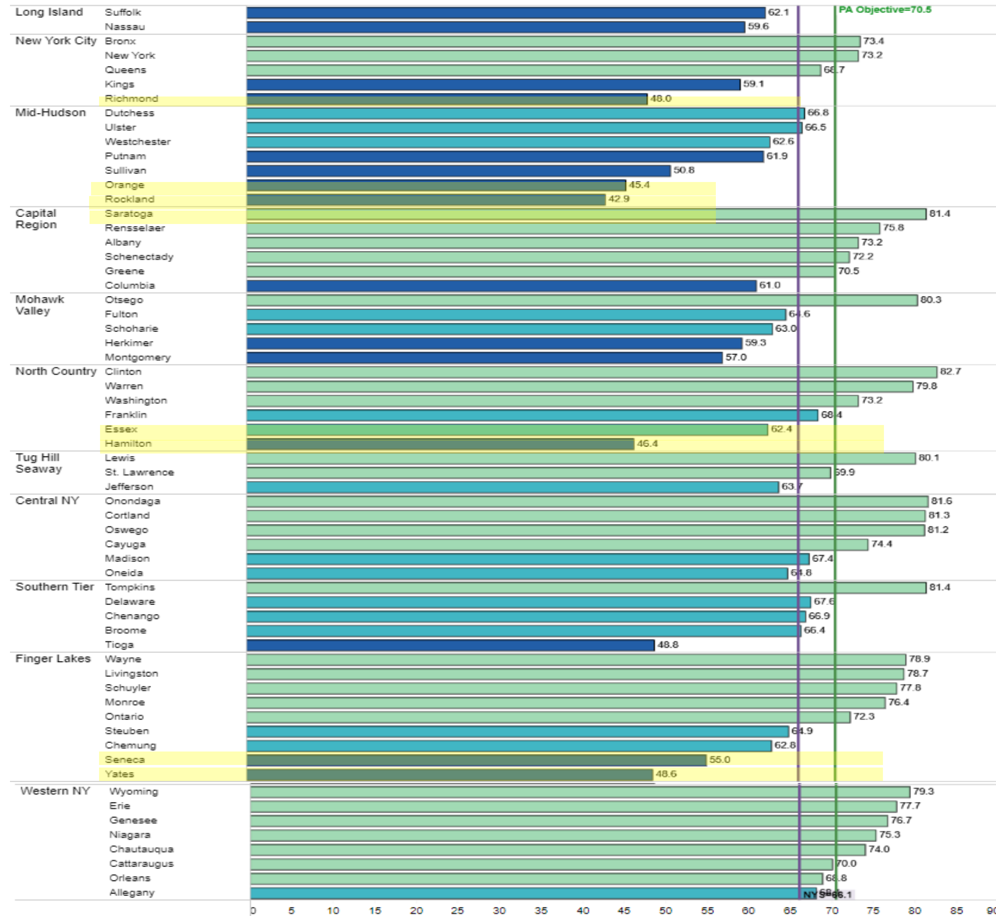
Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020



Data Source: New York State Immunization Information System (NYSIIS) and Citywide Immunization Registry (CIR), data as of October 2022

- During 2021, Rockland and Orange counties in the Mid-Hudson Valley had the lowest percentage of 24-35-month-old children with the immunization series with 39.1% (Rockland) and 43.3% (Orange).
- Additional counties with low percentages include Sullivan (49.1%), Essex (51.6), Franklin (48.4), Seneca (49.7), and Yates (45.8).
- Among NYC counties, Kings/Brooklyn had the lowest percentage, with 54.8% of 24-35-month-old children with the immunization series.

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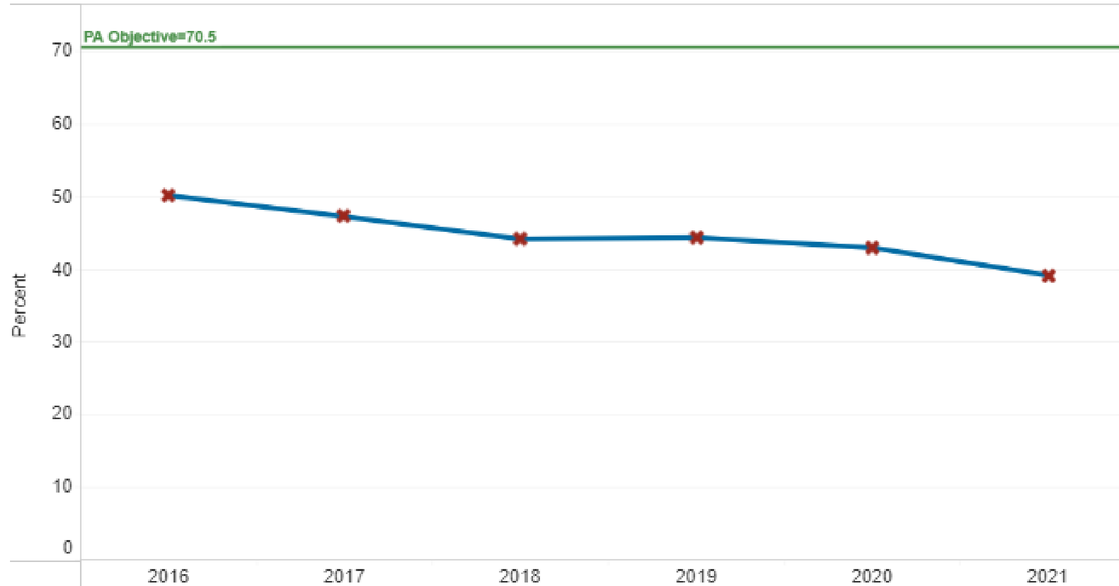


- Rockland County had lowest 2021 series completion.
- Declined from 50.1% in 2016, to 39.1% in 2021.
- Involved in multiple, significant VPD outbreaks;
  - Measles, 2018-2019
  - Polio, 2022-present
  - Intermittent pertussis outbreaks

Data Source: New York State Immunization Information System (NYSIIS) and Citywide Immunization Registry (CIR)

Prevention Agenda Dashboard

https://health.ny.gov/preventionagendadashboard

Prevention Agenda Tracking Dashboard › Reports

New York State Prevention Agenda State Dashboard

About Export

State: Main State Dashboard | State Socio-Demographics

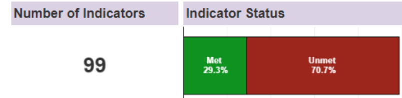
County: Main County Dashboard | County/Region Comparison | Map/Bar/Table | Sub-County

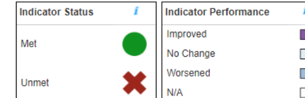
Reset

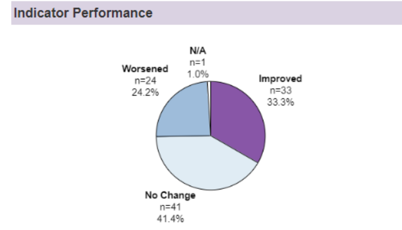
Click on categories in the charts below or the top-right legends to filter. Use Ctrl+Click to select multiple.

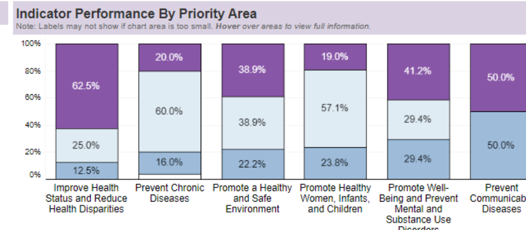
Number of Indicators

99









Select priority area(s) then indicator(s).

Select Priority Area (All)

Select Indicator (or enter search text) (All)

Hover over values to the right of the indicator name for more information where applicable. Click on a value to view the trend graph of the indicator.

Department of Health

{ Thank You! }

Prevention Agenda Team:

- Shane Roberts
- Zahra Alaali
- Salman Khan

Dashboard Team:

- Eli Rosenberg
- Trang Nguyen
- Stephanie Mack
- Changning Xu
- Gene Shackman
- Christopher Davis
- Naila Kabiraj
- Yunshu Li
- Gang Liu

Questions?

Please contact us at

Prevention@health.ny.gov

Closing, Announcements, Updates, Save the Date

New for Fellows: Educational Series Certificate Program!

After today's Educational Series event, we strongly encourage all **Fellows** to return to the LMS to complete the course quiz. **Why?**

In 2024, Fellows will have the ability to receive a professional development certificate of completion for viewing the Educational Series courses in the LMS and answering the associated quiz questions!

We encourage you to complete the three quiz questions associated with today's session in the LMS to receive credit towards the future Educational Series Certificate program!

Announcements & Updates

- Please complete the Evaluation Survey which you will be prompted to take when you close out of Zoom.
- If you want to continue the conversation, join the NYSPHC Fellowship Program LinkedIn Group to continue networking and professional development: https://www.linkedin.com/groups/14059709

Save the Date!

- Educational Series
  - February 14th, 2024, 12PM-1PM
  - April 10th, 2024, 12PM-1:30PM*
  - May 8th, 2024, 12PM-1PM
- Quarterly Consortia
  - March 2024

NYSPHC Training and Resources Website

https://nysphcresources.health.ny.gov/training-resource-center

Fellowship Program

Upcoming Events

Training Resource Center Home

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Fellow Training Resources

Mentor Training Resources

Resources by Region

Public Health Careers

NYSPHC Events Calendar

Thank you!