Cornell Cooperative Extension

Cornell Center for Health Equity

Cornell University
Office of Engagement Initiatives

A guide to New York State's 2019-2024 Prevention Agenda and Community Health Improvement Plans

2021 Edition

Introduction

Since 2008, the Prevention Agenda has served as New York State's health improvement plan for state and county action to improve the health and well-being of all New Yorkers and promote health equity across populations who experience disparities. Updated every 5 years, the Prevention Agenda is based on a comprehensive statewide assessment of health status and health disparities, changing demographics, and the underlying causes of death and diseases. It serves as a guide for addressing the unique needs of each New York State County.

Guided by the Prevention Agenda, every 3-5 years county health departments collaborate with their local hospitals and other community partners to conduct a Community Health Assessment (CHA). Multiple counties may work together to develop regional assessments but must make sure that county-specific needs are addressed. Based on the unique issues and assets of each county, these collaborative groups choose priority and focus areas, goals, objectives, and interventions directly from the Prevention Agenda to develop a Community Health Improvement Plan (CHIP).

Why read on?

Do you know which community health concerns your county and region will be working on for the next 3 years? As Cornell Cooperative Extension (CCE) continues to expand its role in public and community health, this report was created to provide an at-a-glance look at every CHIP in NYS county-by-county (with NYC represented by one DoH). The purpose of this report is to raise awareness and further opportunities for collaboration with your county health departments and other community-based organizations working toward the goals and priorities of the county CHIPs. Since Associations collaborate with counties unique to the CCE system (i.e., Shared Business Networks), this report could assist Associations in alignment both within their counties and across counties they already collaborate with within the CCE system.

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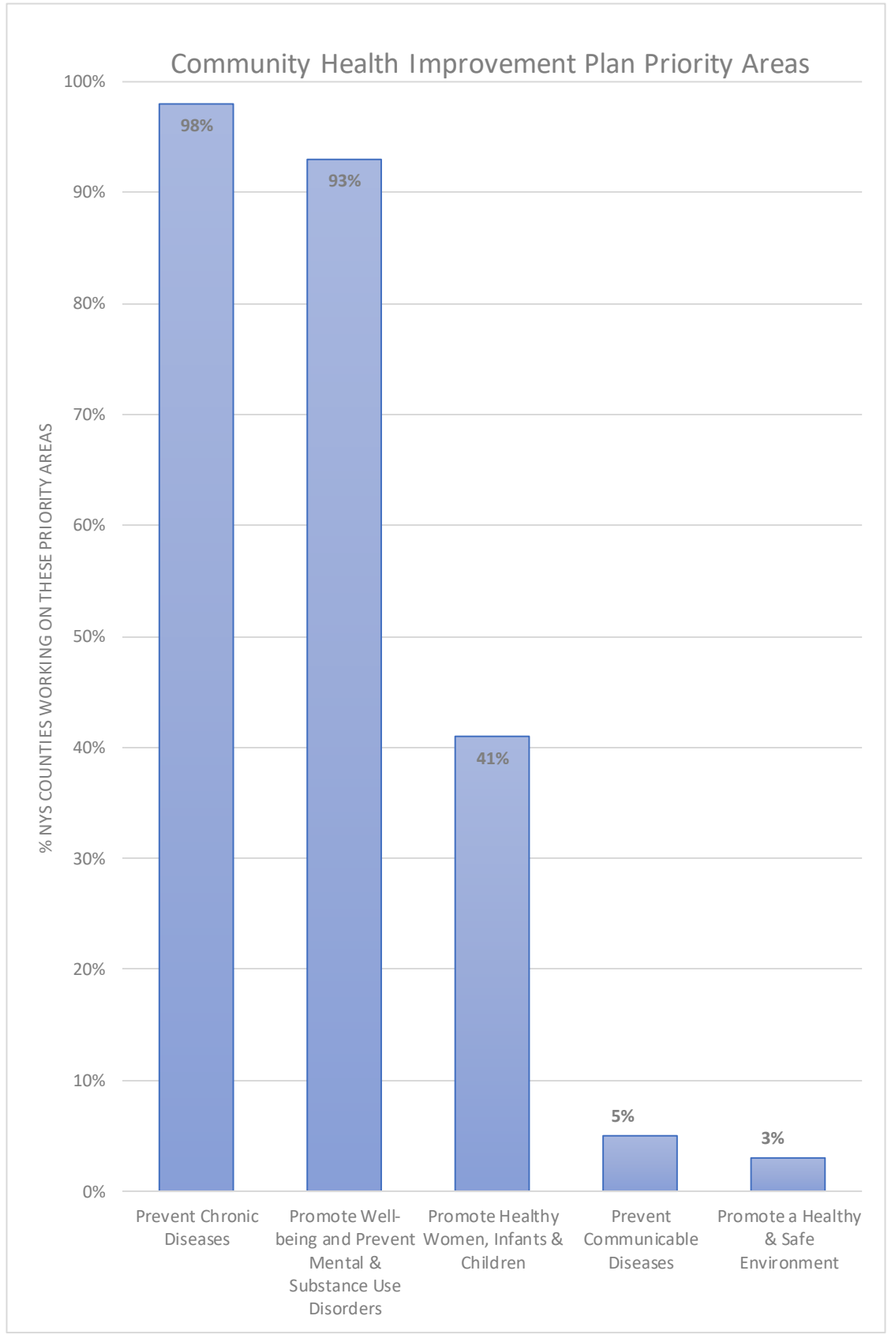

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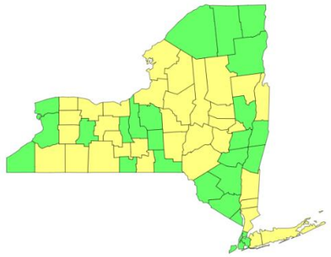
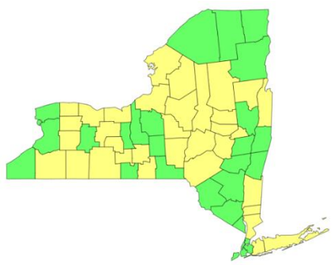
Prevent Chronic Diseases (98% of NYS Counties)*

Focus Area 1: Healthy Eating & Food Security (60% of counties)

Goals	Objectives	Interventions	Counties implementing intervention
Increase access to healthy and affordable foods and beverages 	Decrease the percentage of children with obesity (among **WIC children ages 2-4** years)	Quality nutrition in early learning and childcare settings	Broome, Chemung, Cortland, Onondaga, Rensselaer
	Decrease the percentage of children with obesity (among public school students in NYS exclusive of NYC)	Multi component school-based obesity programs	Broome, Cayuga, Chautauqua, Chemung, Clinton, Cortland, Essex, Livingston, Niagara, Onondaga, Orange, Rensselaer, Rockland, Sullivan, Ulster
	Decrease the percentage of children with obesity (among public school students in NYC)	Worksite nutrition and physical activity program	Albany, Broome, Cayuga, Chautauqua, Chemung, Clinton, Columbia, Cortland, Erie, Essex, Franklin, Greene, Livingston, Niagara, Onondaga, Orange, Rensselaer, Rockland, St. Lawrence, Saratoga, Seneca, Sullivan, Ulster, New York City DoH
	Decrease the percentage of adults ages 18 years and older with obesity (among all adults)		
	Decrease the percentage of adults ages 18 years and older with obesity (among **adults with an annual household income of <$25,000**)		
Increase skills and knowledge to support healthy food and beverage choices 	Decrease the percentage of all adults ages 18 years and older with obesity (among **adults living with a disability**)	Adopt policies to reduce sugary drinks consumption	Broome, Chenango, Cortland, Livingston
	Decrease the percentage of adults who consume one or more sugary drinks per day (among all adults)		
	Decrease the percentage of adults who consume one or more sugary drinks per day (annual income <$25,000)		
	Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults)	Increase the availability of fruits and vegetables incentive programs	Allegany, Broome, Cayuga, Clinton, Erie, Essex, Onondaga, Ontario, Orange, Rockland, Saratoga, Sullivan, Tompkins, New York City DoH
	Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (**non-Hispanic Black**)		
	Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (**Hispanic**)		
	Increase the percentage of adults who buy fresh fruits and vegetables in their neighborhood (**non-Hispanic Black**)		

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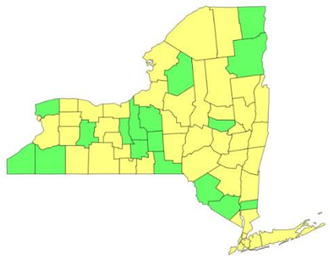
	Increase the percentage of adults who buy fresh fruits and vegetables in their neighborhood (**non-Hispanic Black**)		
Increase food security 	Increase the percentage of adults with perceived food security (among all adults) Increase the percentage of adults with perceived food security (**annual income <$25,000**)	Screen for food insecurity and facilitate/actively support referral	Broome, Cattaraugus, Cayuga, Chautauqua, Clinton, Cortland, Essex, Lewis, Livingston, Montgomery, Niagara, Onondaga, Orange, Putnam, Seneca, Sullivan, Tompkins

Focus Area 2: Physical Activity (43% of counties)

Goals	Objectives	Interventions	Counties implementing intervention
Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities	Decrease the percentage of children with obesity (among **WIC children ages 2-4 years**)	Adopt and implement policies that meet QUALITYstars NY standards to provide infants daily opportunities to move freely under adult supervision	Chemung
	Decrease the percentage of children with obesity (among public school students in NYS exclusive of NYC) Decrease the percentage of children with obesity (among public school students in NYC) Increase the percentage of high school students who were physically active for a total of at least 60 minutes/day on all 7 days (among all high school students)	Implement CDC Comprehensive School Physical Activity Program	Chautauqua, Cortland, Lewis, Livingston, Nassau, Onondaga, Orange, Rockland, Sullivan

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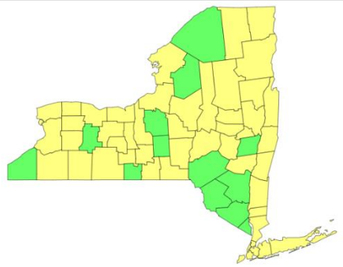
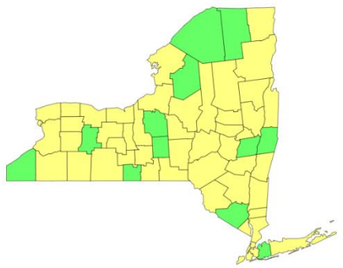
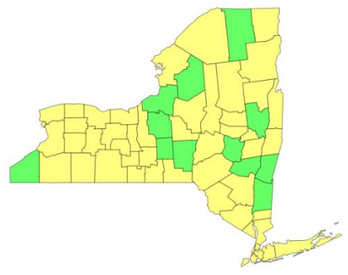
	Increase the percentage of high school students who were physically active for a total of at least 60 minutes/day on all 7 days (among **Black high school students**) Increase the percentage of high school students who were physically active for a total of at least 60 minutes/day on all 7 days (among **Hispanic high school students**)		
Promote school, childcare and worksite environments that increase physical activity 	Decrease the percentage of adults 18+ with obesity (among all adults) Decrease the percentage of adults 18+ with obesity (among adults with an **annual household income of <$25,000**) Decrease the percentage of all adults 18+ with obesity (among **adults living with a disability**) Increase the percentage of adults 18+ meet the aerobic and muscle strengthening physical activity guidelines (among all adults) Increase the percentage of adults 18+ who meet the aerobic and muscle strengthening physical activity guidelines (**among adults with less than a high school education**) Increase the percentage of adults 18+ who meet the aerobic and muscle strengthening physical activity guidelines (among **adults with disabilities**) Increase the percentage of adults 65+ who meet the aerobic and muscle strengthening physical activity guidelines	Implement worksite based physical activity policies, programs, or practices	Albany, Erie, Franklin, Livingston, Rensselaer, Rockland, Saint Lawrence, Sullivan
		Implement and/or promote a combination of community walking, wheeling, or biking programs	Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Franklin, Greene, Hamilton, Lewis, Onondaga, Oswego, Suffolk, Sullivan
Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity 	Increase the percentage of adults 18+ who participate in leisure-time physical activity (among **adults with less than a high school education**) Increase the percentage of adults 18+ who participate in leisure-time physical activity (among **adults with disabilities**) Increase the percentage of adults 65+ who participate in leisure-time physical activity Increase the percentage of adults 18+ who walk or bike to get from one place to another (among all adults)	Implement a new or improved pedestrian/bicycle/transit transportation system (activity-friendly routes)	Chautauqua, Chemung, Lewis, Livingston, Onondaga, Orange, Rockland, Saint Lawrence, Schoharie, Sullivan, Ulster

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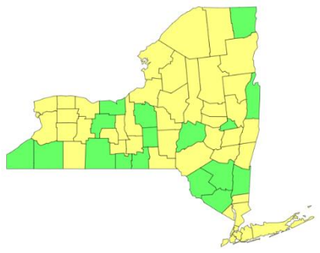
	Increase the percentage of adults 18+ who walk or bike to get from one place to another (**among adults with less than a high school education**) Increase the percentage of adults 18+who walk or bike to get from one place to another (among **adults with disabilities**) Increase the percentage of adults 65+ who walk or bike to get from one place to another		

Focus Area 3: Tobacco Prevention (53% of counties)

Goals	Objectives	Interventions	Counties implementing intervention
Prevent initiation of tobacco use 	Decrease the prevalence of any tobacco use by high school students Decrease the prevalence of combustible cigarette use by high school students Decrease the prevalence of vaping product use by high school students Decrease the prevalence of combustible cigarette use by young adults age 18-24 years Decrease the prevalence of vaping product use by young adults age 18-24 years Increase the number of municipalities that adopt retail environment policies, including those that restrict the density of tobacco retailers, keep the price of tobacco products high, and prohibit the sale of flavored tobacco products	Increase Tobacco Control Program Funding to the CDC-Recommended level, to ensure a comprehensive tobacco control program.	Tioga
		Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.	Cattaraugus, Chemung, Clinton, Cortland, Dutchess, Onondaga, Ontario, Orange, Otsego, Schenectady, Steuben, Sullivan, Ulster, Washington, Wayne
		Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas.	Chautauqua, Chemung, Clinton, Cortland, Onondaga, Ontario, Ulster, Washington
		Keep the price of tobacco uniformly high by regulating tobacco company practices that reduce the real price of cigarettes through discounts.	Onondaga, Ulster, Washington
		Decrease the availability of flavored tobacco products including menthol flavors used in combustible and non-combustible tobacco products and flavored liquids including menthol used in electronic vapor products.	Dutchess, Ontario, Ulster
		Advocate with media parent companies to eliminate youth exposure to tobacco imagery and tobacco marketing in youth-rated movies.	Onondaga
Promote tobacco use cessation	Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1% Decrease the prevalence of cigarette smoking by adults 18+ (among all adults)	Assist medical and behavioral health care organizations and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment	Albany, Chautauqua, Clinton, Cortland, Essex, Franklin, Genesee, Jefferson, Madison, Onondaga, Orleans, Oswego, Putnam, Steuben, Washington, Wyoming

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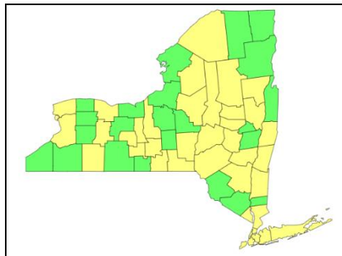
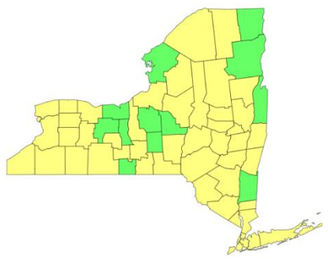
	Decrease the prevalence of cigarette smoking by adults 18+ (among **adults with income less than $25,000**)	Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encourage use of evidence-based quitting, increasing awareness of available cessation benefits and removing barriers to treatment	Cattaraugus, Chemung, Clinton, Essex, Franklin, Ontario, Orange, Putnam, Wayne
	Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among **adults with less than a high school education**)	Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence based quit attempts, to increase awareness of available cessation benefits (especially Medicaid) and to encourage health care provider involvement with additional assistance from the NYS Smoker's Quitline	Chautauqua, Chemung, Cortland, Franklin, Madison, Onondaga, Ontario, Sullivan
	Decrease the prevalence of cigarette smoking by adults 18+ (among adults reporting frequent mental distress)		
	Decrease the prevalence of cigarette smoking by adults ages 18+ (among **adults who self-identify as LGBT**)	Promote Medicaid and other health plan coverage benefit for tobacco dependence counseling and medications	Orange, Oswego, Schenectady, Sullivan, Washington
	Decrease the prevalence of cigarette smoking by adults 18+ (among **adults who are living with any disability**)		
	Increase the utilization of smoking cessation benefits (counseling and/or medications among **smokers who are enrolled in any Medicaid program**)		
Eliminate exposure to secondhand smoke 	Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes	Promote smoke-free and aerosol-free policies in multi-unit housing, including apartment complexes, condominiums, and co-ops, especially those that house low-SES residents	Chemung, Clinton, Cortland, Dutchess, Essex, Madison, Onondaga, Ontario, Seneca, Wayne
	Decrease the percentage of youth (middle and high school students) who were in a room where someone was smoking on at least 1 day in the past 7 days	Increase the number of smoke free parks, beaches, playgrounds, college and other public spaces	Chemung, Clinton, Cortland, Essex, Madison, Onondaga, Ontario
	Increase the number of multi-unit housing units (focus should be on housing with higher number of units) that adopt a smoke-free policy by 5,000 units each year	Educate organizational decision makers, conduct community education, and use paid and earned media to increase community knowledge of the dangers of secondhand smoke exposure and secondhand aerosol/emission exposure from electronic vapor products	Cortland, Jefferson, Ontario, Seneca, Washington

Focus Area 4: Chronic Disease Care (76% of counties)

Goals	Objectives	Interventions	Counties implementing intervention
Increase cancer screening rates	Increase the percentage of **women with an annual household income less than $25,000** who receive a breast cancer screening based on most recent guidelines	Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts).	Broome, Cattaraugus, Essex, Franklin, Herkimer, Oneida, Suffolk, Tompkins, Ulster, Yates

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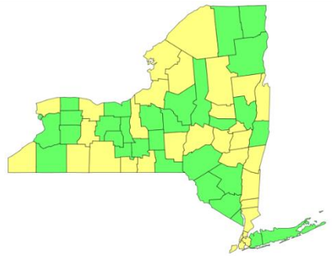
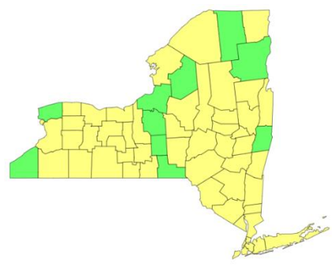
	Increase the percentage **of women with an annual household income less than $25,000** who receive a cervical cancer screening based on the most recent guidelines Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (**adults with an annual household income less than $25,000**) Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines	Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings.	Broome, Cortland, Essex, Franklin, Genesee, Herkimer, Montgomery, Nassau, Oneida, Onondaga, Ontario, Orange, Orleans, Suffolk, Sullivan, Tompkins, Wayne, Wyoming
		Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting).	Clinton, Cortland, Erie, Genesee, Herkimer, Oneida, Ontario, Orleans, Rensselaer, Rockland, Saratoga, Schuyler, Suffolk, Wyoming, Yates
		Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand.	Delaware, Erie, Essex, Herkimer, Madison, Oneida, Ontario, Orange, Rockland, Schuyler, Seneca, Suffolk, Sullivan, Wayne, Yates
		Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance (Provider Assessment and Feedback).	Essex, Herkimer, Madison, Oneida, Onondaga, Orleans, Seneca, Wyoming
		Ensure continued access to health insurance to reduce economic barriers to screening	Essex, Franklin, Herkimer, Madison, Oneida, Orange
Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity 	Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Increase the percentage of **low-income (<$25,000) adults** 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Increase the percentage of children and adolescents ages 3 -17 years with an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year who received appropriate assessment for weight status during the measurement year by 5%	Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.	Broome, Cortland, Essex, Franklin, Lewis, Niagara, Rensselaer
		Promote strategies that improve the detection of undiagnosed hypertension in health systems	Broome, Chautauqua, Essex, Franklin, Onondaga, Oswego
Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis,	Decrease the percentage of adult Medicaid members with diabetes whose most recent HbA1c level indicated poor control (>9%)	Promote the use of Health Information Technology for: Measurement, Registry Development, Patient Alerts, Bi-Directional Referrals, Reporting.	Franklin, Hamilton, Lewis, Oneida, Onondaga, Ontario

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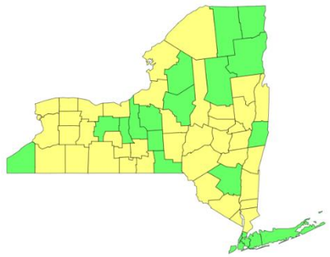
cardiovascular disease, diabetes and prediabetes and obesity 	Decrease the percentage of **adult Black Medicaid members** with diabetes whose most recent HbA1c level indicated poor control (>9%)	Promote referral of patients with prediabetes to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 5% to 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week.	Broome, Clinton, Essex, Franklin, Nassau, Oneida, Rensselaer, Seneca, Ulster
	Decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbA1c level indicated poor control (>9%)		
	Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year	Promote evidence-based medical management in accordance with national guidelines.	Broome, Cayuga, Clinton, Cortland, Franklin, Oneida, Onondaga, Rensselaer, Suffolk, New York City DoH
	Increase the percentage of **adult Black Medicaid members** who had hypertension whose blood pressure was adequately controlled during the measurement year	Promote a team-based approach (which may include pharmacist, community health worker, registered dietitian, podiatrist, and other health workers) to chronic disease care to improve health outcomes.	Chautauqua, Cortland, Essex, Franklin, Oneida, Onondaga, Oswego, New York City DoH
	Increase the percentage of adult Medicaid members 18-44 who had hypertension whose blood pressure was adequately controlled during the measurement year		
	Decrease the asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups	Promote strategies that improve access and adherence to medications and devices.	Franklin, Hamilton, Onondaga, Ontario
	Decrease the asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups	Counsel and refer patients with arthritis to increase physical activity, including participation in arthritis-appropriate evidence-based interventions and walking.	Chautauqua, Lewis
	Increase the percentage of Medicaid members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year		
	Increase the percentage of Medicaid members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year		
	Increase the percentage of adults with HTN who are currently taking medicine to manage their high blood pressure		
	Increase the percentage of adults with arthritis who have been told by their doctor or health professional to be physically active/exercise to help with arthritis or joint symptoms by 5%		

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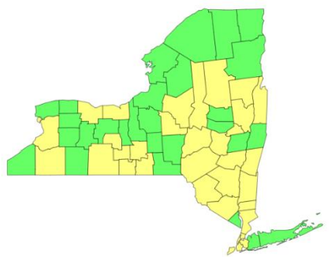
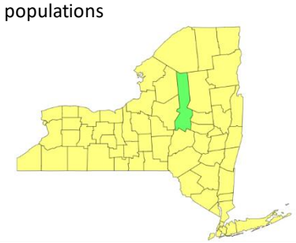
In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity 	Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition Increase the percentage of children (0-17) and adults (18+) with asthma who were ever given an asthma action plan by a doctor or health professional by 10% in both groups	Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.	Albany, Broome, Cayuga, Chautauqua, Chenango, Clinton, Cortland, Essex, Franklin, Jefferson, Lewis, Montgomery, Orleans, Rensselaer, Rockland, Saint Lawrence, Seneca, Suffolk, Wyoming
		Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone.	Albany, Allegany, Broome, Cayuga, Chenango, Cortland, Essex, Franklin, Fulton, Genesee, Jefferson, Lewis, Livingston, Nassau, Niagara, Onondaga, Ontario, Orleans, Oswego, Rensselaer, Rockland, Saint Lawrence, Suffolk, Wyoming
		Expand access to home-based multi-trigger, multicomponent visits by licensed professionals or qualified lay health workers to provide targeted, intensive asthma self-management education and to reduce home asthma triggers for individuals whose asthma is not well-controlled.	Albany, Rensselaer

Promote a Healthy & Safe Environment (3% of NYS Counties)*

Focus Area 1: Injuries, Violence and Occupational Health (1 county)

Goal	Objectives	Interventions	Counties implementing intervention*
Reduce falls among vulnerable populations 	Stop the annual increase in the rate of deaths due to falls among residents ages 65 and over by maintaining the rate at 4.1 per 10,000 residents Decrease the annual rate of hospitalizations due to falls among residents ages 65 and over by 5% to 173.7 per 10,000 residents	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.	Herkimer
		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.	Herkimer
Reduce violence by targeting prevention programs particularly to highest risk populations	Reduce rate of homicide deaths from 0.35 to 0.32 per 10,000. Reduce the rate of assault-related hospitalizations from 3.3 to 3.0 per 10,000.	Implement multi-sector (e.g., local health departments, criminal justice, hospitals, social services, job training, community based organizations) violence prevention programs such as SNUG, also known as Cure Violence, in high-risk communities, including those where gangs are prevalent.	
		Increase school based and community programs in conflict resolution, bystander interventions, and healthy relationship building.	

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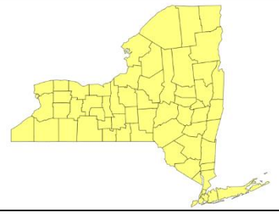
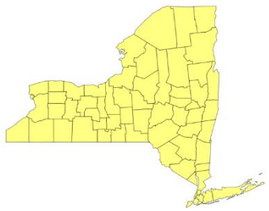
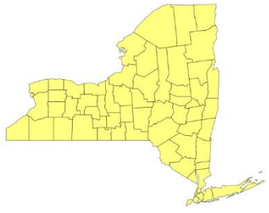
	Reduce disparity of assault-related hospitalizations by 10% Reduce the rate of ED visits due to assault from 42.3 to 38.1 per 10,000. Reduce the rate of hospitalization due to assault by firearm from 0.42 to 0.38 per 10,000	Reduce access to firearms for children and individuals at high-risk for violence.	
		Reduce neighborhood environmental risks (e.g., abandoned buildings, no lighting, deserted streets).	
		Increase educational, recreational and employment opportunities for potentially at-risk youth through after school and summer work experience programs or youth apprenticeship initiatives.	
Reduce occupational injury and illness 	Reduce disparities in work-related emergency department (ED) visits. Reduce disparities in work-related hospitalizations. Reduce the rate of ED visits for occupational injuries among adolescents 15-19 years of age.	Improve safety in workplaces: Develop targeted occupational safety and health training programs for employers and workers in high-risk jobs.	
		Educate teens about their rights and applicable regulations using curricula such as "Talking Safety" or "Passport to Safety", targeting vocational schools and industries hiring large numbers of young workers.	
		Incorporate industry and occupation into electronic health records and other patient-oriented databases.	
Reduce traffic related injuries for pedestrians and bicyclists 	Decrease the annual rate of crash-related pedestrian fatalities by 10% to 1.43 per 100,000 people. Decrease the annual rate of crash-related bicycle emergency department visits by 10% to 26.09 per 100,000 people.	Increase coordinated pedestrian injury prevention activities within the 20 NYS Pedestrian Safety Action Plan (PSAP) focus communities.	
		Provide training to increase enforcement of NYS Vehicle and Traffic Law pertaining to pedestrians.	
		Establish bicycle safety programs including a helmet distribution component. Bicycle helmets when used properly reduce head injuries by up to 88%. Helmet distribution programs should include bicycle safety education and actual fitting of recipients' helmets.	

Focus Area 2: **Outdoor Air Quality (no counties)**

Goal (% of NYS counties)	Objectives	Interventions	Counties implementing intervention*
Reduce exposure to outdoor air pollutants 	Reduce the annual number of days the with Air Quality Index (AQI) >100 to 3 or less (reflecting unhealthy daily ozone or PM levels). Implement policies that target vulnerable groups to reduce exposure to short-term increases in pollutant levels. (No data are available to measure at this time.)	Disseminate time sensitive outreach to regulated facilities serving vulnerable populations when air quality is, or is forecast to be unhealthy. An extensive body of research has found that the very young, the elderly, and people of any age with existing cardiovascular or respiratory disease are at increased risk for health effects from ozone and particulate air pollution.	
		Expand air quality health advisories to respond to episodic smoke events from industrial fires and wildfires. Originally developed to alert the public to pollution episodes based upon weather forecasts and monitoring data, NYSDOH is increasingly working to alert communities of air pollution that results from regional or local episodic events, such as wildfires, industrial fires or infrastructure failures that are not captured by the existing monitoring networks.	
		Implement policies that provide resources and guidance on ways individuals, communities, and governmental entities can work to reduce air pollution and CO2 equivalent emissions. Long term reductions in air pollutants and GHGs will hinge on government, community, and personal commitments.	

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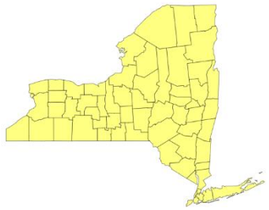
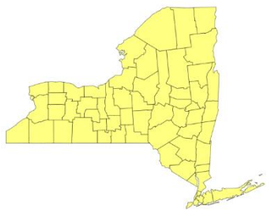
Focus Area 3: **Built and Indoor Environments (no counties)**

Goal (% of NYS counties)	Objectives	Interventions	Counties implementing intervention*
Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability and adaptation to climate change 	Increase the percentage of the population that live in a certified Climate Smart Community by 15%. Increase the percentage of people who commute to work using alternate modes of transportation (e.g., public transportation, carpool, bike/walk) or who telecommute by 5%. Ensure the availability and accessibility of cooling centers or other places where people can cool off during extreme heat events. (Underdeveloped; data is not available across the State.) Increase the percentage of registered cooling towers in compliance with 10 NYCRR Subpart 4-1, Cooling Towers, to reach 93% compliance. Improve control of Legionella in Article 28 facilities by improving the quality of environmental assessments and sampling and management plans prepared by Article 28 facilities. (Underdeveloped; complete dataset is unavailable at this time. May be measured in the future.)	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.	
		Identify and promote the availability and use of cooling centers and other resources to prepare for extreme heat events. A few hours of air-conditioning during an extreme heat event can prevent or reduce the impact of heat on health.	
		Enhance active transportation infrastructure by encouraging utilization and seeking opportunities to expand existing networks.	
		Engage with cooling tower owners and their stakeholders to increase knowledge of, and compliance with, 10 NYCRR Subpart 4-1, titled Cooling Towers. Cooling towers are a potential source of Legionella, the bacteria that causes legionellosis.	
		Engage Article 28 facility stakeholders to strengthen assessment and management of premise water systems, including using proper techniques, practices, and plan development. Healthcare facilities, such as hospitals and nursing homes, usually serve the populations at highest risk for Legionnaires' disease.	
Promote healthy home and school environments 	Increase health care provider's blood lead testing rates of children ages 0-6. Increase the number of homes that are inspected for lead and other health hazards. Reduce the number of children less than six years of age with a blood lead level of 5 ug/dL and over. (This objective may be measured in the future.) Increase the number of homes tested for radon. Increase the number of homes mitigated for radon as needed. Increase the number of houses built with radon resistant features. (No data are available to measure this objective statewide.) By 2024, 10% of NYS public, private, and charter schools enroll in the NYS Clean, Green, and Healthy Schools Program. Reduce children's risk of being exposed to environmental hazards at early care and education (ECE) programs. (Data are not available to measure this objective at this time.)	Educate healthcare providers and parents about blood lead testing requirements and importance. Educate healthcare providers to provide anticipatory guidance concerning lead poisoning prevention to parents and caregivers of children at child health visits	
		Promote the use of and increase referrals from healthcare providers, case management providers, community-based agencies, and others to the Local Health Departments with Primary Prevention Programs and Healthy Neighborhood Programs.	
		Conduct radon outreach and education programs for the public, applicable building construction contractors, and building officials and code inspectors.	
		Explore local level policy and/or code adoption to require radon resistant construction in high radon areas.	
		Promote healthcare provider screening for radon testing particularly in high-risk radon areas. Increase the number of physicians that ask their patients if they have had their homes tested for radon and refer them to the NYSDOH, as needed.	
		Implement the NYS Clean, Green, and Healthy Schools Program in schools across NYS. The program helps schools improve the health and safety of their school environment, which may result in better health, attendance, productivity, and test scores.	
		Promote outreach and increase education regarding environmental hazards among individuals leading and supporting the licensing of early care and education (ECE) programs.	

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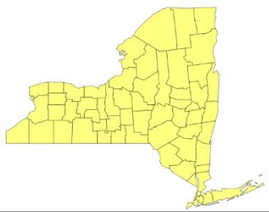
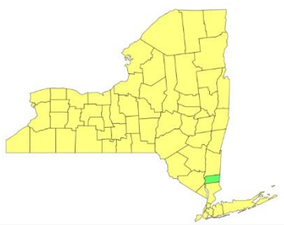
Focus Area 4: Water Quality (1 county)

Goal (% of NYS counties)	Objectives	Interventions	Counties
Protect water sources and ensure quality drinking water 	Increase the number of public water systems that apply for and are awarded infrastructure improvement assistance to reduce exposure to regulated and emerging contaminants and public health impacts associated with aged infrastructure. Promote sustainability by advancing policies and practices that protect NYS drinking water quality and quantity, through source water protection and watershed management planning. (Data may be developed and measured in the future.)	Promote funding opportunities (e.g., DWSRF) through webinars and notices to stakeholders engaged in public water and public water infrastructure	
		Develop and implement monitoring programs, source water assessments, and drinking water protection strategies.	
Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water 	Increase access to information on water that affects the recreational use of NYS and marine antibodies Reduce the annual average number of beach closure days due to HABS by 5%	Enhance the public's accessibility to real-time water quality information for recreational waters including beach status (open, closed) and other information.	Putnam
		Adopt and implement best managements practices to reduce nutrient loading through resource conservation, wastewater, and storm water infrastructure improvements (such as green infrastructure).	Putnam

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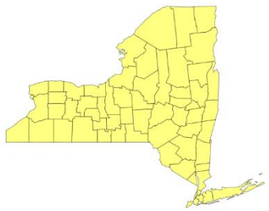
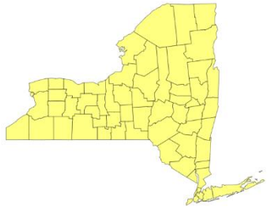
Focus Area 5: Food and Consumer Products (no counties)

Goal (% of NYS counties)	Objectives	Interventions	Counties
Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure 	Reduce the potential for exposure to common chemical soil contaminants by supporting improvements to garden environments and promoting healthy gardening practices. (No data are available to measure this objective.) Educate the public to make informed fish and game consumption decisions to reduce exposures to contaminants by increasing the number of mapped waterbodies detailing contamination. Increase public awareness of chemicals and/or contaminants in products. (Underdeveloped; data may be available to measure this objective in the future.)	Improve garden environments to reduce the potential for exposure to soil contaminants.	
		Provide information to gardeners to help them produce healthy vegetables while minimizing exposure to contaminants for themselves and those with whom they share produce.	
		Evaluate data on emerging and legacy contaminants in fish and game to develop and/or update health advisories based on the sampling and analyses of target fish and wildlife from waterbodies or areas known or suspected to be impacted by chemical contamination.	
		Educate the public, focusing on those populations that consume fish from NYS waterbodies, to adopt healthier fish consumption habits. Utilize a broad range of evidence-based educational tools and distribution methods that are culturally appropriate.	
		Expand access to chemical ingredient and other relevant product information.	
Improve food safety management 	By December 31, 2024, incorporate the food safety requirements of the U.S. Food and Drug Administration 2017 Model Food Code into the New York state level Food safety regulations to provide modernized and uniform food safety requirements for operators across state level and local jurisdictions. (This objective may be measured in the future.) Identify the contributing factors in 56% of foodborne outbreaks on an annual basis.	Adopt Chapters 1-7 of the FDA 2017 Model Food into State Sanitary Code and provide implementation training and resources to Local Health Departments.	
		Provide at minimum one training course to Local Health Department personnel on how to investigate foodborne illness outbreaks to increase the number of trained Local Health Department personnel to carry out foodborne outbreak investigations and to improve the identification of contributing factors in foodborne outbreaks. This intervention focuses on providing targeted resources such as training to Local Health Department staff to improve the completeness and timeliness of outbreak investigations and response.	
		Improve coordination and response during outbreak investigations to reduce the incidence of disease and duration of the outbreak. This intervention will focus on updating outbreak investigation procedures for NYS to improve coordination and response during outbreak investigations.	

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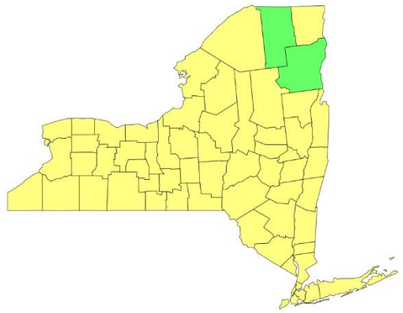
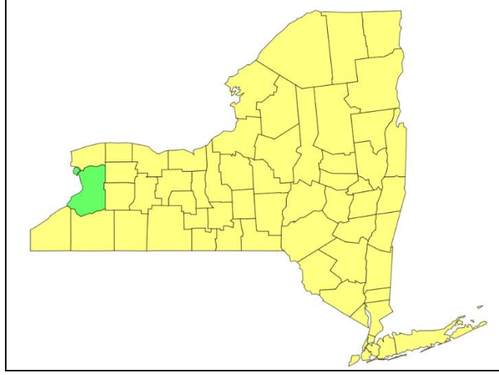
Promote Healthy Women, Infants, and Children (41% of NYS Counties)*

Focus Area 1: Maternal & Women's Health (10% of counties)

Goal	Objectives	Interventions	Counties implementing intervention*
Increase use of primary and preventive health care services among women of all ages, with special focus on women of reproductive age 	Increase the percentage of women ages 18-44 years with a past year preventive medical visit by 10% to 80.6%. Increase the percentage of women ages 45 years and older with a past year preventive medical visit by 2% to 85.0% Increase the percentage of women ages 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy by 10% to 38.1%.	Incorporate strategies to promote health insurance enrollment, well-woman visits, and age-appropriate preventive health care across public health programs serving women	Essex, Franklin
		Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.	Essex, Franklin
Reduce maternal mortality & morbidity 	Decrease the maternal mortality rate by 22% to 16.0 maternal deaths per 100,000 live births. Decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate) by 34% to 3.1. Decrease the rate of severe maternal morbidity by 6% to 202.0 per 10,000 delivery hospitalizations. Increase the percentage of women who report that a health care provider asked them about depression symptoms at a postpartum visit by 5% to 80.0%.	Systematically review maternal deaths and severe maternal morbidities and use results to inform maternal mortality and morbidity prevention efforts.	
		Collaborate with partners to advance a comprehensive maternal health agenda that includes policy, community prevention, and clinical quality improvement strategies, with a focus on reducing disparities in maternal mortality and morbidity.	Erie
		Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.	
		Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	

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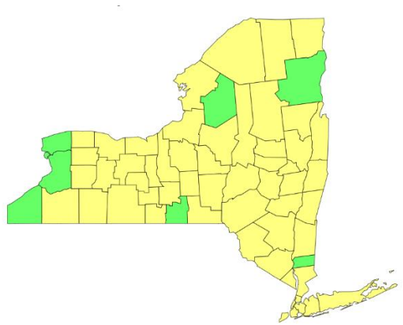
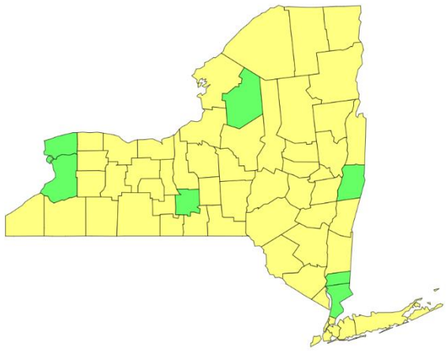
Focus Area 2: Perinatal & Infant Health (10% of counties)

Goal (% of NYS counties)	Objectives	Interventions	Counties implementing intervention*
Reduce infant mortality and morbidity 	Decrease the infant mortality rate by 13% to 4.0 infant deaths per 1,000 live births. Decrease the percentage of births that are preterm by 5% to 8.3 percent of live births. Increase the percentage of very low birthweight (VLBW) infants born in a Level III or higher hospital by 3% to 95.1%. Decrease the rate of infants born with neonatal abstinence syndrome and/or affected by maternal use of drugs of addiction by 10% to 9.1 per 1,000 newborn discharges. Decrease the Sudden Unexpected Infant Death (SUID) mortality rate by 17% to 0.5 per 1,000 live births. Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 47.0% (2016) to 51.7% among all infants	Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals	
		Increase capacity and competencies of local maternal and infant home visiting programs	Chautauqua, Essex, Lewis, Tioga,
		Engage in collaborative strategies to respond to increasing use of opioids among women, including pregnant women, and impact on infants.	Chautauqua, Putnam
		Engage in collaborative clinical and community-based strategies to reduce sleep-related infant deaths.	Erie, Niagara, Tioga
		Increase access to professional support, peer support, and formal education to change behavior and outcomes.	Lewis, Niagara
Increase breastfeeding 	Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 34.0% (2016) to 37.4% among **Hispanic infants**	Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding.	Erie, Niagara, Rensselaer, Westchester
	Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 34.9% (2016) to 38.4% among **Black, non-Hispanic infants**	Promote and implement early skin-to-skin contact in hospitals	Erie
	Increase the percentage of infants who are exclusively breastfed in the hospital by 10% from 34.7% (2016) to 38.2% among **infants insured by Medicaid**	Increase access to primary care practices that are supportive of breastfeeding.	Putnam
	Decrease the percentage of infants supplemented with formula in the hospital by 10% from 46.6% (2016) to 41.9% among breastfed infants	Increase access to community-based interventions that provide mothers with peer support via home visits in the prenatal and early postpartum period.	Lewis, Tompkins
	Decrease the percentage of infants supplemented with formula in the hospital by 10% from 62.6% (2016) to 56.3% among breastfed **Hispanic infants**	Increase support for breastfeeding in the workplace.	Lewis, Putnam
	Decrease the percentage of infants supplemented with formula in the hospital by 10% from 59.4% (2016) to 53.5% among breastfed **Black, non-Hispanic infants**	Increase access to Early Care and Education programs that support breastfeeding families.	Niagara
	Increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 10% from 41.4% (2016) to 45.5% among all **WIC infants**		
	Increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 10% from 37.7% (2016) to 41.5% among **Black, non-Hispanic WIC infants**	Increase access to peer and professional breastfeeding support by creating drop-in centers (e.g., Baby Cafés) in faith-based, community-based or health care organizations in communities.	Niagara, Putnam
	Increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 10% from 41.8% (2016) to 46.0% among **Hispanic, WIC infants**		

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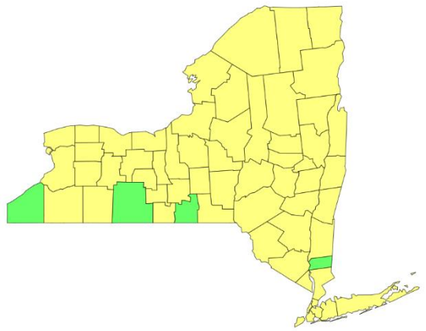
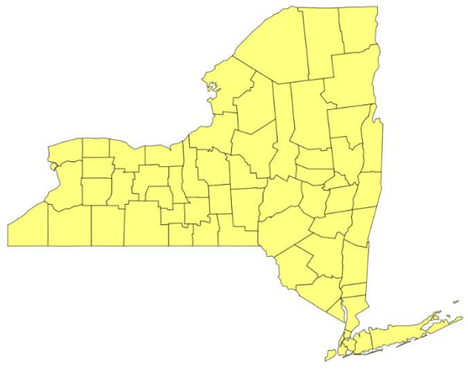
Focus Area 3: Child & Adolescent Health (14% of counties)

Goals	Objectives	Interventions	Counties implementing intervention*
Support and enhance children and adolescents' social-emotional development and relationships 	Increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%. Increase the percentage of children and adolescents, age 3-17 years, with a mental/behavioral health condition who received treatment or counseling by 10% to 49.8%. Decrease the percentage of adolescents in grades 9-12 who felt sad or hopeless for two or more weeks in a row in the past year by 25% to 21.5% Decrease the suicide mortality rate for youth ages 15-19 years by 6% to 4.7 per 100,000. Increase the percentage of infants who fail their initial hearing screening who have a documented follow-up by 60% to 50.0% Increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%.	Increase awareness, knowledge, and skills of providers serving children, youth, and families related to social-emotional development, adverse childhood experiences (ACEs), and trauma-informed care.	Chautauqua, Putnam, Steuben
		Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families.	Steuben
		Engage in collaborative strategies to increase developmental screening of young children in accordance with professional medical guidelines.	Chautauqua, Putnam, Tioga
		Engage health care providers and other partners in efforts to improve newborn hearing screening and follow up, including reporting of results into the New York Early Hearing Detection and Intervention Information System (NYEHDI-IS).	
Increase supports for children and youth with special health care needs 	Increase the percentage of families participating in the Early Intervention Program who meet the state's standard for the NY Impact on Family Scale by 20% to 73.9%	Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families	
	Increase the percentage of children with special health care needs (CSHCN) ages 0-17 years whose families report that they receive care in a well-functioning system by 20% to 13.2%.	Enhance care coordination and transition support services for eligible children and youth with special health care needs.	
	Increase the percentage of adolescents with special health care needs (CSHCN) ages 12-17 years whose families report that they received services necessary to make transitions to adult health care by 20% to 18.4%.		

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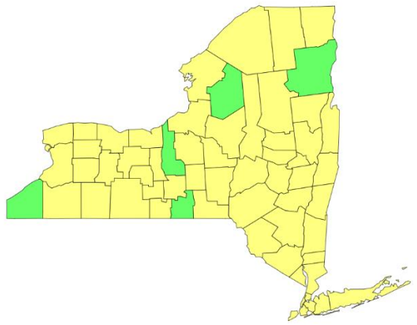
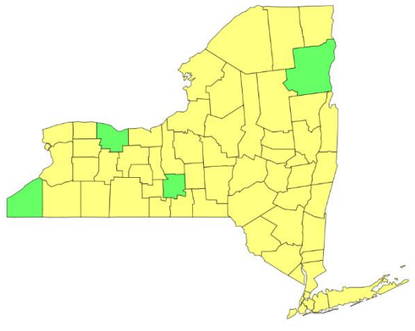
Reduce dental caries among children 	Increase the percentage of New York State residents served by community water systems that have optimally fluoridated water by 9% to 77.5%	Maintain and expand community water fluoridation.	Cayuga
	Decrease the percentage of children ages 1-17 years who had decayed teeth or cavities in the past year by 20% to 6.7%.	Increase delivery of evidence-based preventive dental services across key settings, including school-based and community-based primary care clinics.	Cayuga, Chautauqua, Lewis
	Increase the percentage of children ages 1-17 years who had one or more preventive dental visits in the past year by 10% to 85.4%.	Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.	Cayuga, Essex, Tioga

Focus Area 4: Cross Cutting Healthy Women, Infants & Children (7% of counties)

Goals	Objectives	Interventions	Counties implementing intervention*
Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations 		Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.	Chautauqua, Essex, Monroe, Tompkins

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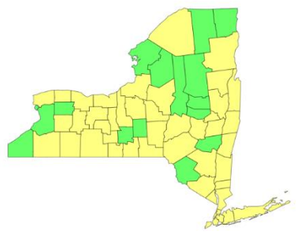
Promote Well-Being and Prevent Mental and Substance Use Disorders (93% of NYS Counties)*

Focus Area 1: Well-Being (47% of counties)

Goal	Objectives	Interventions	Counties implementing intervention*
Strengthen opportunities to build well-being and resilience across the lifespan 	Increase New York State's Opportunity Index Score by 5% Reduce the age-adjusted percentage of adult New Yorkers reporting frequent mental distress during the past month by 10% to no more than 10.7%. Baseline: 11.9% Reduce the percentage of adults 65+ New Yorkers reporting frequent mental distress during the past month by 10% to no more than 13%. Reduce the adult New Yorkers **with income less than $15,000** reporting frequent mental distress during the past month by 10% to no more than 9.9%. Reduce the number of youth grades 9-12 who felt sad or hopeless by 10% to no more than 27.4%	Build community wealth: Approaches include creating and supporting inclusive, healthy public spaces, using the power of anchor institutions such as hospitals to revitalize neighborhoods, supporting democratically operated worker cooperatives, reemployment and supported employment.	Chautauqua, Erie, Franklin, Fulton, Lewis, Montgomery
		Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care.	Clinton, Cortland, Franklin
		Create and sustain inclusive, healthy public spaces: Ensure space for physical activity, food access, sleep; civic and community engagement across the lifespan engagement across the lifespan	Cortland, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Jefferson, Lewis, Monroe, Montgomery, Ontario
		Integrate social and emotional approaches across the lifespan. Support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education	Chautauqua, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Monroe, Montgomery, Sullivan
		Enable resilience for people living with chronic illness: Strengthening protective factors include independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.	Genesee, Hamilton, Montgomery, Tompkins
Facilitate supportive environments that promote respect and dignity for people of all ages	Increase New York State's Economy Scores by 7% to 52.3% Increase New York State's Community Scores by 7% to 61.3% Increase New York State's Education Scores by 7% to 59.9% Increase New York State's Health Scores by 7% to 68.1%	Implement evidence-based Home visiting programs: These programs provide structured visits by trained professionals and paraprofessionals to pregnant	Franklin, Sullivan, Tompkins
		Mental Health First Aid is an evidence- based public education program that teaches people how to respond to individuals who are experiencing one or more acute mental health crises (such as suicidal thoughts or behavior, an acute stress reaction, panic attacks or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (such as depressive, anxiety or psychotic disorders, which may occur with substance abuse).	Albany, Chautauqua, Chenango, Fulton, Monroe, Otsego, Rockland, Seneca, Sullivan
		Policy and program interventions that promote inclusion, integration, and competence	Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Monroe, Montgomery

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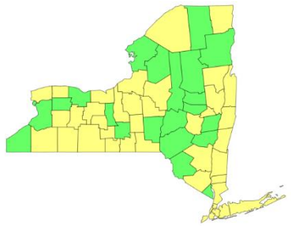
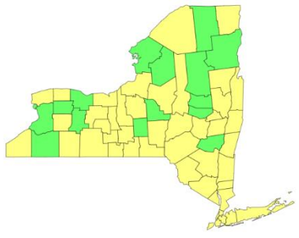
		Use thoughtful messaging on mental illness and substance use: Expert opinion in messaging about Mental, Emotional, and Behavioral Health humanize the experiences and struggles of person living with disorders; highlight structural barriers; avoid blaming people for the disorder or associate disorders with violence.	Delaware, Fulton, Genesee, Jefferson, Lewis, Monroe

Focus Area 2: Mental and Substance Use Disorders Prevention (81% of counties)

Goals	Objectives	Interventions	Counties implementing intervention*
Prevent underage drinking and excessive alcohol consumption by adults 	Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days by 10% from 27.1% in 2017 to 24.4% Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% to no more than 16.4% Reduce the age-adjusted percentage of adult (age 55+ and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% from 21.7% in 2017 to 19.5%	Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access.	Cattaraugus, Cortland, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery
		Implement school-based prevention: Implement/Expand School-Based Prevention Services. Life Skills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting major social and psychological factors that promote the initiation of substance use and other risky behaviors. Teen Intervene is a brief, early intervention program for 12- to 19-year-olds who display the early stages of alcohol or drug involvement. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, the intervention aims to help teens reduce and ultimately eliminate their substance use.	Erie, Essex, Fulton, Herkimer, Livingston, Madison
		Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and cross-system collaboration.	Chautauqua, Lewis, Livingston, Montgomery
		Implement routine screening and brief behavioral counseling in primary care settings to reduce unhealthy alcohol use for adults 18 years or older, including pregnant women.	Fulton, Montgomery
		Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) Electronic screening and brief interventions (e-SBI) using electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI.	Franklin, Fulton, Livingston, Madison, Montgomery
	Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population	Integrate trauma-informed approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration.	Livingston

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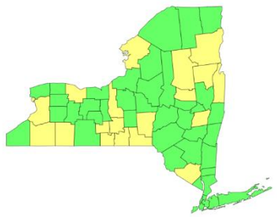
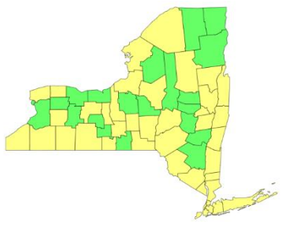
Prevent opioid and other substance misuse and deaths 	Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder by 20% to 415.6 per 100,000 population Reduce the opioid analgesics prescription for pain, age-adjusted rate by 5% to 350.0 per 1,000 population 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	Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine.	Chautauqua, Franklin, Livingston, Madison, Montgomery, Nassau, Niagara, Oneida, Onondaga, Oswego, Otsego, Putnam, Rockland, Saint Lawrence, Schenectady, Suffolk, Sullivan, Ulster, Wyoming, New York City DoH
		Increase availability of/access to overdose reversal (Naloxone) training to prescribers, pharmacists and consumers.	Chautauqua, Columbia, Dutchess, Franklin, Livingston, Madison, Nassau, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Rensselaer, Rockland, Saratoga, Schenectady, Seneca, Steuben, Suffolk, Sullivan, Ulster, Wayne, Westchester, Wyoming, Yates, New York City DoH
		Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations.	Cortland, Lewis, Madison, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saint Lawrence, Seneca, Westchester
		Build support systems to care for opioid users or at risk of an overdose.	Chautauqua, Clinton, Cortland, Delaware, Genesee, Greene, Lewis, Livingston, Madison, Nassau, Oneida, Onondaga, Ontario, Orleans, Rensselaer, Saratoga, Schoharie, Steuben, Ulster, Wayne, Wyoming
		Establish additional permanent safe disposal sites for prescription drugs and organized take-back days.	Herkimer, Niagara, Oneida, Orleans, Rensselaer, Saratoga, Schenectady, Seneca, Wayne, Wyoming, Yates
		Integrate trauma informed approaches in training staff and implementing program and policy.	Livingston, Montgomery, Schenectady
Goals	**Objectives**	**Interventions**	**Counties implementing intervention***
Prevent and address adverse childhood experiences (ACES) 	Reduce the percentage of adults experiencing two or more adverse childhood experiences (ACEs) by 5% to no more than 33.8% Reduce indicated reports of abuse/maltreatment rate per 1,000 children and youth ages 0-17 years by 9% to 15.6 Increase communities reached by opportunities to build resilience by at least 10 percent	Integrate principles of trauma-informed approach in governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing, and evaluation.	Livingston, Onondaga, Schuyler, Tioga
		Address Adverse Childhood Experiences and other types of trauma in the primary care setting.	Essex, Greene, Herkimer, Lewis, Schuyler
		Grow resilient communities through education, engagement, activation/mobilization and celebration.	Clinton, Erie, Essex, Franklin, Fulton, Genesee, Herkimer, Lewis, Livingston, Monroe, Montgomery, Schoharie, Ulster, Wayne, Yates
		Implement evidence-based Home visiting programs: These programs provide structured visits by trained professionals and paraprofessionals to pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.	Franklin, Herkimer, Madison
		Strengthen economic supports: strengthen household financial security; policies that stabilize housing.	Cortland, Essex, Franklin

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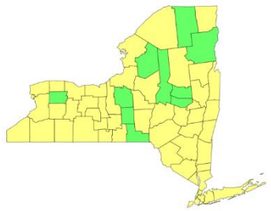
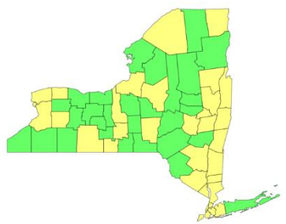
Reduce the prevalence of major depressive disorders 	Reduce the past year prevalence of major depressive episode among adults aged 18 or older by 5% to no more than 6.2% Reduce the past-year prevalence of major depressive episodes among adolescents aged 12-17 years by 10% to no more than 10.4%	Strengthening resources for families and caregivers.	Cortland, Essex, Franklin, Fulton, Genesee, Herkimer, Lewis, Montgomery
		Implement an evidence-based cognitive behavioral approach such as Peter Lewinsohn's Coping with Depression course, Gregory Clarke's Cognitive-Behavioral Prevention Intervention.	Broome, Essex, Fulton, Onondaga
Prevent suicides 	Reduce suicide attempts by New York adolescents (youth grades 9 to 12) who attempted suicide one or more times in the past year by 10% to no more than 9.1% Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000 ‘	Strengthen economic supports: strengthen household financial security; policies that stabilize housing.	Cortland, Essex, Franklin, Livingston
		Strengthen access and delivery of suicide care - Zero Suicide: Zero Suicide is a commitment to comprehensive suicide safer care in health & behavioral health care systems.	Broome, Cattaraugus, Cortland, Fulton, Genesee, Livingston, Onondaga, Tioga, Suffolk
		Create protective environments: Reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches, reduce excessive alcohol use.	Delaware, Essex, Franklin, Fulton, Genesee, Hamilton, Herkimer, Lewis, Madison, Monroe, Montgomery, Otsego, Tioga
		Identify and support people at risk: gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicides.	Allegany, Chautauqua, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Lewis, Madison, Monroe, Montgomery, Ontario, Schuyler, Seneca, Wayne, Yates
		Promote connectedness, each coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program.	Chautauqua, Essex, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Madison, Monroe, Montgomery, Sullivan
Goal	**Objectives**	**Interventions**	**Counties implementing intervention***
Reduce the mortality gap between those living with serious mental illness and the general population	Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%	Implement a multilevel intervention model that focuses on the individual, health systems, community and policy-levels.	Cortland, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Monroe, Montgomery
		Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes. Smokers who receive mental health treatment have higher quit rates than those who do not. For example, people with schizophrenia showed better quit rates with the medication bupropion, compared with placebo, and showed no worsening of psychiatric symptoms. A combination of the medication varenicline and behavioral support has shown promise for helping people with bipolar and major depressive disorders quit, with no worsening of psychiatric symptoms. A clinical trial found that a combination of varenicline and cognitive behavioral therapy (CBT) was more effective	Franklin, Jefferson, Lewis, Rockland

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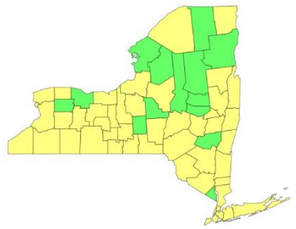
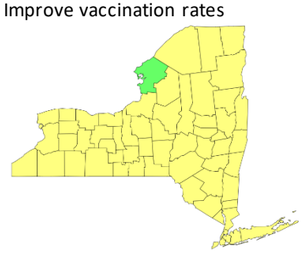
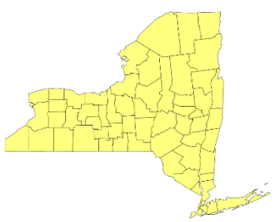
		than CBT alone for helping people with serious mental illness stop smoking for a prolonged period—after 1 year of treatment and at 6 months after treatment ended.	
		Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers.	Montgomery

Prevent Communicable Diseases (5% of NYS Counties)*

Focus Area 1: Vaccine Preventable Diseases (1 county)

Goals	Objectives	Interventions	Counties implementing intervention
Improve vaccination rates 	Increase the rates of immunization among NYS 24-35 month olds by 10% Increase the percentage of NYS 13yo. adolescents with a complete HPV vaccine by 10% Increase influenza immunization rates of New Yorkers aged 6 months and older by 10% Increase the age-adjusted pneumococcal vaccination rate of New Yorkers aged 65 and older by 10%	Ensure and enforce strong immunization requirements for childcare, school and post-secondary institution entry and attendance	
		Maximize use of NYS Immunization Information System (NYSIIS) and the Citywide Immunization Registry (CIR) for vaccine documentation, assessment, decision support, reminder and recall	Jefferson
		Implement and promote use of standing orders for vaccine administration	
Reduce vaccination coverage disparities 	Reduce the disparity measured by the difference in the 4:3:1:3:3:1:4 vaccine series coverage between 19-35 month olds living in **households below the federal poverty level** compared with those living in households at or above the federal poverty level by 40% Reduce the difference in HPV vaccine series completion between NYS adolescent boys and girls by 50%	Minimize client out-of-pocket costs for vaccinations	
		Offer vaccines in locations and hours that are convenient to the public including pharmacies, vaccine only clinics and other sites that are accessible to people of all ages	

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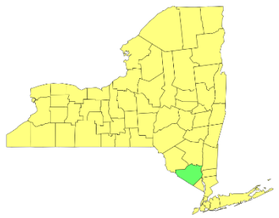
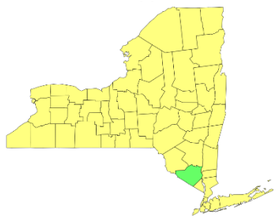
Focus Area 2: Human Immunodeficiency Virus (HIV) (1 county)

Goals	Objectives	Interventions	Counties implementing intervention
Decrease HIV morbidity (new HIV diagnoses) 	Reduce the number of new HIV diagnoses by 70% Reduce the newly diagnosed HIV case rate **among African Americans** by 70% Reduce the newly diagnosed HIV case rate **among Hispanics** by 70%	Facilitate access to Pre-Exposure Prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk persons to keep them HIV-negative. Access can be facilitated by the following: • Statewide education campaign on PrEP and nPEP • Expanding funded programming for PrEP • Creating a statewide mechanism for persons to access PrEP and nPEP • Determining a method for measuring the number of New Yorkers on PrEP and nPEP	Orange
Increase viral suppression 	Increase the percentage of all persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 17% Increase the percentage of **African American persons** living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 23% Increase the percentage of **Hispanic persons** living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 17%	Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission. Linkage and retention to be facilitated by the following activities: • Promoting the message that individuals with a sustained undetectable viral load will not sexually transmit HIV; • Expanding Data to Care (DTC) activities, which uses HIV surveillance data to identify previously-known, HIV-positive individuals who appear to be out of care, with the specific objectives of re-engaging these individuals in medical care and notifying, testing and treating partners; • Expand funded programming aimed at improving outcomes for persons with HIV/AIDS by increasing linkage to care, improving retention in care, and promoting adherence to ART; • Leverage NY Links and other regionally based collaboratives to identify innovative solutions for improving linkage and retention in HIV care services.	Orange

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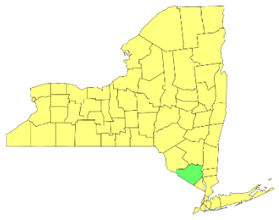
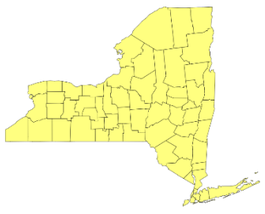
Focus Area 3: Sexually Transmitted Infections (STI) (1 county)

Goals	Objectives	Interventions	Counties implementing intervention
Reduce the annual rate of growth for STIs 	Reduce the annual rate of growth for early syphilis by 50% Reduce the annual rate of growth for gonorrhea by 50% Reduce the annual rate of growth for chlamydia by 50% Keep the age-adjusted diagnosis rate of gonorrhea no more than 242.6 per 100,000 population Keep the age-adjusted diagnosis rate of chlamydia no more than 676.9 per 100,000 population Keep the age-adjusted diagnosis rate of early syphilis no more than 79.6 per 100,000 population	Increase Partner Services: Partner Services is the front-line public health intervention for interrupting HIV and STI transmission in the community. Trained state/local health department workers work with persons newly diagnosed with HIV and STIs to ensure they and their partners are linked to care, treatment, and prevention.	
		Increase STI testing and treatment: Ensuring that all persons at risk for STIs have access to affordable, accessible, convenient, and culturally-responsive STI testing and treatment services is the bedrock of any STI prevention and control strategy.	Orange
		Promote distribution of Condoms: While new methods for preventing HIV have garnered attention over the last several years, the foremost primary prevention method for sexually active people remains condoms.	Orange
		Promote Expedited Partner Therapy: Expedited Partner Therapy (EPT) is a practice that allows health care providers to provide a patient with either antibiotics or a written prescription, intended for the patients' sexual partner(s). In New York State, EPT is used for treatment of exposure to chlamydia	Orange

Focus Area 4: Hepatitis C Virus (HCV) (no counties)

Goals	Objectives	Interventions	Counties implementing intervention
Increase the number of persons treated for Hepatitis C Virus (HCV) 	Increase the cumulative number of **Medicaid enrollees** treated for HCV by 497% - 724%	Conduct educational campaign promoting testing and treatment for HCV	
		Increase capacity for HCV treatment across NYS by increasing provider knowledge and skills for prescribing HCV medications	
Reduce the number of the new HCV cases among people who inject drugs	Increase the number of individuals with a syringe transaction at an AIDS-Institute registered syringe exchange program by 3% annually	Increase access to HCV screening among injection drug users <30 years of age by providing onsite HCV rapid testing	
		Expand capacity for harm reduction services	

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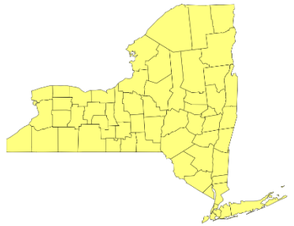
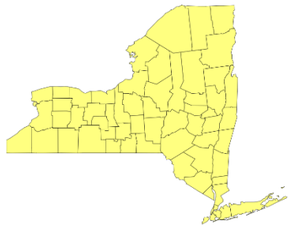
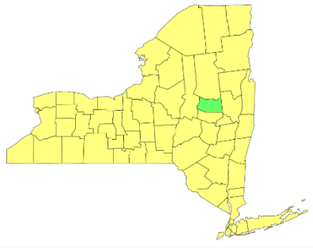
Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections (1 county)

Goal	Objectives	Interventions	Counties implementing intervention
Improve infection control in healthcare facilities 	100% of hospitals and 85% of long-term care facilities implement interfacility communication system regarding patient multidrug-resistant organism (MDRO) infection or colonization history Reduce the central line-associated bloodstream infections (CLABSIs) in hospital intensive care units and wards by 25%	Regularly review healthcare facility lead Infection Prevention and Control NYS HCS roles in order for infection prevention and control staff to receive important health notices and report healthcare-associated outbreaks.	
Reduce infections caused by multidrug resistant organisms and *Clostridium difficile* 	Expand surveillance of healthcare associated multidrug-resistant organisms (MDROs) Reduce hospital onset CRE bloodstream infections (BSIs) by 25% Reduce admission prevalent CRE BSIs by 25% Reduce hospital-onset CDIs by 25% Reduce admission prevalent CDIs by 25% Reduce the total number of CRE infections/colonizations identified statewide by 10% Improve identification of Candida auris (C. auris) infection and colonization	Institute healthcare facility surveillance system for MDROs. Ensure hospital evaluation of hospital onset CDI rates and submission of an improvement plan. Expand laboratory testing capability for *C. auris*	
Reduce inappropriate antibiotic use 	Reduce potentially avoidable antibiotic prescribing rates for adult outpatient acute respiratory infections by 25% 100% of hospitals and long-term care facilities will have an antimicrobial stewardship (ASP) that meets the seven CDC core elements of antimicrobial stewardship	Use healthcare provider-level feedback data to inform antibiotic prescribing. Conduct an educational campaign for the public on antimicrobial resistance and appropriate antibiotic use. Offer healthcare provider education and public health detailing to prescribers	Fulton
		Evaluate the impact of the healthcare facility ASP (or an element of the program) to determine areas for improvement	

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Links to Community Health Improvement Plans for Every NYS County

Albany	https://www.albany .com/home/showdocument?id=3338
Allegany	https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/jones-memorial/about-us/images/Allegany-County-CHA-CSP-2019-2021-combined-signed 2.pdf
Broome	https://www.nyuhs.org/about-us/community-service-reports/
Cattaraugus	https://www.ogh.org/CHNA-CHIP%20final%20report%202019-2021.pdf
Cayuga	https://www.cayuga .us/DocumentCenter/View/11866/2019-CHIP-Workplan-PDF
Chautauqua	https://chqgov.com/public-health/public-health
Chemung	http://www.chemung health.org/usr/Comm Health Assessment/Chemung parts cha.pdf
Chenango	http://www.co.chenango.ny.us/public-health/documents/Chenango%20 %20Community%20Health%20Assessment%202019-2021.pdf
Clinton	https://www.cvph.org/data/files/CHNA%20Files/CSP-compressed%2012%2030%2019.pdf
Columbia	http://www.hcdiny.org/content/sites/hcdi/chips/2019 CHNA CHIP CSP Columbia-Greene.pdf
Cortland	https://www.cortland-co.org/DocumentCenter/View/7168/2019-2024-Cortland- -Community-Health-Assessment-and-Improvement-Plan
Delaware	http://delaware publichealth.com/wp-content/uploads/2020/02/2019-DC-CHA-12.30.2019.pdf
Dutchess	https://www.dutchessny.gov/Departments/DBCH/Docs/CHIP-Community-Health-Improvement-Plan-2019-2021.pdf
Erie	https://www.kaleidahealth.org/community/2019%20Kaleida%20Health%202019-2021%20CHNA-CSP.pdf
Essex	https://www.co.essex.ny.us/Health/wp-content/uploads/ESSEX CHA CHISP Executive-Summary.pdf
Franklin	https://www.alicehyde.com/data/files/Community%20Health%20Needs%20Assessment%20and%20Community%20Service%20Plan%202019-2021.pdf
Fulton	http://www.fulton ny.gov/sites/default/files/CHNA%20%20CSP-CHIP%20NLH%20and%20Fulton.pdf
Genesee	https://www.rochesterregional.org/-/media/files/gow-cha-20192021 123119.pdf?la=en&hash=559B040763E881566302E276857F4B403D5DF84D
Greene	http://www.hcdiny.org/content/sites/hcdi/chips/2019 CHNA CHIP CSP Columbia-Greene.pdf
Hamilton	https://www.hamilton health.org/wp-content/uploads/2018-2020 CHIP Final-1.pdf
Herkimer	https://www.herkimer .org/services-and-departments/public-health.php
Jefferson	https://co.jefferson.ny.us/media/Public%20Health/2019%202021%20JC%20CHA%20CHIP.pdf
Lewis	https://cnycares.org/media/3616/lewis- -chip-workplan-2019-2021-final.pdf
Livingston	https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/noyes/documents/Livingston-Executive-Summary-and-CHIP-12-4-19.pdf
Madison	https://www.madison .ny.gov/DocumentCenter/View/10715/2020CHIP?bidId=
Monroe	https://www2.monroe .gov/files/health/DataReports/Final-CHIP-2019.pdf
Montgomery	https://docs.google.com/document/d/1QLIq2daJOiKS3 uGsUyCQ Gm6Geuf8My/edit?dls=true
Nassau	https://www.nassau ny.gov/1656/Data-Reports
Niagara	https://www.kaleidahealth.org/community/2019%20Kaleida%20Health%202019-2021%20CHNA-CSP.pdf
Oneida	https://ocgov.net/sites/default/files/health/CommunityHealthAssessment/2020/CHA CSP CHIP Final%20Report CHIP 12.30.19 with%20CHIP.pdf

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Onondaga	http://www.ongov.net/health/documents/Onondaga CHA-CHIP.pdf
Ontario	https://www.co.ontario.ny.us/DocumentCenter/View/22257/Ontario-Exec-Summary-and-CHIP-all-attchments-10-21-19
Orange	https://www.orange gov.com/DocumentCenter/View/14537/Orange- -Community-Health-Improvement-Plan-2019-2021-PDF
Orleans	https://www.rochesterregional.org/-/media/files/gow-cha-20192021_123119.pdf?la=en&hash=559B040763E881566302E276857F4B403D5DF84D
Oswego	https://docs.google.com/spreadsheets/d/1blJewTQn-RXoPfn6AxDVsROzXqcCLG7mGsnFtYIbhks/edit?usp=sharing
Otsego	https://www.bassett.org/sites/default/files/2019%20CHNA-CSP-CHIP%20AOF-BMC-Otsego%20Co%20FINAL.pdf
Putnam	https://www.putnam ny.com/wordpress/wp-content/uploads/2020/01/2019-CHA-2020-22-CHIP-FINAL.pdf
Rensselaer	http://www.hcdiny.org/content/sites/hcdi/chips/Rensselaer__CHIP_.pdf
Rockland	http://rocklandgov.com/files/1915/7962/1104/Rockland__Community_Health_Improvement_Plan_2019-2021.pdf
St. Lawrence	https://www.stlawco.org/sites/default/files/PublicHealth/12.18.19_CHIP_FINAL.pdf
Saratoga	https://www.saratoga ny.gov/wp/wp-content/uploads/2020/01/FINAL-2019-CHA-CHIP.pdf
Schenectady	https://www.schenectady .com/sites/default/files/2019-2021_CHIP_CHNA_Report.pdf
Schoharie	https://www.bassett.org/sites/default/files/2019%20CHNA-CSP-CHIP%20Schoharie%20-%20CRH.pdf
Schuyler	https://www.schuyler .us/DocumentCenter/View/8161/Schuyler-Executive-Summary-and-CHIP-12-2-19
Seneca	https://www.co.seneca.ny.us/wp-content/uploads/2020/04/Seneca-CHA-and-CHIP-12-2-19-3.pdf
Steuben	https://steubencony.org/Files/Documents/publichealth/Steuben%20CHA%20and%20CHIP%2012-2-19.pdf
Suffolk	https://licommunityhospital.org/wp-content/uploads/2020/01/2019-2021-SC-CHA-CHIP-LI-Community-Hospital-Narrative.pdf
Sullivan	https://sullivanny.us/sites/default/files/departments/PHS/HealthInfo/Sullivan%20%20Community%20Health%20Improvement%20Plan%202021-2019%20Approved.pdf
Tioga	https://www.tioga ny.com/media/7261/tioga- -chip-20192021.pdf
Tompkins	https://tompkins ny.gov/health/cha-chip
Ulster	https://ulster ny.gov/sites/default/files/documents/health/UC%20CHA-CHIP%202019-21.pdf
Warren	https://www.glensfallshospital.org/wp-content/uploads/2019/12/GFH-CHNA-2019-2021-FINAL-with-Appendices.pdf
Washington	https://washington ny.gov/DocumentCenter/View/14141/2019-2021-Washington- -Community-Health-Assessment
Wayne	https://web.co.wayne.ny.us/wp-content/uploads/2019/12/Wayne-CHA-12-2-19.pdf
Westchester	https://www.wphospital.org/WPHRedesign/media/Emerge_WPHRedesign/Documents/2019-Community-Health-Needs-Assessment-and-Implementation-Report.pdf
Wyoming	https://www.rochesterregional.org/-/media/files/gow-cha-20192021_123119.pdf?la=en&hash=559B040763E881566302E276857F4B403D5DF84D
Yates	https://www.yates .org/DocumentCenter/View/3213/2019-2021-Yates-CHA-and-CHIP?bidId=
NYC DOH	https://www1.nyc.gov/assets/doh/downloads/pdf/tcny/community-health-assessment-plan.pdf

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