

# Prevention Agenda 2019-2024



Developed by the  
NYS Public Health and Health Planning Council  
and the NYS Department of Health  
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Version: 1.7

New York's State Health Improvement Plan

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## Revision History

### Version 1.0 (12/03/2018)

- Initial draft released.

### Version 1.1 (2/22/2019)

- Target and baseline data were updated.
- Minor formatting and edits throughout.
- Added a Revision History log.
- Added an Acknowledgements section.
- Added a Participating Organizations section.
- Added an Implementation Partners section.
- Added an appendix section within the Healthy Women, Infants, and Children Action Plan.

### Version 1.2 (3/05/2019)

- Minor formatting and edits throughout..

### Version 1.3 (4/25/2019)

- Minor formatting edits throughout.
- Specified that Prevent Communicable Diseases objectives 3.1.4, 3.1.5 and 3.1.6 are based on age-adjusted rates.
- Replaced Prevent Communicable Diseases Objective 4.2.1 due to a change in data source.
- Removed Intervention #1 from Prevent Communicable Diseases Goal 4.2.
- Added a new intervention (Intervention #2) to Prevent Communicable Diseases Goal 4.2.
- Revised baseline years, and data sources for Promote Healthy Women, Infants, and Children objectives 1.2.1 and 1.2.2.
- Baselines and targets for the three cross-cutting objectives related to preventable hospitalizations were recalculated using AHRQ QI software version v2018 (released in 6/2018). Previously, the calculations were made using version v7.0 Beta (released in 9/2017).

### Version 1.4 (10/21/2019)

- Minor formatting and edits throughout.
- Baselines and targets updated for cross-cutting objective and sub-objectives related to preventable hospitalizations (Figure 7)
- Baseline updated for Promote a Healthy and Safe Environment Objective 3.1.d.
- Baseline and target updated for Promote a Healthy and Safe Environment objectives 3.2.b and 4.1.a.

- Revised baseline and removed the intermediate target for Promote a Healthy and Safe Environment Objective 5.2.b.
- Baseline updated for Promote Healthy Women, Infants, and Children Objective 3.2.1.
- Prevent Communicable Diseases Objective 3.1.6 corrected to pertain to early syphilis, rather than to primary and secondary syphilis.
- Revised the definition, baseline, baseline year, target, and data source for Promote Healthy Women, Infants, and Children Objective 2.1.4 in order to broaden the scope to also include infants affected by maternal use of drugs of addiction.
- Revised the baseline, baseline year, and target to reframe Prevent Communicable Diseases Objective 4.1 in terms of the cumulative (rather than year-over-year) number of Medicaid enrollees treated.
- Revised the data source and baseline and target for Promote Well-Being and Prevent Mental and Substance Use Disorders objectives 2.1.2 and 2.2.1.
- Revised the data source and geographic level of data for Promote Well-Being and Prevent Mental and Substance Use Disorders Objective 2.1.3.
- Revised definition of Promote Well-Being and Prevent Mental and Substance Use Disorders objectives 1.1.2., 1.1.2.1, 1.1.2.2, and 1.1.2.3.
- Revised baseline, target, and data source for Promote Well-Being and Prevent Mental and Substance Use Disorders Objective 2.3.1.
- Revised baseline and target for Promote Well-Being and Prevent Mental and Substance Use Disorders objectives 2.2.2, 2.2.3, 2.2.4, and 2.3.2.
- Revised baseline year for Promote Healthy Women, Infants, and Children Objective 2.1.3.
- Revised baselines and targets for Promote a Healthy and Safe Environment objectives 1.1.b, 1.2.b, 1.3.a, 1.3.b, and 3.1.b.
- Revised the baseline and target for the third Prevent Chronic Diseases Leisure-time Physical Activity Objective
- Revised the baselines and targets for the third Prevent Chronic Diseases asthma objectives related to emergency department visits and hospitalizations.
- Revised the baselines and targets for Prevent Communicable Diseases objectives 1.1.1, 1.1.2, 3.1.4, 3.1.5, and 3.1.6.

#### **Version 1.5 (2/27/2020)**

- Revised definition for Promote Well-Being and Prevent Mental and Substance Use Disorders Objective 2.2.2.
- Revised the baseline and target for Promote Well-Being and Prevent Mental and Substance Use Disorders Objective 2.2.3.
- Revised the geographic level of data for Promote Well-Being and Prevent Mental and Substance Use Disorders Objective 2.3.1.
- Revised the target and baseline year for Promote a Healthy and Safe Environment Objective 3.1.a.

**Version 1.6 (4/27/2021)**

- Added an implementation resource for Prevent Communicable Diseases Intervention 4.1.1.
- Added to the evidence base for Prevent Communicable Diseases Intervention 4.2.2.

**Version 1.7 (6/30/2023)**

- Revised the baseline, target, and data source for Promote Healthy Women, Infants, and Children Objective 1.2.3.

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## Acknowledgements

On December 13, 2018, the New York State Public Health and Health Planning Council moved to accept the Prevention Agenda 2019-2024, which establishes the priorities for State and local action to achieve the vision of making New York State the healthiest state for people of all ages. The Council agreed to the new focus of the plan, including action by additional State agencies to support the Governor's Health-Across-All-Policies initiative, goals for an Age-Friendly New York State, and emphasis on the broad determinants of health. The Council committed itself to a regular review of progress during 2019-2024 to support successful implementation.

The Council's Ad Hoc Committee to Lead the Prevention Agenda played an essential role in the development of the new Prevention Agenda 2019-2024. Members of the Ad Hoc Committee were asked to identify specific goals that they will work on during 2019-2024. Some organizations committed to working on implementing all of the goals. Other organizations selected individual goals to focus on. The Ad Hoc Committee will track this information in an [Implementation Partners Matrix](#) (page 18), and update it on a regular basis.

The Public Health and Health Planning Council and the NYS Department of Health wish to acknowledge the following individuals and organizations who served on the Ad Hoc Committee in developing the Prevention Agenda 2019-2024:

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# Participating Organizations



# The New York State Prevention Agenda 2019-2024: An Overview

Updated: June 30, 2023

The Prevention Agenda 2019-2024 is New York State's health improvement plan, 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. In partnership with more than 100 organizations across the state, the Prevention Agenda is updated by the New York State Public Health and Health Planning Council at the request of the Department of Health. This is the third cycle for this statewide initiative that started in 2008.

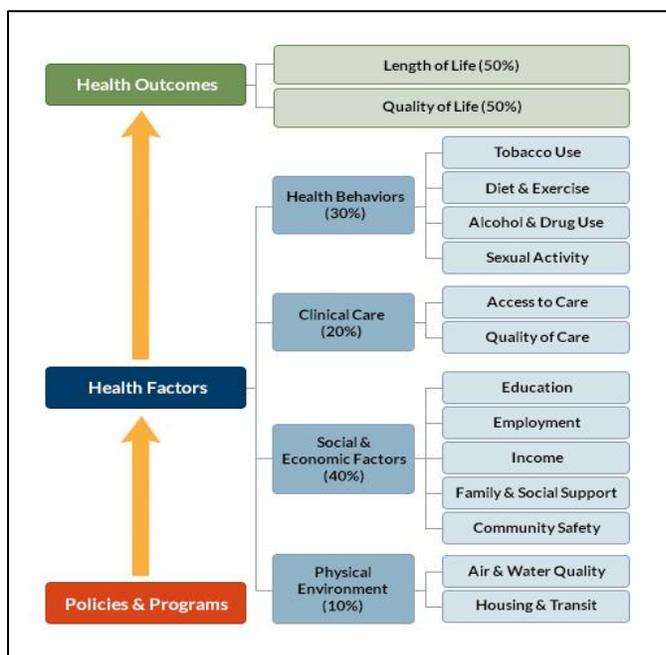
The vision of the Prevention Agenda for 2019-2024 is that New York is the Healthiest State in the Nation for People of All Ages. We are proud that, since 2008, New York has moved from the 28<sup>th</sup> to 10<sup>th</sup> healthiest state on America's Health Rankings,<sup>1</sup> demonstrating real progress toward achieving our vision.

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. We used the County Health Rankings model (*Figure 1*) as the framework for understanding the modifiable determinants of health (without discounting the role of genetics).<sup>2</sup> New to this 2019-2024 cycle is the incorporation of a Health Across All Policies approach, initiated by New York State in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. It embraces Healthy Aging to support the State's commitment to making New York the first age-friendly state. The 2019-2024 cycle also builds on the important experiences—both successes and challenges—of local

Prevention Agenda coalitions from across the state, who were formed in previous cycles of the Prevention Agenda to identify and address their local communities' health priorities.

The overarching strategy of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. This strategy includes an emphasis on social determinants of health – defined by Healthy People 2020 as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Figure 1: County Health Rankings model © 2014 UWPHI



Such determinants include social and economic opportunities, education, safety in neighborhoods and communities, the quality of physical environments (e.g., the cleanliness of our water, food, air, and housing), and social interactions and relationships. Health behaviors and access to health care are also important (*Figure 2*).

*Figure 2*<sup>3,4</sup>

### **Examples of Social Determinants**

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources that support healthy lifestyles and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash, lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the accompanying stressful conditions)
- Residential segregation
- Language and literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet and social media)
- Culture
- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes, and roads
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements (e.g., good lighting, trees, and benches)

The conditions in the environments where people live, work and play have a significant influence on health status and quality of life and are root causes of poor health and adverse outcomes. Changing these outcomes requires us to address collaboratively the social, economic, and physical conditions that contribute to poor health and well-being.

To achieve our vision, the Prevention Agenda calls for cross-sector partnerships (e.g., public health, health care, housing, education, and social services, etc.) to address social determinants of health across five key areas (Figure 3):

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

especially by encouraging alignment of investments in primary prevention<sup>5</sup> and using community and policy-level interventions to have widespread and lasting positive health impacts (Figure 4).

Figure 3: Social Determinants of Health



Figure 4: Social Ecological Model<sup>6</sup>



## Process for Developing the Updated Prevention Agenda

Active participation and feedback from the Ad Hoc Committee to Lead the Prevention Agenda and stakeholders across the state were essential for updating the Prevention Agenda for 2019-2024. Many organizations were engaged in developing this updated plan, including local health departments, health care providers, community-based organizations, advocacy groups, academia, employers, schools, and businesses. These organizations reviewed the data on health status and emerging health issues, participated in finalizing the Cross-Cutting Principles (Figure 5), updated the list of priorities and developed priority-specific action plans.

Figure 5

**Cross-Cutting Principles**

To improve health outcomes, enable well-being, and promote equity across the lifespan, the Prevention Agenda:

- Focuses on addressing social determinants of health and reducing health disparities
- Incorporates a Health Across All Policies approach
- Emphasizes healthy aging across the lifespan
- Promotes community engagement and collaboration across sectors in the development and implementation of local plans
- Maximizes impact with evidence-based interventions for state and local action
- Advocates for increased investments in prevention from all sources
- Concentrates on primary and secondary prevention, rather than on health care design or reimbursement

The New York State Office of Mental Health and the New York State Office of Alcoholism and Substance Abuse Services have been core partners since 2013. New in this 2019-2024 cycle is the involvement of the New York State Office for the Aging and other State agencies in identifying specific interventions that they will implement to advance the Prevention Agenda in improving the health of individuals of all ages. These collaborations are the foundation of the 2019-2024 plan.

The Prevention Agenda 2019-2024 has five priorities with priority-specific action plans developed collaboratively with input from community stakeholders (Figure 6).

Figure 6: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

<b>Priority Area: Prevent Chronic Diseases</b>	<b>Focus Area 1: Healthy Eating and Food Security</b>
	Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 1.1: Increase access to healthy and affordable foods and beverages
	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
	Goal 1.3: Increase food security
	<b>Focus Area 2: Physical Activity</b>
	Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
	Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
	Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
	<b>Focus Area 3: Tobacco Prevention</b>
	Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
	Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
	Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
	<b>Focus Area 4: Preventive Care and Management</b>
	Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	
Goal 4.3: Promote the use of evidence-based care to manage chronic diseases	
Goal 4.4: Improve self-management skills for individuals with chronic conditions	
<b>Priority Area: Promote a Healthy and Safe Environment</b>	<b>Focus Area 1: Injuries, Violence and Occupational Health</b>
	Goal 1.1: Reduce falls among vulnerable populations
	Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
	Goal 1.3: Reduce occupational injuries and illness
	Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
	<b>Focus Area 2: Outdoor Air Quality</b>
	Goal 2.1: Reduce exposure to outdoor air pollutants
	<b>Focus Area 3: Built and Indoor Environments</b>
	Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
	Goal 3.2: Promote healthy home and school environments
	<b>Focus Area 4: Water Quality</b>
	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
	<b>Focus Area 5: Food and Consumer Products</b>
	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

Figure 6 Continued: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

<b>Priority Area: Promote Healthy Women, Infants and Children</b>	<b>Focus Area 1: Maternal &amp; Women’s Health</b>
	Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
	Goal 1.2: Reduce maternal mortality and morbidity
	<b>Focus Area 2: Perinatal &amp; Infant Health</b>
	Goal 2.1: Reduce infant mortality and morbidity
	Goal 2.2: Increase breastfeeding
	<b>Focus Area 3: Child &amp; Adolescent Health</b>
	Goal 3.1: Support and enhance children and adolescents’ social-emotional development and relationships
	Goal 3.2: Increase supports for children and youth with special health care needs
	Goal 3.3: Reduce dental caries among children
<b>Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders</b>	<b>Focus Area 4: Cross Cutting Healthy Women, Infants, &amp; Children</b>
	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
	<b>Focus Area 1: Promote Well-Being</b>
	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
	<b>Focus Area 2: Prevent Mental and Substance Use Disorders</b>
	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	
<b>Priority Area: Prevent Communicable Diseases</b>	<b>Focus Area 1: Vaccine-Preventable Diseases</b>
	Goal 1.1: Improve vaccination rates
	Goal 1.2: Reduce vaccination coverage disparities
	<b>Focus Area 2: Human Immunodeficiency Virus (HIV)</b>
	Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)
	Goal 2.2: Increase viral suppression
	<b>Focus Area 3: Sexually Transmitted Infections (STIs)</b>
	Goal 3.1: Reduce the annual rate of growth for STIs
	<b>Focus Area 4: Hepatitis C Virus (HCV)</b>
	Goal 4.1: Increase the number of persons treated for HCV
	Goal 4.2: Reduce the number of new HCV cases among people who inject drugs
	<b>Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections</b>
	Goal 5.1: Improve infection control in healthcare facilities
Goal 5.2: Reduce infections caused by multidrug resistant organisms and <i>C. difficile</i>	
Goal 5.3: Reduce inappropriate antibiotic use	

Each priority-specific action plan includes focus areas, goals, objectives, and measures for evidence-based interventions to track their impacts – including reductions in health disparities among racial, ethnic, and socioeconomic groups, age groups, and persons with disabilities. These objectives will be tracked on the New York State [Prevention Agenda Dashboard](#). The Prevention Agenda Action Plans provide communities with recommended evidence-based interventions, promising practices, and guidance to support implementation (e.g., by highlighting organizations that are well-positioned to take leading or supporting roles). The plans emphasize interventions that address social determinants of health, promote health equity across communities, and support healthy and active aging.

Implementing the five priority-specific action plans in the Prevention Agenda 2019-2024 will improve major cross-cutting health outcomes and reduce health disparities (*Figure 7*), as measured by the following indicators:

*Figure 7: New York State Prevention Agenda 2019-2024 Cross-Cutting Objectives*

Prevention Agenda (PA) Indicator	Baseline Year	Baseline	Prevention Agenda 2024 Objective	Percent Improvement from Baseline
<b>Cross-Cutting Objectives to Improve Health Status and Reduce Health Disparities</b>				
Percentage of premature deaths (before age 65 years)	2016	24	22.8	-5%
Difference in percentage (Black non-Hispanic and White non-Hispanic) of premature deaths	2016	18.2	17.3	-5%
Difference in percentage (Hispanic and White non-Hispanic) of premature deaths	2016	17.1	16.2	-5%
Preventable hospitalizations among adults, age-adjusted rate per 10,000	2016	121.1	115.0	-5%
Preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black non-Hispanics and White non-Hispanics	2016	98.9	94.0	-5%
Preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics	2016	25.2	23.9	-5%
Percentage of adults (aged 18-64) with health insurance	2016	91.4	97.0	+ 6%
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2016	82.6	86.7	+ 5%

The Prevention Agenda aims to be a dynamic plan and a catalyst for action. Key to its success will be the alignment of efforts across State agencies, working with local governments and Prevention Agenda coalitions, and facilitating active community engagement. The Ad Hoc Committee will encourage its members and partners across the state to share effective strategies for improving community health. The Public Health and Health Planning Council will oversee implementation and use lessons learned to advance the Prevention Agenda.

## References

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<sup>1</sup> United Health Foundation. America's Health Rankings Annual Report, 2017.

<https://www.americashealthrankings.org/about/methodology/our-reports>

<sup>2</sup> Our Methods. County Health Rankings and Roadmaps web site.

<http://www.countyhealthrankings.org/explore-health-rankings/our-methods>. Accessed November 2, 2018.

<sup>3</sup> US Department of Health and Human Services. Healthy People 2020. Social Determinants of Health. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

<sup>4</sup> Social Determinants of Health, 2nd Edition. M Marmot and R Wilkinson (eds). Oxford University Press, 2006.

<sup>5</sup> NYS Department of Health Letter and Community Health Planning Guidance 2016-18

[https://www.health.ny.gov/prevention/prevention\\_agenda/2013-2017/docs/letter\\_community\\_planning\\_guidance\\_2016\\_18.pdf](https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/letter_community_planning_guidance_2016_18.pdf)

<sup>6</sup> Social Ecological Model. Centers for Disease Control and Prevention web site. Updated January 28, 2013. <https://www.cdc.gov/cancer/nbccedp/sem.htm>. Accessed November 2, 2018.



# New York State Prevention Agenda Prevent Chronic Diseases Action Plan

Updated: June 30, 2023

## Define the Priority:

Chronic diseases such as cancer, diabetes, heart disease, stroke, asthma and arthritis are among the leading causes of death, disability and rising health care costs in New York State (NYS). However, chronic diseases are also among the most preventable. Three modifiable risk behaviors – unhealthy eating, lack of physical activity, and tobacco use – are largely responsible for the incidence, severity and adverse outcomes of chronic disease. As such, improving nutrition and food security, increasing physical activity, and preventing tobacco use form the core of the *Preventing Chronic Diseases Action Plan*. The plan also emphasizes the importance of preventive care and management for chronic diseases, such as screening for cancer, diabetes, and high blood pressure; promoting evidence-based chronic disease management; and improving self-management skills for individuals with chronic diseases.

Some organizations and communities have found the 3-4-50 framework a helpful way to focus interventions on the **three** behaviors (unhealthy eating, lack of physical activity, and tobacco use) that contribute to **four** chronic diseases (cancer, heart disease and stroke, type 2 diabetes and chronic lung diseases) that cause over **50** percent of all deaths worldwide.<sup>1</sup>

Additional information about the burden of chronic diseases, underlying risk factors, associated disparities, and social determinants of health can be found at:

[https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf#page=2](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf#page=2)

The *Preventing Chronic Diseases Action Plan* contains four focus areas, each with several goals:

### Focus Area 1: Healthy Eating and Food Security

**Overarching Goal:** Reduce obesity and the risk of chronic diseases

**Goal 1:** Increase access to healthy and affordable foods and beverages

**Goal 2:** Increase skills and knowledge to support healthy food and beverage choices

**Goal 3:** Increase food security

### Focus Area 2: Physical Activity

**Overarching Goal:** Reduce obesity and the risk of chronic diseases

**Goal 1:** Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities

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<sup>1</sup> Several communities have implemented the 3-4-50 framework including the [Population Health Collaborative in Western NY](#), [the state of Vermont](#), and [San Diego county](#).

**Goal 2:** Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities

**Goal 3:** Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity

**Focus Area 3: Tobacco Prevention**

**Goal 1:** Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults

**Goal 2:** Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low socioeconomic status; frequent mental distress/substance use disorder; lesbian, gay, bisexual and transgender; and disability

**Goal 3:** Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products

**Focus Area 4: Preventive Care and Management**

**Goal 1:** Increase cancer screening rates for breast, cervical, and colorectal cancer

**Goal 2:** Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity

**Goal 3:** Promote the use of evidence-based care to manage chronic diseases

**Goal 4:** Improve self-management skills for individuals with chronic conditions

## Focus Area 1: Healthy Eating and Food Security

**Overarching Goal:** Reduce obesity and the risk of chronic diseases

**Goal 1:** Increase access to healthy and affordable foods and beverages

**Goal 2:** Increase skills and knowledge to support healthy food and beverage choices

**Goal 3:** Increase food security

### Combined Objectives for Focus Area 1

#### ***[Childhood Obesity]***

By December 31, 2024, decrease the percentage of children with obesity:

- By 5% from 13.7% (2016) to 13.0% among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- By 5% from 17.3% (2014-16) to 16.4% among public school students in NYS exclusive of New York City (NYC).
- By 5% from 20.4% (2015-16) to 19.4% among public school students in NYC.

*Data Sources: Pediatric Nutrition Surveillance System (PedNSS), Student Weight Status Category Reporting System (SWSCR), NYC Fitnessgram*

#### ***[Adult Obesity]***

By December 31, 2024, decrease the percentage of adults ages 18 years and older with obesity:

- By 5% from 25.5% (2016) to 24.2% among all adults.
- By 5% from 30.5% (2016) to 29.0% among adults with an annual household income of <\$25,000.
- By 5% from 38.1% (2016) to 36.2% among adults living with a disability.

*Data Source: Behavioral Risk Factor Surveillance System (BRFSS)*

#### ***[Sugary Drink Consumption]***

By December 31, 2024, decrease the percentage of adults who consume one or more sugary drinks per day:

- By 5% from 23.2% (2016) to 22.0% among all adults.
- By 10% from 31.7% (2016) to 28.5% among adults with an annual household income of <\$25,000.

*Data Source: BRFSS*

#### ***[Fruit and Vegetable Consumption]***

By December 31, 2024, decrease the percentage of adults who consume less than one fruit and less than one vegetable per day:

- By 5% from 31.2% (2016) to 29.6% among all adults.
- By 5% from 41.2% (2016) to 39.1% among adults who are non-Hispanic black.
- By 5% from 41.2% (2016) to 39.1% among adults who are Hispanic.

*Data Source: Expanded Behavioral Risk Factor Surveillance System (eBRFSS)*

**[Fruit and Vegetable Purchasing]**

By December 31, 2024, increase the percentage of adults who buy fresh fruits and vegetables in their neighborhood:

- By 5% from 86.3% (2015) to 90.6% among adults who are non-Hispanic black.

*Data Source: BRFSS*

**[Food Security]**

By December 31, 2024, increase the percentage of adults with perceived food security:

- By 5% from 76.4% (2016) to 80.2% among all adults.
- By 10% from 55.8% (2016) to 61.4% among adults with an annual household income of <\$25,000.

*Data Sources: BRFSS*

**Combined Interventions for Focus Area 1**

**Intervention:** Adopt policies and implement practices to reduce (over)consumption of sugary drinks

Sugar-sweetened beverages (SSBs) are the largest source of added sugar and an important contributor of calories in the U.S. diet. Several social and environmental factors have been linked to the purchase and consumption of SSBs, and several mechanisms have been proposed to explain the association between SSB consumption and obesity. Research indicates that consumption of SSB is a modifiable behavior and that change in consumption is associated with change in body weight or obesity. There is growing evidence that adopting policies and implementing practices, such as limiting access to SSBs, promoting access to and consumption of more healthful alternatives to SSBs, limiting marketing of SSBs, and implementing differential pricing of SSBs to reduce the relative cost of more healthful beverages, are associated with reductions in the purchase and consumption of SSBs. Local health departments, other agencies, hospitals, businesses, community-based organizations (CBOs) and other stakeholders can collaboratively work to support promising policies, practices and environmental changes.

**Evidence base:**

- [County Health Rankings and Roadmaps: Sugar Sweetened Beverage Taxes](#)
- [IOM: Preventing Childhood Obesity: Health in the Balance](#)
- [Public Health Law Center: Sickly Sweet: Why the Focus on Sugary Drinks](#)
- [Evidence that a tax on sugar sweetened beverages reduces the obesity rate: a meta-analysis](#)
- [Academy Health: Rapid Evidence Review: How do taxes on sugar-sweetened beverages affect health and health care costs?](#)
- [Cochrane Protocol: Taxation of sugar-sweetened beverages for reducing their consumption and preventing obesity or other adverse health outcomes](#)

**Resources:**

- [CDC: Community Strategies and Measurements to Prevent Obesity in the United States](#)
- [IOM: Strategies to Limit Sugar-Sweetened Beverage Consumption in Young Children](#)
- [CDC: Guide to Strategies for Reducing the Consumption of Sugar-Sweetened Beverages](#)
- [CDC: A Toolkit for Creating Healthy Hospital Environments: Making Healthier Food, Beverage, and Physical Activity Choices](#)
- [ChangeLab Solutions: SSB Restrictions](#)
- [Public Health Law Center: Sugar-Sweetened Beverages](#)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Food security; education; built environment

**Sector(s) playing lead role:** Policy makers and elected officials; employers, businesses and unions; schools; colleges and universities

**Sector(s) playing contributing role:** Media; governmental public health agencies; governmental agriculture agencies; agriculture organizations; urban planning agencies

**Intermediate-level measure:** Number of entities that adopt policies or implement practices to reduce consumption of sugary drinks

- [The Healthy Hospital Food, Beverage, and Physical Activity Environment Scans](#)
- [The Healthy Hospital Toolkit](#)
- [Nutrition Environment Measures Survey \(NEMS\)](#)

**Intervention:** Quality nutrition (and physical activity) in early learning and child care settings

As the obesity epidemic has grown, even the youngest children are affected. The prevalence of young children with obesity or overweight has increased, and for many, this will persist through childhood and adulthood. With the identification of risk factors and obesogenic environments, a growing body of evidence research identifies policy and environmental strategies that support improved nutrition, increased physical activity and reduced screen time to prevent and reduce early childhood overweight and obesity. Local health departments, other agencies, businesses, CBOs and other stakeholders can work with local child care providers to promote and support evidence-based policy and environmental changes.

**Evidence base:**

- [IOM: Early Childhood Obesity Prevention Policies](#)
- [Caring for Our Children: Preventing Childhood Obesity in Early Care and Education Programs](#)

**Resources:**

- [County Health Rankings & Roadmaps: Nutrition and physical activity interventions in preschool child care](#)
- [Caring for Our Children: Preventing Childhood Obesity in Early Care and Education Programs](#)

- [CDC: The Spectrum of Opportunities Framework for State-level Obesity Prevention Efforts Targeting the Early Care and Education Setting](#)
- [CDC State Obesity Prevention Efforts Targeting Early Care and Education Setting](#)
- [University of North Carolina: Go NAP SACC](#)

**Age range(s):** Children 6 weeks up to age 6 years

**Social Determinant of Health addressed:** Built environment

**Sector(s) playing lead role:** Governmental children’s agencies; child care centers; day care homes; policy makers and elected officials

**Sector(s) playing contributing role:** Community and neighborhood residents; governmental public health agencies; parents

**Intermediate-level measure:** Number of early care and education sites that improve nutrition policies and practices

- [Enrollment data from CACFP](#)
- [The Nutrition and Physical Activity Self-Assessment for Child Care \(NAPSACC\)](#)

**Intervention:** Worksite nutrition and physical activity programs designed to improve health behaviors and results

Local health departments, hospitals, health centers, businesses, CBOs and other stakeholders can implement wellness programs at their own worksite and work with local worksites to implement nutrition and physical activity interventions as part of a comprehensive worksite wellness program. Recommended components include:

- Educating and informing through classes, distributing written information or utilizing educational software.
- Conducting activities that target thoughts and social factors to influence behavior change. Examples include individual or group behavioral counseling, skill-building activities, providing rewards, and building support systems among co-workers and family members.
- Changing physical or organizational structures that reach the entire workforce and make the healthy choice the easy choice. Examples include changing the options in cafeterias or vending machines; providing more opportunities for physical activity; modifying health insurance benefits; or offering memberships to health clubs.

**Evidence base:**

- [The Community Guide: Obesity Worksite Programs](#)
- [County Health Rankings & Roadmaps: Worksite Obesity Prevention Interventions](#)

**Resources:**

- [CDC: Workplace Health Model](#)
- [CDC: Tips for Offering Healthier Options and Physical Activity at Workplace Meetings and Events](#)
- [CDC: Creating Healthier Hospital Food, Beverage and Physical Activity Environments](#)
- [CDC: A Step-by-Step Guide Using the Healthy Hospital Food, Beverage, and Physical Activity Environment Scans](#)

- [CDC: Workplace Health Promotion](#)
- [CDC: Smart Food Choices: How to Implement Food Service Guidelines in Public Facilities](#)
- [A Report and Recommendations by the Workgroup on Food Procurement Guidelines to the: New York State Council on Food Policy](#)
- [NYC Food Policy: Procurement Standards for Meals and Snacks](#)
- [CSPI: Healthy Meetings](#)
- [CSPI: Healthier Food Choices for Public Places](#)

**Age range(s):** Adolescents (13-21), adults (21-60), older adults (60+)

**Social Determinant of Health addressed:** Health care; built environment

**Sector(s) playing lead role:** Employers, businesses and unions

**Sector(s) playing contributing role:** Healthcare delivery system; insurers; governmental public health agencies

**Intermediate-level measure:** Number of worksites that improve nutrition policies and practices

- [The CDC Worksite Health ScoreCard](#)
- [Smart Food Choices: How to Implement Food Service Guidelines in Public Facilities- APPENDIX B](#)

**Related to other interventions, focus areas and goals from other priorities:** Promote a Healthy and Safe Environment; Promote Well-Being and Prevent Mental and Substance Use Disorders

**Intervention:** Multi-component school-based obesity prevention interventions

Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders can collaborate to work with local school districts and parent-teacher organizations to support policy, and environmental changes that target physical activity and nutrition before, during or after school. Recommended components include:

- Increasing the availability of healthier foods and beverages.
- Selling healthier snack foods and beverages.
- Using strategies to market healthier foods and beverages.
- Limiting access to less healthy foods and beverages.
- Providing healthy eating learning opportunities.
- Creating school meal policies to ensure school breakfasts or lunches meet specific nutrition requirements.
- Providing fresh fruits and vegetables to students at lunch and/or snack.
- Increasing access to school breakfast.
- Participating in Farm to School Programs.

**Evidence base:**

- [The Community Guide: Multicomponent Interventions Increase Availability Healthier Foods and Beverages in Schools](#)

- [Obesity: Meal or Fruit and Vegetable Snack Interventions to Increase Healthier Foods and Beverages Provided by Schools](#)
- [County Health Rankings & Roadmaps: Multi-Component School-Based Obesity Prevention Interventions](#)
- [County Health Rankings & Roadmaps: School Breakfast Programs](#)

**Resources:**

- [CDC: School-Based Obesity Prevention Strategies for State Policymakers](#)
- [CDC: Healthy Schools - School Nutrition](#)
- [CDC: Comprehensive Framework for Addressing School Nutrition Environment and Services](#)
- [CDC: School Health Guidelines to Promote Healthy Eating and Physical Activity](#)
- [CDC: Healthy Schools - Parents for Healthy Schools](#)
- [IOM: Nutrition Standards for Foods in Schools: Leading the Way toward Healthier Youth](#)
- [Alliance for Healthier Generation - Schools](#)
- [USDA: School Breakfast Program](#)
- [FRAC: School Breakfast Program](#)
- [Hunger Solution New York's School Breakfast page](#)
- [Farm to School in New York - Resources](#)

**Age range(s):** Children up to age 12, adolescents (13-21)

**Social Determinant of Health addressed:** Food security; education, community cohesion

**Sector(s) playing lead role:** Governmental education agencies; governmental agricultural agencies; agricultural organizations; schools (K-12); policy makers and elected officials

**Sector(s) playing contributing role:** Community or neighborhood residents; media; CBOs and human service agencies; governmental public health agencies

**Intermediate-level measure:** Number of schools that improve nutrition policies and practices

- [School Health Index](#)
- [The Wellness School Assessment Tool, WellSAT 2.0](#) (The WellSAT-i measures implementation, and can be adapted for local use)
- [NYS Education Department, Average Daily Participation for School Meal Participation in NYS schools](#)
- [Hunger Solutions Annual Report, School Breakfast Participation Data: Bridging the Gap, Ending Student Hunger with Breakfast After the Bell](#)

**Related to other interventions, focus areas and goals from other priorities:** Promote a Healthy and Safe Environment, Promote Healthy Women, Infants and Children; Promote Well-Being and Prevent Mental and Substance Use Disorders

**Intervention:** Increase the availability of fruit and vegetable incentive programs

Systematic evidence reviews find that financial incentive programs can increase affordability, access, purchases, and consumption of fruits and vegetables. Incentive programs for the purchase of fruits and vegetables have also been shown to increase sales and use of food assistance benefits (e.g., SNAP or WIC) at farmers' markets. Financial incentives can be a dollar-for-dollar match or a set amount per dollar spent (i.e., \$2 for every \$5 spent). Local health departments, hospitals, health centers, insurers, businesses, CBOs, hunger prevention advocates and other stakeholders can collaborate with local agencies to increase the availability and/or provide matching funds for low-income persons to purchase healthy foods, especially fresh fruits and vegetables.

**Evidence base:**

- [County Health Rankings & Roadmaps: Fruit and Vegetable Incentive Programs](#)
- [Pricing strategies to encourage availability, purchase, and consumption of healthy foods and beverages: A systematic review](#)

**Resources:**

- [How to Run a Nutrition Incentive Program: A toolkit for Wholesome Wave's National Nutrition Incentive Network](#)
- [How to Grow Your Nutrition Incentive Program: A toolkit for Wholesome Wave's National Nutrition Incentive Network](#)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Food security

**Sector(s) playing lead role:** Governmental public health agencies; governmental social support agencies; governmental agricultural agencies

**Sector(s) playing contributing role:** Healthcare delivery system; CBOs and human service agencies

**Intermediate-level measure:** Number of programs that adopt policies and practices to increase consumption of fruits and vegetables.

- [How to Run a Nutrition Incentive Network-PAGE 34, 47, APPENDICES](#)
- [How to Grow Your Nutrition Incentive Program-CHAPTER 5 AND APPENDICES](#)

**Related to other interventions, focus areas and goals from other priorities:** Promote Healthy Women, Infants, and Children

**Intervention:** Screen for food insecurity, facilitate and actively support referral

Effective systems for referral are necessary to help individuals and families access services and benefits for which they are eligible. Screening for food insecurity in clinical settings has been recommended by several national organizations, as food insecurity can adversely impact a patient's health outcomes. Some studies have shown that screening for food insecurity is feasible and adds minimal time to the appointment. Screening can ensure timely referral to public health nutrition programs such as WIC, SNAP, CACFP and Commodity Supplemental Food Program (CSFP), and, if necessary, local emergency food services. Screening and referral alone, however, may not be sufficient. Successful case studies have included additional information

technology (IT), systems and/or staff resources to facilitate connection, application, and enrollment in the appropriate public health nutrition and/or community program(s).

Local hospitals, health centers, businesses, and other stakeholders can partner with CBOs and governmental or private human services organizations to:

- Promote and support screening of pediatric patients by healthcare providers, facilitate referral and support active connection to WIC and/or SNAP;
- Promote screening of older-adult populations for food insecurity, facilitate referral and support active connection to SNAP; and
- Provide IT, systems and/or staff resources to help individuals and families access, connect and enroll in appropriate nutrition and/or community programs to receive the benefits for which they eligible.

**Evidence base:**

- [Addressing Social Determinants of Health at Well Child Care Visits: A Cluster RCT](#)
- [Clinicians' Perceptions of Screening for Food Insecurity in Suburban Pediatric Practice](#)
- [Screening for social determinants of health in clinical care: Moving from the margins to the mainstream.](#)
- [Taking action on the social determinants of health in clinical practice: a framework for health professionals](#)
- [https://www.chcs.org/media/HFCO-Case-Study\\_080918.pdf](https://www.chcs.org/media/HFCO-Case-Study_080918.pdf)
- [Hunger Free Colorado: Connecting Vulnerable Patients to Food and Nutrition Resources \(Case Study\)](#)

**Resources:**

- [AAP, FRAC: Addressing Food Insecurity: A Toolkit for Pediatricians](#)
- [AARP: Implementing Food Security Screening and Referral for Older Patients in Primary Care: A resource Guide and Toolkit](#)
- [FRAC: Free Online Course to Help Health Care Providers Address Senior Hunger](#)
- [Feeding America: Addressing Food Insecurity in Health Care Settings](#)
- [AARP, FRAC: Combating Food Insecurity: Tools for Helping Older Adults Access SNAP](#)
- [Nutrition & Obesity Network: Addressing Food Insecurity: Clinic-to-Community Treatment Models](#)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Food security

**Sector(s) playing lead role:** Health care delivery system; CBOs and human service agencies

**Intermediate-level measure:** 1) Number of health practices that screen for food insecurity and facilitate referrals to supportive services; 2) Percent of eligible New Yorkers participating in SNAP; 3) Percent of eligible New Yorkers participating in WIC.

- [USDA Program Data Site: SNAP, WIC, School Lunch](#)
- [NYS OTDA Monthly Caseload Statistics](#)
- [NYS SNAP Data](#)

- [Feeding America: Assessment and Evaluation Resources](#)
- [USDA: Community Food Security Assessment Toolkit](#)

**Related to other interventions, focus areas and goals from other priorities:** Promote Healthy Women, Infants, and Children

## Focus Area 2: Physical Activity

**Overarching Goal:** Reduce obesity and the risk of chronic diseases

**Goal 1:** Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities

**Goal 2:** Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities

**Goal 3:** Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity

### Combined Objectives for Focus Area 2

#### ***[Childhood Obesity]***

By December 31, 2024, decrease the percentage of children with obesity:

- By 5% from 13.7% (2016) to 13.0% among WIC children ages 2-4 years.
- By 5% from 17.3% (2014-16) to 16.4% among public school students in NYS exclusive of NYC.
- By 5% from 20.4% (2015-16) to 19.4% among public school students in NYC.

*Data Sources: Pediatric Nutrition Surveillance System (PedNSS), Student Weight Status Category Reporting System (SWSCR), NYC Fitnessgram*

#### ***[Adult Obesity]***

By December 31, 2024, decrease the percentage of adults ages 18 years and older with obesity:

- By 5% from 25.5% (2016) to 24.2% among all adults.
- By 5% from 30.5% (2016) to 29.0% among adults with an annual household income of <\$25,000.
- By 5% from 38.1% (2016) to 36.2% among adults living with a disability.

*Data Source: Behavioral Risk Factor Surveillance System (BRFSS)*

#### ***[Leisure-time Physical Activity]***

By December 31, 2024, increase the percentage of adults age 18 years and older who participate in leisure-time physical activity:

- By 5% from 73.7% (2016) to 77.4% among all adults.
- By 10% from 53.4% (2016) to 58.7% among adults with less than a high school education.
- By 10% from 56.2% (2016) to 61.8% among adults with disabilities.
- By 10% from 69.0% (2016) to 75.9% among adults age 65 years or older.

*Data Source: BRFSS*

#### ***[Physical Activity Guidelines]***

By December 31, 2024, increase the percentage of adults age 18 years and older who meet the aerobic and muscle strengthening physical activity guidelines:

- By 5% from 20% (2015) to 21.0% among all adults.
- By 10% from 10.9% (2015) to 12.0% among adults with less than a high school education.
- By 10% from 9.5% (2015) to 10.5% among adults with disabilities.
- By 10% from 16.4% (2015) to 18.0% among adults age 65 years or older.

*Data Source: BRFSS*

### ***[Walking or Biking]***

By December 31, 2024 increase the percentage of adults age 18 and over who walk or bike to get from one place to another

- By 5% from XX% (2018) to YY% among adults age 18 years and older.
- By 10% from XX% (2018) to YY% among adults with less than a high school education.
- By 10% from XX% (2018) to YY% among adults with disabilities.
- By 10% from XX% (2018) to YY% among adults age 65 years or older.

*Data source: BRFSS (Baseline data will be collected in 2018)*

### ***[Physical Activity – High School Students]***

By December 31, 2024, increase the percentage of high school students who were physically active for a total of at least 60 minutes/day on all 7 days:

- By 5% from 23.2% (2017) to 24.4% among high school students.
- By 10% from 17% (2017) to 18.7% among Black high school students.
- By 10% from 18.3% (2017) to 20.1% among Hispanic high school students.

*Data source: Youth Risk Behavior Survey (YRBS)*

**Goal 1:** Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.

**Intervention:** Implement a combination of one or more new or improved pedestrian, bicycle, or transit transportation system components (i.e., activity-friendly routes):

- Street pattern design and connectivity
- Pedestrian infrastructure
- Bicycle infrastructure
- Public transit infrastructure and access

with new or improved land use or environmental design components (i.e., connecting everyday destinations):

- Mixed land use
- Increased residential density
- Community or neighborhood proximity
- Parks and recreational facility access

through comprehensive master/transportation plans or Complete Streets resolutions, policies, or ordinances to connect sidewalks, multi-use paths and trails, bicycle routes, and public transit with homes, early care and education sites, schools, worksites, parks, recreation facilities, and natural or green spaces.

**Evidence base:**

- [Community Preventive Services Task Force Recommendation for Built Environment Interventions to Increase Physical Activity](#)

**Resources:**

- [Community Guide: Combined Built Environment Approaches](#)
- [The Surgeon General's Call to Action to Promote Walking and Walkable Communities](#)
- [Community Health Inclusion Sustainability Planning Guide](#)
- [Inclusive Community Health Implementation Package \(iCHIP\)](#)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Built environment, economic stability, transportation, community cohesion

**Sector(s) playing lead role:** Governmental public health agencies

**Sector(s) playing contributing role:** Transportation agencies, urban planning agencies, policy makers, environmental agencies, employers, insurers, media, colleges and universities, schools (K-12), community or neighborhood residents, CBOs and human service agencies, housing agencies, economic development agencies, natural environment agencies

**Intermediate-level measure:** Number of places that implement new, or improve existing, community planning and transportation interventions that support safe and accessible physical activity

**Related to other interventions, focus areas and goals from other priorities:** Healthy Eating and Food Security; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants, and Children; Promote Well-Being and Prevent Mental and Substance Use Disorders

**Goal 2:** Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities.

**Intervention (School):** Implement the Centers for Disease Control and Prevention (CDC) Comprehensive School Physical Activity Program in school districts through Local School Wellness Policy Committees aligned with school district educational outcomes; Local School Wellness Policy requirements; School Health Improvement Plans; CDC's Whole School, Whole Community, Whole Child Model; New York State Education Department's Every Student Succeeds Act Plan; School Health Index and Wellness School Assessment Tool (WellSAT) assessments; school staff and teacher professional development and training standards, and with resource or materials support.

**Evidence base:**

- [Physical Activity: Enhanced School-Based Physical Education](#)
- [Behavioral Interventions that Aim to Reduce Recreational Sedentary Screen Time Among Children](#)

**Resources:**

- [Comprehensive School Physical Activity Programs: A Guide for Schools](#)
- [School Health Guidelines to Promote Healthy Eating and Physical Activity](#)
- [Strategies for Recess in Schools](#)
- [Parents for Healthy Schools](#)
- [WellSAT Physical Activity and Physical Education Items](#)

**Age range(s):** Children up to age 12, Adolescents (13-21)

**Social Determinant of Health addressed:** Education, community cohesion

**Sector(s) playing lead role:** Governmental public health agencies

**Sector(s) playing contributing role:** Schools (K-12), community residents, policy makers, governmental education agencies, media, colleges and universities, community or neighborhood residents, CBOs and human service agencies, housing agencies, economic development agencies

**Intermediate-level measure:** Number of schools with comprehensive school physical activity programs

**Related to other interventions, focus areas and goals from other priorities:** Promote a Healthy and Safe Environment; Promote Healthy Women, Infants, and Children; Promote Well-Being and Prevent Mental and Substance Use Disorders

**Intervention (Child Care):** Adopt and implement policies, programs, and best practices that meet QUALITYstars NY standards to provide infants daily opportunities to move freely under adult supervision to explore indoor and outdoor environments, including tummy time when awake; to provide opportunities for toddlers and/or preschoolers to have at least 15 minutes of developmentally appropriate, structured and unstructured, moderate to vigorous physical activity (both inside and outside) for every hour they are in care; and develop policies that limit screen time use of TV/video for children, including that TV/video is never used during nap and meal time or for children birth to age 2. For children ages 2 to 5 there is no more than 30 minutes once a week of high quality educational or movement-based commercial-free programming. Programs should also encourage parental involvement, provide portable play equipment on playgrounds and other play spaces, and provide staff with training in the delivery of structured physical activity sessions and increase the time allocated for such sessions.

**Evidence base:**

- [Childcare and Preschool Settings \(pg.29\)](#)
- [Caring for Our Children](#)
  - 3.1.3.1: [Active Opportunities for Physical Activity](#)
  - 3.1.3.4: [Caregivers'/Teachers' Encouragement of Physical Activity](#)
  - 2.2.0.3: [Screen Time/Digital Media Use](#)

**Resources:**

- [CDC Spectrum of Opportunities for Obesity Prevention in the Early Care and Education Setting \(ECE\)](#)
- [State Obesity Prevention Efforts Targeting the Early Care and Education Setting](#)
- [QUALITYstarsNY](#)
- [Nutrition and Physical Activity Self-Assessment in Childcare](#)
- [Early Care and Education State Indicator Report 2016](#)

**Age range(s):** Infants and toddlers up to age 5

**Social Determinant of Health addressed:** Education, community cohesion

**Sector(s) playing lead role:** Governmental public health agencies

**Sector(s) playing contributing role:** Governmental children and family services and state education agencies, media, colleges and universities, schools (K-12), community or neighborhood residents, CBOs and Human service agencies, Housing agencies, Economic development agencies

**Intermediate-level measure:** Number of early care and education sites that improve physical activity policies and practices using an evidence-based assessment tool

**Related to other interventions, focus areas and goals from other priorities:** Healthy Eating and Food Security; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants, and Children; Promote Well-Being and Prevent Mental and Substance Use Disorders

**Intervention (Worksites):** Implement a combination of worksite-based physical activity policies, programs, or best practices through multi-component worksite physical activity and/or nutrition programs; environmental supports or prompts to encourage walking and/or taking the stairs; or structured walking-based programs focusing on overall physical activity that include goal-setting, activity monitoring, social support, counseling, and health promotion and information messaging.

**Evidence base:**

- [Physical Activity: Point-of-Decision Prompts to Encourage Use of Stairs](#)
- [Worksite Nutrition and Physical Activity Programs](#)
- [Technology-Supported Multicomponent Coaching or Counseling Interventions – To Reduce Weight](#)
- [Technology-Supported Multicomponent Coaching or Counseling Interventions – To Maintain Weight Loss](#)

**Resources:**

- [CDC Workplace Physical Activity Interventions](#)
- [CDC Worksite Physical Activity Resources](#)
- [CDC Worksite Health Scorecard-Physical Activity Module](#)

**Age range(s):** Adolescents (13-21), Adults (21-60), Older Adults (60+)

**Social Determinant of Health addressed:** Economic Stability, Health Care

**Sector(s) playing lead role:** Governmental Public Health Agencies

**Sector(s) playing contributing role:** Healthcare System, Employers, Unions, Insurers,

**Intermediate-level measure:** Number of worksites that improve physical activity policies and practices using an evidence-based assessment tool

**Related to other interventions, focus areas and goals from other priorities:** Promote a Healthy and Safe Environment, Promote Well-Being and Prevent Mental and Substance Use Disorders

**Goal 3:** Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.

**Intervention:** Implement and/or promote a combination of community walking, wheeling, or biking programs, Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety and decreased incivilities (i.e., litter, graffiti, dogs off leash, unmaintained equipment), new or upgraded park or facility amenities or universal design features (i.e. playgrounds and structures; walking loops, recreation fields; gymnasiums; pools; outdoor physical activity equipment, fitness stations or zones; skate zones; picnic areas; concessions or food vendors; and pet waste stations); supervised activities or programs combined with onsite marketing, community outreach, and safety education.

(Note: Parks can include mini-parks, pocket parks, or parklets; neighborhood parks; community and large urban parks; sports complexes; and natural resource areas.)

**Evidence base:**

- [Social Support Interventions in Community Settings](#)
- [Community Preventive Services Task Force Recommendation for Built Environment Interventions to Increase Physical Activity](#)
- [The First National Study of Neighborhood Parks](#)

**Resources:**

- [Community Guide: Combined Built Environment Approaches](#)
- [The Surgeon General's Call to Action to Promote Walking and Walkable Communities](#)
- [Community Health Inclusion Sustainability Planning Guide](#)
- [Inclusive Community Health Implementation Package \(iCHIP\)](#)
- [Parks for Inclusion](#)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Built environment, natural environment, economic stability, transportation, community cohesion

**Sector(s) playing lead role:** Governmental public health agencies

**Sector(s) playing contributing role:** Transportation agencies, urban planning agencies, policy makers, environmental agencies, employers, insurers, media, colleges and universities, schools (K-12), community or neighborhood residents, CBOs and human service agencies, housing agencies, economic development agencies, natural environment agencies

**Intermediate-level measure:** Number of indoor and/or outdoor facilities that can be accessed by walking, biking, or wheeling

**Related to other interventions, focus areas and goals from other priorities:** Healthy Eating and Food Security; Promote a Healthy and Safe Environment; Promote Healthy Women, Infants, and Children; Promote Well-Being and Prevent Mental and Substance Use Disorders

## Focus Area 3: Tobacco

Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure. Tobacco products include combustible cigarettes, cigars, cigarillos, pipe, and hookah, electronic cigarettes and other vaping products, and smokeless tobacco. Novel tobacco products may be added as necessary.

**Goal 1:** Prevent initiation of tobacco use, including combustible tobacco and vaping products (defined as e-cigarettes and similar devices) by New York youth and young adults.

### Objectives:

#### ***[Any Tobacco Use-High School]***

By December 31, 2024, decrease the prevalence of any tobacco use by high school students by 22.4% from 25.4% (2016) to 19.7%.

*Data source: NYS Youth Tobacco Survey (NYS YTS)*

#### ***[Cigarette Use-High School]***

By December 31, 2024, decrease the prevalence of combustible cigarette use by high school students by 23.3% from 4.3% (2016) to 3.3%.

*Data source: NYS YTS*

#### ***[Electronic Vapor Products-High School]***

By December 31, 2024, decrease the prevalence of vaping product use by high school students by 22.8% from 20.6% (2016) to 15.9%.

*Data source: NYS YTS*

#### ***[Cigarette Use -Young Adults]***

By December 31, 2024, decrease the prevalence of combustible cigarette use by young adults age 18-24 years by 22.2% from 11.7% to 9.1%.

*Data source: Behavioral Risk Factor Surveillance System (BRFSS)*

#### ***[Electronic Vapor Products - Young Adults]***

By December 31, 2024, decrease the prevalence of vaping product use by young adults age 18-24 years by 23.1% from 9.1% (2016) to 7.0%.

*Data source: BRFSS*

#### ***[Retail Environment Policy]***

By December 31, 2024, 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, from 15 (2018) to 30.

*Data Source: Community Activity Tracking (CAT) (Retail policies include restrictions on the number, type and location of licensed tobacco retailers including retailers that sell*

*primarily electronic vapor products whether they are licensed or not. Flavored tobacco products include characterizing flavors and menthol used in combustible and non-combustible tobacco products and flavored liquids including menthol used in electronic cigarettes and similar products.)*

**Intervention:** Increase Tobacco Control Program Funding to the CDC-Recommended level, to ensure a comprehensive tobacco control program.

**Resources:** [Best Practices]; 2016 Independent Evaluation Report of the New York Tobacco Control Program

[https://www.cdc.gov/tobacco/stateandcommunity/best\\_practices/index.htm](https://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Social and community context/health and health care

**Sector(s) playing lead role:** Advocates, state government

**Sector(s) playing contributing role:** Local government, community organizations and individuals

**Intermediate-level measure:** Raise program funding to \$52 million, approximately 25 percent of recommended full funding

**Intervention:** Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.

**Resources:** The Community Guide: The Role of the Media in Promoting and Reducing Tobacco Use <https://www.thecommunityguide.org/topic/tobacco>

**Age range(s):** All ages

**Social Determinant of Health addressed:** Social and community context: Social cohesion

**Sector(s) playing lead role:** Media, state and local health departments

**Sector(s) playing contributing role:** Advocates, community organizations and health department grantees

**Intermediate-level measure:** Evidence of increasing support for effective tobacco control measures that would reduce youth initiation

**Intervention:** Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas.

**Resources:** Public Health Law Center,

<http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-guide-policy-WashU-2014.pdf>

**Age range(s):** All ages

**Social Determinant of Health addressed:** Neighborhood and environment: Environmental conditions

**Sector(s) playing lead role:** Local government

**Sector(s) playing contributing role:** Advocates, community organizations, local business

**Intermediate-level measure:** Evidence of increasing support for effective tobacco control measures that would reduce youth initiation

**Intervention:** Keep the price of tobacco uniformly high by regulating tobacco company practices that reduce the real price of cigarettes through discounts.

**Resources:** Public Health Law Center

<http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-guide-policy-WashU-2014.pdf>

**Age range(s):** All ages

**Social Determinant of Health addressed: Neighborhood and Environment:**

Environmental conditions

**Sector(s) playing lead role:** Local government,

**Sector(s) playing contributing role:** Advocates, community organizations, local business

**Intermediate-level measure:** Evidence of increasing support for effective tobacco control measures that restrict tobacco company practices that decrease the real price of tobacco products through industry discounts

**Intervention:** 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.

**Resources:** Public Health Law Center

<http://www.publichealthlawcenter.org/sites/default/files/resources/Regulating-Flavored-Tobacco-Products-2017.pdf>

**Age range(s):** All ages

**Social Determinant of Health addressed: Neighborhood and environment:**

Environmental conditions

**Sector(s) playing lead role:** Local government,

**Sector(s) playing contributing role:** Advocates, community organizations

**Intermediate-level measure:** Evidence of increasing support for effective tobacco control measures that would restrict the sale of flavored tobacco products and flavored liquids used in electronic vapor products

**Intervention:** Advocate with media parent companies to eliminate youth exposure to tobacco imagery and tobacco marketing in youth-rated movies.

**Resources:** University of California, San Francisco, <https://smokefreemovies.ucsf.edu/>

**Age range(s):** Birth - 18

**Social Determinant of Health addressed: Social and Community Context:** Social cohesion

**Sector(s) playing lead role:** Entertainment

**Sector(s) playing contributing role:** Advocates, community organizations, youth

**Intermediate-level measure:** Evidence of increasing support for effective tobacco control measures that would eliminate youth exposure to tobacco imagery and marketing in youth-rated movies

**Goal 2:** Promote tobacco use cessation, especially among populations disparately affected by tobacco use including: low SES, frequent mental distress or substance use disorders, LGBT, and disability.

**Objectives:**

***[Health Care Provider Assist with Quitting]***

By December 31, 2024, 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%.

*Data Source: NY Adult Tobacco Survey; NYS ATS*

By December 31, 2024, decrease the prevalence of cigarette smoking by adults ages 18 years and older by 23%:

- ***[Cigarette Use-All Adults]*** from 14.2% (2016) to 11.0% among all adults.
- ***[Cigarette Use-Low Income Adults]*** from 19.8% (2016) to 15.3% among adults with income less than \$25,000.
- ***[Cigarette Use-Less Educated Adults]*** from 19.2% (2016) to 14.9% among adults with less than a high school education.
- ***[Cigarette Use-Adults Reporting Frequent Mental Distress]*** from 26.0% (2016) to 20.1% among adults who report frequent mental distress.
- ***[Cigarette Use- Adults Identifying as LGBT]*** from 19.3% (2014-2016 pooled) to 14.9% among adults who self-identify as LGBT.
- ***[Cigarette Use-Adults Living with a Disability]*** from 20.1% (2016) to 15.6% among adults who are living with any disability.

*Data Source: BRFSS*

***[Utilization of Medicaid Cessation Benefits]***

By December 31, 2024, increase the utilization of smoking cessation benefits (counseling and/or medications) among smokers who are enrolled in any Medicaid\* program by 27.8% from 20.5% (2016) to 26.2%.

*Data source: Medicaid Program. \*Any Medicaid includes managed care and fee for service and special population programs (HARP and SNIPS). Excludes dual-eligible enrollees (Medicaid/Medicare) and those under 18 or over 64.*

**Intervention:** Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on federally qualified health centers, community health centers and behavioral health providers.

**Resources:** <https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html>  
<https://talktoyourpatients.health.ny.gov/>

**Age range(s):** 18 years and older

**Social Determinant of Health addressed:** Health and health care: Access to health care

**Sector(s) playing lead role:** FQHCs, CHC, behavioral health clinics, provider practices

**Sector(s) playing contributing role:** Local health departments, state health department

**Intermediate-level measure:** Health care providers exhibit greater propensity to provide counseling and medications where appropriate to treat tobacco dependence in their patients

**Intervention:** 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 Smokers' Quitline.

**Resources:**

<https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html>

<https://talktoyourpatients.health.ny.gov/>

<https://www.nysmokefree.com/>

**Age range(s):** 18 years and older

**Social Determinant of Health addressed:** Health and health care: Access to health care

**Sector(s) playing lead role:** State health department, local health departments

**Sector(s) playing contributing role:** Healthcare delivery system, media

**Intermediate-level measure:** Promote and educate smokers about the benefits of evidence-based quitting approaches

**Intervention:** Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based

quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.

**Resources:** <https://talktoyourpatients.health.ny.gov/>

**Age range(s):** 18 years and older

**Social Determinant of Health addressed:** Health and health care: Access to health care

**Sector(s) playing lead role:** Health care organizations and providers; NYS Smokers' Quitline; community based organizations

**Sector(s) playing contributing role:** County health departments; ACS, AHA, ALA

**Intermediate-level measure:** Work with departmental health system grantees to promote the delivery of evidence-based cessation services by health care providers

**Intervention:** Promote Medicaid and other health plan coverage benefits for tobacco dependence counseling and medications.

**Resources:** CDC: <https://www.cdc.gov/mmwr/volumes/67/wr/mm6713a3.htm>

**Age range(s):** 18 years and older

**Social Determinant of Health addressed:** Health and health care: Access to health care

**Sector(s) playing lead role:** Medicaid offices, county health departments,

**Sector(s) playing contributing role:** Community based organizations, ACS, AHA, ALA

**Intermediate-level measure:** Increase awareness of Medicaid benefits for tobacco use cessation among Medicaid enrollees and health care providers

**Goal 3:** Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products.

#### **Objectives:**

##### ***[Secondhand Smoke Exposure-Multiunit Housing]***

By December 31, 2024, decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes by 22.7%, from 35.2% (2017) to 27.2%.

*Data source: NYS ATS*

##### ***[Secondhand Smoke Exposure -Middle School & High School Age Youth]***

By December 31, 2024, 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 by 22.5% from 23.1% (2016) to 17.9%.

*Data source: NYS YTS*

##### ***[Secondhand Smoke Policies]***

By December 31, 2024, 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 5000 units each year.

*Data source: CAT (Note: Smoke-free units count only when all units in a building are smoke-free. Units in buildings partially smoke-free do not count.)*

**Intervention:** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents.

**Resources:** HUD Smoke Free Public Housing

[https://www.hud.gov/program\\_offices/healthy\\_homes/smokefree](https://www.hud.gov/program_offices/healthy_homes/smokefree)

**Age range(s):** All

**Social Determinant of Health addressed:** Neighborhood and environment:  
Environmental conditions

**Sector(s) playing lead role:** Housing

**Sector(s) playing contributing role:** Advocates, community organizations

**Intermediate-level measure:** Increase the number of 100% smoke-free public housing units. Increase the proportion of leases that require that smoking policies be transparent

**Related to other interventions, focus areas and goals from other priorities:** Related to tobacco free outdoor areas, as many policies include both

**Intervention:** Increase the number of smoke-free parks, beaches, playgrounds, college and other public spaces.

**Resources:** Public Health and Tobacco Policy Center

<http://tobaccopolicycenter.org/tobacco-control/tobacco-free-outdoor-areas/>

**Age range(s):** All

**Social Determinant of Health addressed:** Neighborhood and environment:  
Environmental conditions

**Sector(s) playing lead role:** Government, business, educational institutions, healthcare institutions

**Sector(s) playing contributing role:** Advocates, community organizations

**Intermediate-level measure:** Increasing support for or actual policies passed that increase the number of smoke-free parks, beaches, playgrounds and other public spaces

**Intervention:** 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.

**Resources:**

[https://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/secondhand\\_smoke/general\\_facts/index.htm](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Neighborhood and environment:  
Environmental conditions

**Sector(s) playing lead role:** Business, government, educational institutions

**Sector(s) playing contributing role:** Advocates, health care, community organizations

**Intermediate-level measures:**

- Number of times decision makers were educated about secondhand smoke and aerosol/emissions
- Number of community education forums or media campaigns conducted

## Focus Area 4: Chronic Disease Preventive Care and Management

**Goal 1:** Increase cancer screening rates for breast, cervical and colorectal cancer screening

### Objectives:

#### ***[Breast Cancer Screening]***

By December 31, 2024, 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 (women aged 50 to 74 years who have received a mammogram in the past two years) by 5% to 79.7%. (Baseline: 75.9%; Year 2016)

*Data Source: Behavioral Risk Factor Surveillance System (BRFSS)*

#### ***[Cervical Cancer Screening]***

By December 31, 2024 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 (women ages 21 to 65 years who have received a Pap test within the past three years or women ages 30 to 65 years who have received a Pap and HPV co-test within the past five years from) by 5% to 80.0%. (Baseline: 76.1%; Year 2016)

*Data Source: BRFSS*

#### ***[Colorectal Cancer Screening]***

By December 31, 2024, increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (adults ages 50 to 75 years who received either a blood stool test within the past year, or a sigmoidoscopy within the past 5 years and a blood stool test within the past 3 years, or a colonoscopy within the past 10 years) by 17% to 80%\*. (Baseline: 68.5%; Year 2016)

- By 5% from 60.7% (2016) to 63.7% for adults with an annual household income less than \$25,000.
- By 5% from 63.1% (2016) to 66.3% for adults aged 50-64.

*Data Source: BRFSS*

\*The NYS 80% target is set to align with National goals

**Intervention:** 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).

**Evidence:** [The Community Guide](#)

**Age Range(s):** See objectives

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system, insurers

**Sector(s) playing contributing role:** Governmental public health agencies

**Intermediate-level measures:**

- Number of health systems that implement or improve provider and patient reminder systems
- Number of patients reached through patient reminder systems
- Compliance with screening guidelines among patients reached through patient reminder systems/among patients of health systems that adopted systems
- Provider, clinic or insurer breast, cervical and colorectal cancer screening rates

**Intervention:** 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).

**Evidence:** [The Community Guide](#)

**Age Range(s):** See objectives

**Social Determinants of Health addressed:** Education

**Sector(s) playing lead role:** Governmental public health agencies, health care delivery system, CBOs and human service agencies

**Sector(s) playing contributing role:** Employers, businesses and unions, insurers, community or neighborhood residents

**Intermediate-level measures:**

- Number of individuals reached through one-on-one or group education that were referred to health providers for cancer screening
- Change in knowledge and awareness of need for cancer screening among individuals reached through one-on-one or group education
- Compliance with screening guidelines among individuals that were reached through one-on-one or group education

**Intervention:** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand.

**Evidence:** [The Community Guide](#)

**Age Range(s):** See objectives

**Social Determinants of Health addressed:** Education

**Sector(s) playing lead role:** Governmental public health agencies, health care delivery system, insurers, CBOs and human service agencies

**Sector(s) playing contributing role:** Employers, businesses and unions

**Intermediate-level measures:**

- Number and type of locations where materials were distributed
- Change in knowledge and awareness of need for cancer screening among groups reached through small media dissemination

**Intervention:** 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).

**Evidence:** [The Community Guide](#)

**Age Range(s):** See objectives

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system, insurers

**Sectors playing a contributing role:** Governmental public health agencies

**Intermediate-level measures:**

- Number of health systems or providers that adopt or improve provider assessment and feedback systems for cancer screening
- Provider or clinic-level breast, cervical, and colorectal cancer screening rates

**Intervention:** 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.

**Evidence:** [The Community Guide](#)

**Age Range(s):** See objectives

**Social Determinants of Health addressed:** Health care, transportation

**Sector(s) playing lead role:** Governmental public health agencies, health care delivery system, employers, businesses, unions, CBOs and human service agencies, transportation agencies

**Intermediate-level measure:**

- Number of organizations that adopt practices and policies that reduce structural barriers to cancer screening

**Intervention:** Ensure continued access to health insurance to reduce economic barriers to screening.

**Evidence:** [The Community Guide](#)

**Age Range(s):** Adults ages 21-64

**Social Determinants of Health addressed:** Economic stability, health care

**Sector(s) playing lead role:** Governmental public health agencies, health care delivery system, employers, businesses and unions, insurers, CBOs and human service agencies, policy makers and elected officials

**Intermediate-level measure:**

- Change in the percent of NYS population that has health insurance coverage

**Resources:**

- <https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-CancerScreening.pdf>
- <https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102265&choice=default> (Colorectal)

- <https://www.ncbi.nlm.nih.gov/pubmed/29304835> (Colorectal)
- <https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102263&choice=default> (Breast)
- <https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102264&choice=default> (Cervical)

**Goal 2:** Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity

**Objectives:**

***[Diabetes Early Detection]***

By December 31, 2024, increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%.

(Baseline: 68.3%; Year 2016. Target: 71.7%)

*Data Source: BRFSS*

***[Diabetes Early Detection, Disparity – Low-Income Adults]***

By December 31, 2024, 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%.

(Baseline: 64.2%; Year 2016. Target: 67.4%)

*Data Source: BRFSS*

***[Weight Status Assessment – Children]***

By December 31, 2024 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%. (Baseline: 77% [HMO]; 77% [MMC]; Year 2016. Target: 80.6% [HMO]; 80.6% [MMC])

*Data Source: Quality Assurance Reporting Requirements (QARR)*

**Intervention:** Promote strategies that improve the detection of undiagnosed hypertension in health systems.

**Resources:** [Million Hearts](#)

**Age Range(s):** Adults, with a focus on those over 45 years

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system, insurers

**Sector(s) playing contributing role:** Governmental public health agencies

**Intermediate-level measures:**

- Number of health systems with policies/practices to identify patients with undiagnosed hypertension
- Number/percentage of patients served by health systems with policies/practices in place
- Number of patients identified with undiagnosed hypertension

**Related to other interventions, focus areas and goals from other priorities:** Delivery System Reform Incentive Payment (DSRIP) Program: 3bi Project - Evidence-based strategies for disease management in high risk/affected populations (adult only)

**Intervention:** Promote testing for prediabetes and risk for future diabetes in asymptomatic adults of any age with obesity or overweight (i.e., BMI  $\geq 25$  kg/m<sup>2</sup> or  $\geq 23$  kg/m<sup>2</sup> in Asian Americans) 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.

**Resources:**

- <https://www.cdc.gov/sixteen/diabetes/index.htm>
- <http://clinical.diabetesjournals.org/content/36/1/14>

**Age Range(s):** Adults, with a focus on those over 45 years

**Social Determinants of Health addressed:** Health Care

**Sector(s) playing lead role:** Healthcare delivery system, insurers

**Sector(s) playing contributing role:** Governmental Public Health Agencies

**Intermediate-level measures:**

- Number of health systems with policies/practices to identify patients with diabetes or prediabetes
- Number/percentage of patients served by health systems with policies/practices in place
- Number of patients identified with diabetes/prediabetes

**Goal 3:** Promote evidence-based care to prevent and manage chronic diseases in the clinical setting including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.

**Objectives:**

***[Diabetes Control - Adults]***

By December 31, 2024, decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%) by 5%. (Baseline: 28% [HMO]; 33% [MMC]; Year 2016. Target: 26.6% [HMO]; 31.4% [MMC])

*Data Source: QARR*

***[Diabetes Control, Disparity – Adult Black Medicaid Members]***

By December 31, 2024, decrease the percentage of adult Black Medicaid members with diabetes whose most recent HbA1c level indicated poor control (>9%) by 5%. (Baseline: 40%; Year 2016. Target: 38%)

*Data Source: QARR*

***[Diabetes Control, Disparity – Medicaid Members Aged 18-44]***

By December 31, 2024, decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbA1c level indicated poor control (>9%) by 5%. (Baseline: 41%; Year 2016. Target: 39%)

*Data Source: QARR*

***[Hypertension Control - Adults]***

By December 31, 2024, increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year by 5%. (Baseline: 63% [HMO]; 62% [MMC]; Year 2016. Target: 66.2% [HMO]; 65.1% [MMC])

*Data Source: QARR*

***[Hypertension Control, Disparity - Adult Black Medicaid Members]***

By December 31, 2024, increase the percentage of adult Black Medicaid members who had hypertension whose blood pressure was adequately controlled during the measurement year by 5%. (Baseline: 54%; Year 2016. Target 56.7%)

*Data Source: QARR*

***[Hypertension Control, Disparity - Medicaid Members Aged 18-44]***

By December 31, 2024, increase the percentage of adult Medicaid members 18-44 who had hypertension whose blood pressure was adequately controlled during the measurement year by 5%. (Baseline: 50%; Year 2016. Target 52.5%)

*Data Source: QARR*

***[Asthma - Emergency Department Visits]***

By December 31, 2024, decrease the Asthma ED rate for those aged 0-4, 0-17, and all age groups by 5%. (Baseline: 0-4: 185.1 per 10,000; 0-17: 138.0 per 10,000; all: 76.8 per 10,000; Year 2016. Target: 0-4: 175.8 per 10,000; 0-17: 131.1 per 10,000; all: 73.0 per 10,000)

*Data Source: SPARCS*

***[Asthma - Hospitalizations]***

By December 31, 2024, decrease the Asthma hospitalization rate for those aged 0-4, 0-17, and all age groups by 10%.

(Baseline: 0-4: 42.9 per 10,000; 0-17: 23.5 per 10,000; all: 10.7 per 10,000; Year 2016. Target: 0-4: 38.6 per 10,000; 0-17: 21.2 per 10,000; all: 9.6 per 10,000)

*Data Source: SPARCS*

***[Asthma - Controller Medications]***

By December 31, 2024, increase the percentage of 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 by 10%. (Baseline: 5-18: 54%; 19-64: 68%; Year 2016. Target: 5-18: 59%; 19-64: 75%)

*Data Source: QARR*

***[Asthma – Ratio of Controller to Total Medications]***

By December 31, 2024, increase the percentage of members (ages 5 to 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 by 10%. (Baseline: 5-18: 63%; 19-64: 56%; Year 2016. Target: 5-18: 69%; 19-64: 62%)

*Data Source: QARR*

***[Hypertension - Medication Use]***

By December 31, 2024, increase the percentage of adults with hypertension who are currently taking medicine to manage their high blood pressure by 5%. (Baseline: 76.90%; Year 2016. Target: 80.70%.)

*Data Source: BRFSS*

***[Arthritis – Physical Activity/Exercise]***

By December 31, 2024, 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%. (Baseline: 63.40%; Year 2015. Target: 66.60%)

*Data Source: BRFSS*

**Intervention:** 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.

**Resources:**

- [Million Hearts](#)
- [CDC Best Practice Guide for CVD](#)

**Age Range(s):** All ages

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Health care delivery system

**Sector(s) playing contributing role:** Governmental public health agencies; insurers

**Intermediate-level measures:**

- Number of health systems that implement policies/practices to promote team-based care
- Number/percentage of patients in health systems with policies/practices in place

**Related to other interventions, focus areas and goals from other priorities:** DSRIP 3bi Project - Evidence-based strategies for disease management in high risk/affected populations (adult only)

**Intervention:** Promote evidence-based medical management in accordance with national guidelines.

**Resources:**

- Cardiovascular Disease: [2017 Hypertension Guidelines](#), [2013 Cholesterol Guidelines](#)
- Chronic Kidney Disease: [https://kdigo.org/wp-content/uploads/2017/02/KDIGO\\_2012\\_CKD\\_GL.pdf](https://kdigo.org/wp-content/uploads/2017/02/KDIGO_2012_CKD_GL.pdf)  
<https://www.ahajournals.org/doi/abs/10.1161/01.cir.0000437738.63853.7a>
- Diabetes: <https://professional.diabetes.org/content-page/standards-medical-care-diabetes>  
<http://www.nyspma.org/aws/NYSPMA/pt/sp/diabetes>
- Asthma: <https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma>

**Age Range(s):** All ages

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies; insurers

**Intermediate-level measures:**

- Number of health systems that implement policies/practices to promote guideline-concordant chronic disease care
- Number/percentage of patients in health systems with policies/practices in place

**Related to other interventions, focus areas and goals from other priorities:**

DSRIP 3bi & 3diii Projects

**Intervention:** Promote the use of Health Information Technology for: Measurement, Registry Development, Patient Alerts, Bi-Directional Referrals, Reporting.

**Resources:** [Merit-Based Incentive Payment System \(MIPS\)](#)

**Age Range(s):** All ages

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies; insurers

**Intermediate-level measures:**

- Number of providers using a registry to identify patients with a chronic condition
- Number/percentage of health systems with certified EHRs
- Number/percentage of health systems with connections to a Qualified Entity
- Number/percentage of patients served by health systems with a certified EHR and/or QE connected health system

**Related to other interventions, focus areas and goals from other priorities:** Medicare Access and CHIP Reauthorization Act (MACRA) and Merit-Based Incentive Payment System (MIPS)

**Intervention:** Promote strategies that improve access and adherence to medications and devices.

**Resources:**

- Cardiovascular: [CDC 6/18 Intervention](#)
- Asthma: <https://www.cdc.gov/sixteenteen/asthma/index.htm>

**Age Range(s):** All ages

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies; insurers

**Intermediate-level measures:**

- Number of health systems that implement policies/practices to encourage self-management behaviors, including adherence to medication
- Number of health systems that include pharmacists as members of the care team
- Number/percentage of patients served by health systems with policies/practices related to self-management behaviors, including adherence to medication
- Number of patients identified with a self-management plan

**Related to other interventions, focus areas and goals from other priorities:** DSRIP 3bi & 3diii Projects - Evidence-based strategies for disease management in high risk/affected populations (adult only) and Implementation of evidence-based medicine guidelines for asthma management

**Intervention:** 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.

**Resources:** <http://clinical.diabetesjournals.org/content/36/1/14>

**Age Range(s):** Adults, including those over 65 years old

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies; insurers; CBOs and human service agencies

**Intermediate-level measures:**

- Number of health systems that have policies/practices for identifying and referring patients to National DPP programs
- Number of National DPP programs in community settings
- Number patients referred to National DPP
- Number of patients who participate in National DPP
- Percentage of patients who complete National DPP

**Intervention:** Counsel and refer patients with arthritis to increase physical activity, including participation in arthritis-appropriate evidence-based interventions and walking.

**Resources:**

[https://www.cdc.gov/mmwr/volumes/67/wr/mm6717a2.htm?s\\_cid=mm6717a2](https://www.cdc.gov/mmwr/volumes/67/wr/mm6717a2.htm?s_cid=mm6717a2)

**Age Range(s):** Adults with arthritis, including those over 65 years old

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies; insurers; employers, businesses and unions; media; CBOs and human service agencies; colleges and universities; community and neighborhood residents; policy-makers and elected officials; transportation agencies; housing agencies; natural environment agencies; urban planning agencies

**Intermediate-level measures:**

- Number of health systems that have policies/practices for identifying and counseling patients with arthritis on PA
- Number patient with arthritis identified and counseled
- Number of patients referred to evidence-based walking programs
- Number evidence-based walking programs in the community
- Number of patients who participate in programs/percentage who complete

**Goal 4:** In the community setting, improve self-management skills for individuals with chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.

**Objectives:**

***[Self-Management]***

By December 31, 2024, 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 by 5%. (Baseline: 10.10%; Year 2016. Target: 10.60%)

*Data Source: BRFSS*

***[Asthma Action Plan]***

By December 31, 2024, 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. (Baseline: 0-17: 48.3%; 18+: 24.21%. Year 2011-2013 (0-17); 2014 (18+). Target: 0-17: 53.1%; 18+: 26.6%.)

*Data Source: BRFSS Asthma Call-Back Survey*

**Intervention:** 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 with NAEPP Guidelines' medical management and asthma self-management education (ASME).

**Resources:**

- <https://www.cdc.gov/sixeighteen/asthma/index.htm>

- <https://www.thecommunityguide.org/findings/asthma-home-based-multi-trigger-multicomponent-environmental-interventions-children-and>
- [https://www.epa.gov/sites/production/files/2018-05/documents/asthma\\_home\\_environment\\_checklist.pdf](https://www.epa.gov/sites/production/files/2018-05/documents/asthma_home_environment_checklist.pdf)

**Age Range(s):** All, with focus on ages 0-17

**Social Determinants of Health addressed:** Health Care; Housing

**Sector(s) playing lead role:** CBOs and human service agencies;

**Sector(s) playing contributing role:** Governmental public health agencies; insurers; employers, businesses and unions; media; colleges and universities; community and neighborhood residents; policy-makers and elected officials; transportation agencies; housing agencies; economic development agencies

**Intermediate-level measures:**

- Number of providers trained on NAEPP Guidelines including ASME and home-based interventions
- Number of health systems that have policies/practices for referring patients with asthma to home-based services
- Number of patients referred to home-based services

**Related to other interventions, focus areas and goals from other priorities:** DSRIP 3dii Project - Expansion of asthma home-based self-management program

**Intervention:** 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.

**Resources:**

- Arthritis: <http://www.ymca.net/enhancefitness>
- <https://www.selfmanagementresource.com/programs/small-group/chronic-disease-self-management/>
- Asthma: <https://www.cdc.gov/sixeighteen/asthma/index.htm>
- Cardiovascular Disease: [Million Hearts Self-Measured BP](#)
- Diabetes: [http://care.diabetesjournals.org/content/41/Supplement\\_1/S38](http://care.diabetesjournals.org/content/41/Supplement_1/S38)

**Age Range(s):** All, including those over 65 years old and children age 0-17 for asthma only

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** CBOs and human service agencies

**Sector(s) playing contributing role:** Governmental public health agencies; insurers; employers, businesses and unions; colleges and universities; community and neighborhood residents; policy-makers and elected officials; transportation agencies; housing agencies; economic development agencies

**Intermediate-level measures:**

- Number of health systems that have policies/practices for identifying and referring patients to evidence-based self-management education (EBSMPs) programs
- Number and type of EBSMP programs in community settings

- Number patients referred to EBSMP
- Number of patients who participate in EBSMP
- Percentage of patients who complete EBSMP
- Number of schools using the NYSDOH Guide for Asthma Management in Schools

**Related to other interventions, focus areas and goals from other priorities:** DSRIP 3bi Project - Evidence-based strategies for disease management in high risk/affected populations (adult only)

**Intervention:** Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.

**Resources:** <https://www.cdc.gov/sixteen/diabetes/index.htm>

**Age Range(s):** Adults, including older adults 65+ years

**Social Determinants of Health addressed:** Health care

**Sector(s) playing lead role:** CBOs and human service agencies

**Sector(s) playing contributing role:** Governmental public health agencies; insurers; employers, businesses and unions; community and neighborhood residents

**Intermediate-level measures:**

- Number of health systems that have policies/practices for identifying and referring patients to National DPP programs
- Number of National DPP programs in community settings
- Number patients referred to National DPP
- Number of patients who participate in National DPP
- Percentage of patients who complete National DPP

# New York State Prevention Agenda

## Promote a Healthy and Safe Environment Action Plan

Updated: June 30, 2023

### Introduction

The 2019-2024 State Health Improvement Plan to “Promote a Healthy and Safe Environment” in New York State focuses on five core areas that impact health. These are: the quality of the *water* we drink and enjoy for recreation; the *air* we breathe; the *food and products* we ingest and use; the built *environments* where we live, work, learn and play; as well as *injuries, violence* and *occupational health*. ‘Environment,’ as used here, incorporates all dimensions of the physical environment that impact health and safety.

The Plan was developed by the Department’s Center for Environmental Health in collaboration with diverse stakeholders representing environmental health; occupational health; violence and injury prevention; health care providers, local, State and Federal government agencies; community based and non-profit organizations; and academic and research organizations.

The Plan is organized by focus area and includes goals, objectives, and evidence-based interventions. Additional information about the impact of the environment on health, including underlying risk factors, associated disparities, and social determinants of health can be found at:

[https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf)

## Focus Area 1: Injuries, Violence and Occupational Health

Injuries – both unintentional and intentional – are a leading cause of death and disability among all age groups in NYS. They are the leading cause of death for New Yorkers ages 1-44 years. The overall rates of injury-related deaths and hospitalizations have been increasing since 2000.

The leading causes of injury deaths, hospitalizations, and/or emergency department (ED) visits include falls; violence, including gun violence, intimate partner violence, sexual violence, elder abuse, child abuse, and suicide; and injuries to motor vehicle occupants, pedestrians, bicyclists and motorcyclists.

In addition, nearly 200 New Yorkers die every year because of a work-related injury. The leading cause of work-related injury deaths, hospitalizations, and/or ED visits include falls, struck by/against, machinery and cut/pierce incidents.

The burden of injuries on NYS and data trends can be viewed in the NYS Health Assessment *Contributing Causes of Health Challenges* Chapters:

[https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf)

### **Goal 1.1:** Reduce falls among vulnerable populations

**Objective 1.1.a.** 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. (Baseline year is 2016. Data Source: Vital Statistics Death Files; Available Data: State/County level)

**Objective 1.1.b.** Decrease the annual rate of hospitalizations due to falls among residents ages 65 and over by 5% to 173.7 per 10,000 residents (Baseline 182.8 in 2016. Data Source: NYS SPARCS Data; Available Data: State/County level)

### **Interventions**

**1.1.1:** (Supporting Objectives 1.1.a. and 1.1.b.)

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.

**Evidence Base:** National Council on Aging comprehensive list of evidence-based falls prevention programs

<https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults-2/>

**Implementation Resources:** Centers for Disease Control and Prevention (CDC) Guide to Implementing Effective Community Based Fall Prevention Programs

[https://www.cdc.gov/homeandrecreationalsafety/falls/community\\_preventfalls.html](https://www.cdc.gov/homeandrecreationalsafety/falls/community_preventfalls.html)

NYSDOH and Broome County Health Department Falls Prevention Video

<https://www.youtube.com/watch?v=XxDr4V06KaU&feature=youtu.be>

**Target Population by Age:** Older Adults (65+ years), people with disabilities

**Social Determinants of Health:** Housing, Transportation, Health Care, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies, Community or Neighborhood Residents, Healthcare Delivery Systems, Older Adult Community Based Programs

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Community or Neighborhood Residents, Healthcare Delivery Systems

**Intermediate Measures:** Number of staff or community partners trained to provide evidence-based programs. Number of older adults that have taken evidence-based classes.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Disease*, (4) Chronic Disease Preventive Care and Management, (4.4) Improve self-management skills for individuals with chronic diseases including arthritis

**1.1.2:** (Supporting Objectives 1.1.a. and 1.1.b.)

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.

**Evidence Base:** Johnston, Y., Bergen, G., Bauer, M., Parker, E., Wentworth, L., McFadden, M., Reome, C., Garnett, M. (2018). Implementation of the Stopping Elderly Accidents Deaths and Injuries (STEADI) Initiative in Primary Care: An Outcome Evaluation. *The Gerontologist*, gny101, <https://doi.org/10.1093/geront/gny101>

**Implementation Resources:** CDC STEADI (Stopping Elderly Accidents, Deaths & Injuries) initiative <https://www.cdc.gov/steady/>

**Target Population by Age:** Older Adults (65+ years), people with disabilities

**Social Determinants of Health:** Health Care, Housing, Transportation, Built Environment

**Sectors Playing Lead Role:** Healthcare Delivery Systems

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Older Adult Community Based Programs.

**Intermediate Measures:** Number of older adults screened for fall risk.

Number of older adults at risk for falls given a falls plan of care

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Disease*, (4) Chronic Disease Preventive Care and Management, (4.4) Improve self-management skills for individuals with chronic diseases including arthritis

**1.1.3:** (Supporting Objectives 1.1.a. and 1.1.b.)

Use a home fall prevention checklist to assess the homes of older adults for fall hazards. Make modifications as necessary.

**Evidence Base:** Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics Society. Summary of the Updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. *J Am Geriatr. Soc.* 2011;59(1):148-157.

**Implementation Resources:**

CDC Check for Safety: A Home Fall Prevention Checklist for Older Adults

[https://www.cdc.gov/steady/pdf/check\\_for\\_safety\\_brochure-a.pdf](https://www.cdc.gov/steady/pdf/check_for_safety_brochure-a.pdf)

New York City Department of Health and Mental Hygiene Falls Prevention Home Safety Checklist

<https://www1.nyc.gov/assets/doh/downloads/pdf/ip/prevent-falls-checklist.pdf>

**Target Population by Age:** Older Adults (65+ years), people with disabilities

**Social Determinants of Health:** Housing, Transportation, Health Care, Built Environment

**Sectors Playing Lead Role:** Healthcare Delivery Systems

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Older Adult Community Based Programs, Other Governmental Agencies: Dormitory Authority of State of New York and NYC Housing Preservation and Development

**Intermediate Measures:** Number of homes assessed for fall risk with modifications made

**1.1.4:** (Supporting Objectives 1.1.a. and 1.1.b.)

Integrate exercise and fall prevention activities into physical or occupational therapy.

**Evidence Base:** Shubert, T. E., Smith, M.L., Jiang, L., Jiang and M. G. Ory (2016). Disseminating the Otago Exercise Program in the United States: Perceived and Actual Physical Performance Improvements From Participants. *J Appl Gerontol.*

**Implementation Resources:** American Hospital Association, Tools to Implement the Otago Exercise Program: A Program to Reduce Falls

<http://www.hret-hiin.org/resources/display/tools-to-implement-the-otago-exercise-program-a-program-to-reduce-falls>

**Target Population by Age:** Older Adults (65+ years), people with disabilities

**Social Determinants of Health:** Housing, Transportation, Health Care, Built Environment

**Sectors Playing Lead Role:** Healthcare Delivery Systems

**Sectors Playing Contributing Role:** NA

**Intermediate Measures:** Number of older adults given exercise and fall prevention activities during physical or occupational therapy.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Disease*, (4) Chronic Disease Preventive Care and Management, (4.4) Improve self-management skills for individuals with chronic diseases including arthritis

**1.1.5:** (Supporting Objectives 1.1.a. and 1.1.b.)

Engage pharmacists in medication review for older adults and people with disabilities at higher risk for falls.

**Evidence Base:** Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics Society. Summary of the Updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. *J Am Geriatr. Soc.* 2011;59(1):148-157.

**Implementation Resources:** CDC STEADI initiative

<https://www.cdc.gov/steady/training.html>

**Target Population by Age:** Older Adults (65+ years), people with disabilities

**Social Determinants of Health:** Health Care

**Sectors Playing Lead Role:** Healthcare Delivery Systems

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Older Adult Community Based Programs

**Intermediate Measures:** Number of pharmacists engaged. Number of pharmacists committed to medication review and management for older adults. (Both would be measured at a local level).

**Goal 1.2:** Reduce violence by targeting prevention programs regularly to highest risk populations

Objective 1.2.a. Reduce rate of homicide deaths from 0.35 to 0.32 per 10,000. (Baseline year is 2016. Data Source: Vital Statistics Death Files; Available Data: State/County level)

Objective 1.2.b. Reduce the rate of assault-related hospitalizations from 3.3 to 3.0 per 10,000. (Baseline year is 2016.)

Reduce disparity (Ratio=1 means no disparity) by 10%:

- Ratio of Black non-Hispanic rate of assault-related hospitalizations to White non-Hispanic rate of assault-related hospitalizations (Target: 5.54; Baseline: 6.16; Year: 2016. Data Source: NYS SPARCS Data; Available Data: State/County level)
- Ratio of Hispanic rate of assault-related hospitalizations to White non-Hispanic rate of assault-related hospitalizations (Target: 2.50; Baseline: 2.78; Year: 2016. Data Source: NYS SPARCS Data; Available Data: State/County level)
- Ratio of assault-related hospitalization rate in low income ZIP codes to assault-related hospitalization rate in non-low income ZIP codes (Target: 2.66; Baseline: 2.95; Year: 2016. Data Source: NYS SPARCS Data; Available Data: State/County level)

Objective 1.2.c. Reduce the rate of ED visits due to assault from 42.3 to 38.1 per 10,000. (Data Source: NYS SPARCS Data; Available Data: State/County level)

Objective 1.2.d. Reduce the rate of hospitalization due to assault by firearm from 0.42 to 0.38 per 10,000 (Target 0.38; Baseline: 0.42; Baseline year: 2016. Data Source: NYS SPARCS Data; Available Data: State/ County level)

## Interventions

### 1.2.1: (Supporting Objectives 1.2.a., 1.2.b., 1.2.c. and 1.2.d.)

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. These programs work best when they include wraparound services to support victims, families, and other community members impacted by crime.

**Evidence Base:** John Jay College of Criminal Justice

<https://johnjayrec.nyc/cureviolence/>

Cure Violence, Scientific Evaluation Results

<http://cureviolence.org/results/scientific-evaluations/>

SNUG Evaluation

<https://www.rit.edu/cla/criminaljustice/sites/rit.edu.cla.criminaljustice/files/docs/WorkingPapers/2013/2013-10.pdf>

**Implementation Resources:** Cure Violence

<http://cureviolence.org>

Cure Violence New York (SNUG State and Cure Violence NYC Sites)

<http://cureviolence.org/partners/us-partners/snug/>

New York City Office to Prevent Gun Violence, Crisis Management System

<https://www1.nyc.gov/site/peacenyc/interventions/crisis-management.page>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Economic Stability, Education, Food Security, Housing, Community Cohesion, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies (State and Local Health Departments), Governmental Public Safety Agencies, Healthcare Delivery System, Community Based Organizations and Social Services, Community or Neighborhood Residents

**Sectors Playing Contributing Role:** Colleges and Universities, Policy Makers and Elected Officials, Other: Criminal Justice Partners and NYS Department of Corrections and Community Supervision (NYSDOCCS)

**Intermediate Measures:** Number of multi-sector violence prevention programs. Number of partners involved in the violence prevention programs. Number of New Yorkers served a range of intervention/programs.

**Supporting Other Goals and Interventions from other Priorities:** *Promote Well-Being and Prevent Mental and Substance Use Disorders and Promote Healthy Women, Infants, and Children*, (3) Child and Adolescent Health, (3.1) Support and enhance children and adolescents' social-emotional development and relationships

### 1.2.2: (Supporting Objectives 1.2.a., 1.2.b., 1.2.c. and 1.2.d.)

Increase school based and community programs in conflict resolution, bystander interventions, and healthy relationship building.

**Evidence Base:** Fenton, R.A., Mott, H.L., McCartanm K., and Rumney, P.N.S. (2015) Public Health England review of evidence for bystander intervention to prevent sexual and domestic violence in universities. London: Public Health England and Bristol University of the West of England

<http://www2.uwe.ac.uk/faculties/BBS/BUS/law/Law%20docs/dvilitreviewproof0.6.forCLR.pdf>

CDC Sexual Violence Prevention Strategies

<https://www.cdc.gov/violenceprevention/sexualviolence/prevention.html>

CDC Prevention STOP Sexual Violence, A Technical Package to Prevent Sexual Violence

<https://www.cdc.gov/violenceprevention/pdf/SV-Prevention-Technical-Package.pdf>

**Implementation Resources:**

Culture of Respect, Bringing in the Bystander

<https://cultureofrespect.org/program/bringing-in-the-bystander/>

National Institute of Justice, Green Dot Intervention Program

<https://www.crimesolutions.gov/ProgramDetails.aspx?ID=509>

NYSDOH Enough is Enough Program

[https://www.health.ny.gov/prevention/sexual\\_violence/enough\\_is\\_enough.htm](https://www.health.ny.gov/prevention/sexual_violence/enough_is_enough.htm)

NYSDOH Rape Prevention and Education Program

[https://www.health.ny.gov/prevention/sexual\\_violence/education\\_program.htm](https://www.health.ny.gov/prevention/sexual_violence/education_program.htm)

New York State Education Department: Social Emotional Learning: Essential for Learning, Essential for Life

<http://www.p12.nysed.gov/sss/documents/SELEssentialforLearningandLife.pdf>

New York City Office to Prevent Gun Violence, Crisis Management System

<https://www1.nyc.gov/site/peacenyc/interventions/crisis-management.page>

Cure Violence New York (SNUG State and Cure Violence NYC Sites)

<http://cureviolence.org/partners/us-partners/snug/>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Community Cohesion, Education

**Sectors Playing Lead Role:** Governmental Educational Agencies, Schools (K-12), Colleges and Universities, Community or Neighborhood Residents

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Healthcare Delivery System, Policy Makers and Elected Officials, Community Based and Social Services Organizations, Criminal Justice partners

**Intermediate Measures:** Number of schools, Colleges/University, and Community programs engaged in conflict resolution, bystander interventions, and healthy relationship building.

**Supporting Other Goals and Interventions from other Priorities:** *Promote Healthy Women, Infants, and Children*, (3) Child and Adolescent Health, (3.1) Support and enhance children and adolescents' social-emotional development and relationships

**1.2.3:** (Supporting Objectives 1.2.a., 1.2.b., 1.2.c. and 1.2.d.)

Reduce access to firearms for children and individuals at high-risk for violence.

**Evidence Base:** Santaella-Tenorio, J., Cerda, M., Villaveces, A., Galea, S., What Do We Know About the Association Between Firearm Legislation and Firearm-Related Injuries? *Epidemiologic Reviews*, Volume 38, Issue 1, 1, January 2016, Pages 140-157,

<https://doi.org/10.1093/epirev/mxv012>

Rowhani-Rahbar, A., Simonetti, J.A., Rivara, F.P., Effectiveness of Interventions to Promote Safe Firearm Storage, *Epidemiologic Reviews*, Volume 38, Issue 1, 1 January 2016, Pages 111–124,

<https://doi.org/10.1093/epirev/mxv006>

**Implementation Resources:** Prevention Institute: Gun Violence Must Stop. Here’s What We Can Do to Prevent More Deaths

<https://www.preventioninstitute.org/focus-areas/preventing-violence-and-reducing-injury/preventing-violence-advocacy>

New York City Office to Prevent Gun Violence, Crisis Management System

<https://www1.nyc.gov/site/peacenyc/interventions/crisis-management.page>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Economic Stability, Housing

**Sectors Playing Lead Role:** Policy Makers and Elected Officials and Community Advocates

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Governmental Public Safety Agencies, Community or Neighborhood Residents, Others: Law Enforcement

**Intermediate Measures:** Propose and pass gun safety legislation. Promote use of locked gun safes. Strengthen gun purchasing laws.

**Supporting Other Goals and Interventions from other Priorities:** *Promote Well-Being and Prevent Mental and Substance Use Disorders and Promote Healthy Women, Infants, and Children*, (3) Child and Adolescent Health, (3.1) Support and enhance children and adolescents’ social-emotional development and relationships

#### **1.2.4:** (Supporting Objectives 1.2.a., 1.2.b., 1.2.c. and 1.2.d.)

Reduce neighborhood environmental risks (e.g., abandoned buildings, no lighting, deserted streets).

**Evidence Base:** Cerda, M., Morenoff, J., Hansen, B., Tessari Hicks, K.J., Duque, L.F., Restrepo, A., Diez-Roux, A.V., Reducing Violence by Transforming Neighborhoods: A Natural Experiment in Medellin, Colombia. *Am J. Epidemiol*, 2012 May 15; 175(10): 1045-1053.

<https://academic.oup.com/aje/article/175/10/1045/89012>

**Implementation Resources:** New York State Department of State: Opportunities Waiting To Happen, Redeveloping Abandoned Buildings and Sites to Revitalize Communities

<https://www.dos.ny.gov/opd/programs/pdfs/Guidebooks/ab/AbandonedBuildings.pdf>

New York State Department of Environmental Conservation (NYSDEC), Brownfield Cleanup Program

<https://www.dec.ny.gov/chemical/8450.html>

Michigan Youth Violence Prevention Center

<http://yvpc.sph.umich.edu/>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Housing, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies and Governmental Public Safety Agencies

**Sectors Playing Contributing Role:** Community or Neighborhood Residents, Community Based Organizations, Economic Development Agencies; Natural Environment Agencies (NYSDEC); Urban Planning Agencies

**Intermediate Measures:** Number of environmental risks addressed.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (2) Physical Activity, (2.3) Facilitate access to *safe* and accessible places for physical activity

**1.2.5:** (Supporting Objectives 1.2.a., 1.2.b., 1.2.c. and 1.2.d.)

Increase educational, recreational and employment opportunities for potentially at-risk youth through after school and summer work experience programs or youth apprenticeship initiatives.

**Evidence Base:** Miller, C., Millenky, M., Schwartz, L., Goble, L., Stein, J., Building a Future: Interim Impact Findings from the YouthBuild Evaluation. Washington, DC: MDRC in partnership with Mathematica Policy Research.

<https://www.mathematica-mpr.com/our-publications-and-findings/publications/building-a-future-interim-impact-findings-from-the-youthbuild-evaluation>

**Implementation Resources:** CDC's STRYVE: Striving to Reduce Youth Violence Everywhere

<https://www.cdc.gov/violenceprevention/stryve/index.html>

New York State Department of Labor's Apprenticeship Program.

<https://labor.ny.gov/formsdocs/app/p532.pdf>

New York State Department of Labor's Youth Jobs Program.

<https://labor.ny.gov/careerservices/youth-tax-credit.shtm>

WorkforceGPS Youth Apprenticeship.

<https://apprenticeshipusa.workforcegps.org/resources/2017/02/02/10/56/Apprenticeship-Youth>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Economic stability, Education

**Sectors Playing Lead Role:** Governmental Public Health Agencies; Employers, Businesses and Unions; Colleges and Universities; Schools (K-12); Community Based and Social Services Organizations

**Sectors Playing Contributing Role:** Economic Development Agencies, Policy Makers and Elected Officials, Natural Environment Agencies, Urban Planning Agencies

**Intermediate Measures:** Number of new educational, recreational, and employment opportunities.

**Supporting Other Goals and Interventions from other Priorities:** *Promote Well-Being and Prevent Mental and Substance Use Disorders; Promote Healthy Women, Infants, and Children*, (3) Child and Adolescent Health, (3.1) Support and enhance children and adolescents' social-emotional development and relationships; *Prevent Chronic Diseases*, (2) Physical Activity, (2.3) Facilitate access to *safe* and accessible places for physical activity

### **Goal 1.3:** Reduce occupational injuries and illness

#### **Objective 1.3.a.** Reduce disparities in work-related emergency department (ED) visits.

- Work-related ED visits: Ratio of the rate of black non-Hispanics to white non-Hispanics (Baseline: 1.45 per 10,000 workers; Baseline year: 2016; Target: 1.3. Data Source: NYSDOH, Statewide Planning and Research Cooperative System; Available Data: State/County level)
- Work-related ED visits: Ratio of the rate of Hispanics to white non-Hispanics (Baseline: 0.93 per 10,000 workers; Baseline year: 2016; Target: 1.0. Data Source: NYSDOH, Statewide Planning and Research Cooperative System; Available Data: State/County level)

#### **Objective 1.3.b.** Reduce disparities in work-related hospitalizations.

- Work-related hospitalizations: Ratio of the rate of black non-Hispanics to white non-Hispanics (Baseline: 1.10 per 10,000 workers; Baseline year: 2016; Target = 1.0. Data Source: NYSDOH, Statewide Planning and Research Cooperative System; Available Data: State/County level)
- Work-related hospitalizations: Ratio of the rate of Hispanics to white non-Hispanics (Baseline: 0.95 per 10,000 workers; Baseline year: 2016; Target: 1.0. Data Source: NYSDOH, Statewide Planning and Research Cooperative System; Available Data: State/County level)

**Objective 1.3.c.** Reduce the rate of ED visits for occupational injuries among adolescents 15-19 years of age. (Baseline: 21.32 per 10,000 adolescents aged 15-19; Baseline year: 2016; Target: 19.2 Data Source: NYSDOH, Statewide Planning and Research Cooperative System; Available Data: State level)

### **Interventions**

#### **1.3.1:** (Supporting Objectives 1.3.a., 1.3.b.)

Improve safety in workplaces: Develop targeted occupational safety and health training programs for employers and workers in high-risk jobs.

**Evidence Base:** CDC National Institute for Occupational Safety and Health (NIOSH), Institute for Work & Health, A systematic review of the effectiveness of training & education for the protection of workers

<https://www.cdc.gov/niosh/docs/2010-127/pdfs/2010-127.pdf>

**Implementation Resources:** National Council for Occupational Safety and Health - Local COSH Groups

<http://www.coshnetwork.org/COSHGroupsList>

New York State Occupational Health Clinic Network

[https://www.health.ny.gov/environmental/workplace/clinic\\_network.htm](https://www.health.ny.gov/environmental/workplace/clinic_network.htm)

**Target Population by Age:** Adolescents (ages 13-21); Adults (ages 21-60); Older adults (60+)

**Social Determinants of Health:** Natural Environment, Built Environment

**Sectors Playing Lead Role:** Employers

**Sectors Playing Contributing Role:** Community Groups and Worker Centers; Committee for Occupational Safety and Health (COSH) groups; Employers, Businesses and Unions; Media  
**Intermediate Measures:** Identify high-risk workers and employers and identify potential risks in these jobs as a first step to developing educational materials/training.

**1.3.2:** (Supporting Objectives 1.3.c.)

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.

**Evidence Base:** CDC NIOSH, Promoting Safe Work for Young Workers

<https://www.cdc.gov/niosh/docs/99-141/pdfs/99-141.pdf>

**Implementation Resources:** CDC NIOSH, Youth@Work—Talking Safety Curriculum for New York:

<https://www.cdc.gov/niosh/talkingsafety/states/ny/2015-138/default.html>

**Target Population by Age:** Adolescents (13-21)

**Social Determinants of Health:** Natural Environment, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies

**Sectors Playing Contributing Role:** COSH groups; Schools/BOCES; Employers, Businesses and Unions; Media; Other Governmental Agencies: NYS Department of Education

**Intermediate Measures:** Identify industries and employers where large number of young workers are employed and target one to two for education.

**1.3.3:** (Supporting Objectives 1.3.a., 1.3.b. and 1.3.c.)

Incorporate industry and occupation into electronic health records and other patient-oriented databases.

**Evidence Base:** CDC NIOSH, Collecting and Using I&O Data:

<https://www.cdc.gov/niosh/topics/coding/collecting.html>

American Public Health Association, Incorporating Occupational Information in Electronic Health Records

<https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/11/16/27/incorporating-occupational-information-in-electronic-health-records>

**Implementation Resources:** Regional Health Information Organizations (RHIOs)

<https://www.nyacp.org/i4a/pages/index.cfm?pageID=3760&activateFull=true>

**Target Population by Age:** Adolescents (13-21); Adults (ages 21-60); Older Adults (60+)

**Social Determinants of Health:** Health Care, Built Environment

**Sectors Playing Lead Role:** Healthcare Delivery Systems

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Regional Health Information Organization, Employers, Businesses and Unions, Policy Makers

**Intermediate Measures:** Provide methods to link electronic reporting records with occupational health registries and databases. Require that all NYSDOH databases collect information on occupation and industry.

**Goal 1.4:** Reduce traffic related injuries for pedestrians and bicyclists

**Objective 1.4.a.** Decrease the annual rate of crash-related pedestrian fatalities by 10% to 1.43 per 100,000 people. (Baseline 1.59 in 2016. Data Source: Vital Statistic Death Files; Available Data: State/County level)

**Objective 1.4.b.** Decrease the annual rate of crash-related bicycle emergency department visits by 10% to 26.09 per 100,000 people. (Baseline 28.99 in 2016. Data Source: SPARCS; Available Data: State/County level)

**Interventions**

**1.4.1:** (Supporting Objectives 1.4.a. and 1.4.b.)

Increase coordinated pedestrian injury prevention activities within the 20 NYS Pedestrian Safety Action Plan (PSAP) focus communities. Engage local partners within PSAP focus communities to conduct pedestrian safety education, engineering, and enforcement activities through provision of resources and technical assistance, training, and promotion of funding opportunities.

<https://www.ny.gov/programs/pedestrian-safety-action-plan>

**Evidence Base:** [Countermeasures that Work: A Highway Safety Countermeasure Guide For State Highway Safety Offices, Ninth Edition 2017 \(pdf\)](#)

**Implementation Resources:**

National Highway Traffic Safety Administration

[www.nhtsa.gov/road-safety](http://www.nhtsa.gov/road-safety)

New York State Governor's Traffic Safety Committee

[www.safeny.ny.gov](http://www.safeny.ny.gov)

NYSDOH Pedestrian Safety

[www.health.ny.gov/prevention/injury\\_prevention/pedestrians.htm](http://www.health.ny.gov/prevention/injury_prevention/pedestrians.htm)

New York State Department of Transportation

[www.dot.ny.gov/index](http://www.dot.ny.gov/index)

New York State Pedestrian Safety Action Plan

[www.ny.gov/programs/pedestrian-safety-action-plan](http://www.ny.gov/programs/pedestrian-safety-action-plan)

NYS Pedestrian Safety, Tips for Drivers and Pedestrians, and Projects

[www.ny.gov/pedestrian-safety/pedestrian-safety-and-projects#pedestrian-safety](http://www.ny.gov/pedestrian-safety/pedestrian-safety-and-projects#pedestrian-safety)

NYS Pedestrian Safety Resources

[www.ny.gov/pedestrian-safety/additional-information#resources](http://www.ny.gov/pedestrian-safety/additional-information#resources)

Pedestrian Bicycle and Information Center

[www.pedbikeinfo.org](http://www.pedbikeinfo.org)

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Education, Transportation, Built Environment

**Sectors Playing Lead Role:** Transportation and Highway Safety Agencies, Governmental Public Health Agencies

**Sectors Playing Contributing Role:** Community Based Organizations, Community or Neighborhood Residents, Local Law Enforcement Agencies, Urban Planning Agencies

**Intermediate Measure:** Establishment of community based pedestrian safety partnerships/coalitions committed to engaging in education, engineering, and/or enforcement activities. Number of partners participating. Number of pedestrian safety educational activities planned and/or conducted. Number of infrastructure improvements planned, built, and/or installed.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (2) Physical Activity, (2.1) Create community environments for physical activity and (2.3) Facilitate access to safe and accessible places for physical activity

**1.4.2:** (Supporting Objectives 1.4.a. and 1.4.b.)

Provide training to increase enforcement of NYS Vehicle and Traffic Law pertaining to pedestrians.

The NYSDOH, National Highway Traffic Safety Administration, NYS Governor's Traffic Safety Committee, and NYS Department of Transportation produced training modules that encourage active participation among law enforcement by providing education about specific laws and instruction for targeted enforcement efforts. The role of engineering and public education is also included in the training curriculum.

**Evidence Base:** US Department of Transportation, National Highway Traffic Safety Administration, Countermeasures that Work: A Highway Safety Countermeasure Guide for State Highway Safety Offices, Ninth Edition 2017

[https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/812478\\_v5\\_countermeasures-that-work-a-highway-safety-countermeasures-guide-9thedition-2017.pdf](https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/812478_v5_countermeasures-that-work-a-highway-safety-countermeasures-guide-9thedition-2017.pdf)

**Implementation Resources:**

National Highway Traffic Safety Administration

[www.nhtsa.gov/road-safety](http://www.nhtsa.gov/road-safety)

New York State Governor's Traffic Safety Committee

<http://safeny.ny.gov/peds-ndx.htm#Programs>

NYSDOH Pedestrian Safety

[www.health.ny.gov/prevention/injury\\_prevention/pedestrians.htm](http://www.health.ny.gov/prevention/injury_prevention/pedestrians.htm)

New York State Department of Transportation

[www.dot.ny.gov/index](http://www.dot.ny.gov/index)

New York State Pedestrian Safety Action Plan

[www.ny.gov/programs/pedestrian-safety-action-plan](http://www.ny.gov/programs/pedestrian-safety-action-plan)

Pedestrian Bicycle and Information Center

[www.pedbikeinfo.org](http://www.pedbikeinfo.org)

**Target Population:** Law Enforcement.

**Social Determinants of Health:** Transportation, Built Environment

**Sectors Playing Lead Role:** Transportation, Highway Safety Agencies, Governmental Public Health Agencies

**Sectors Playing Contributing Role:** Local Law Enforcement Agencies, Community Based Organizations

**Intermediate Measures:** Number of Law Enforcement Officers trained. Increase in tickets written for pedestrian law violations for both drivers and pedestrians

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases, (2) Physical Activity*

**1.4.3:** (Supporting Objectives 1.4.b.)

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.

**Evidence Base:** US Department of Transportation, National Highway Traffic Safety Administration, Countermeasures that Work: A Highway Safety Countermeasure Guide for State Highway Safety Offices, Ninth Edition 2017

[https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/812478\\_v5\\_countermeasures-that-work-a-highway-safety-countermeasures-guide-9thedition-2017.pdf](https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/812478_v5_countermeasures-that-work-a-highway-safety-countermeasures-guide-9thedition-2017.pdf)

CDC Bicycle Helmet Laws for Children

[www.cdc.gov/motorvehiclesafety/calculator/factsheet/bikehelmet.html](http://www.cdc.gov/motorvehiclesafety/calculator/factsheet/bikehelmet.html)

**Implementation Resources:** Countermeasures that Work: A Highway Safety Countermeasure Guide For State Highway Safety Offices, Ninth Edition 2017

[https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/812478\\_countermeasures-that-work-a-highway-safety-countermeasures-guide-.pdf](https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/812478_countermeasures-that-work-a-highway-safety-countermeasures-guide-.pdf)

National Highway Traffic Safety Administration

[www.nhtsa.gov/road-safety](http://www.nhtsa.gov/road-safety)

New York State Governor's Traffic Safety Committee

[www.safeny.ny.gov/bike-ndx.htm](http://www.safeny.ny.gov/bike-ndx.htm)

NYSDOH Bicycle and Wheeled Recreation Safety

[https://www.health.ny.gov/prevention/injury\\_prevention/bicycles.htm](https://www.health.ny.gov/prevention/injury_prevention/bicycles.htm)

CDC Bicycle Safety

<https://www.cdc.gov/motorvehiclesafety/bicycle/index.html>

Pedestrian Bicycle and Information Center

[www.pedbikeinfo.org](http://www.pedbikeinfo.org)

**Target Population by Age:** Children and Adolescents; New Yorkers of all Ages

**Social Determinants of Health:** Transportation

**Sectors Playing Lead Role:** Governmental Public Health Agencies, Transportation and Highway Safety Agencies

**Sectors Playing Contributing Role:** Community Based Organizations, Schools, Law Enforcement Agencies, Healthcare Delivery System

**Intermediate Measures:** Number of helmets fitted and distributed.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases, (2)*  
Physical Activity

## **Focus Area 2: Outdoor Air Quality**

Poor outdoor air quality leads to illness and death. People with underlying respiratory disease, including asthma or cardiovascular disease, the very young, and the very old, are particularly at risk from poor air quality. Cardiovascular disease is the leading cause of death nationally and in New York. Extensive evidence shows that both ozone and fine particulate matter (particles that are smaller than 2.5 micrometers in diameter) exposures are associated with increased respiratory and cardiovascular disease and deaths. Some evidence shows that ongoing, long term exposures to these pollutants is associated with increasing rates of asthma development.

Toxic air pollutants, also known as hazardous air pollutants, are known or suspected to cause cancer or other serious health effects, such as reproductive effects, birth defects, or adverse environmental effects. Depending on the level and duration of exposure, people exposed to toxic air pollutants may have an increased chance of developing cancer or experiencing other serious health effects. Although the air quality concentrations in New York for many of the toxic air pollutants has significantly improved in recent decades, for some of the air toxics, the general ambient air concentration is still above levels of concern.

The United States Environmental Protection Agency (US EPA) regulates certain outdoor air pollutants under the Federal Clean Air Act. US EPA has designated six air pollutants, i.e., carbon monoxide, lead, nitrogen oxides, ozone, fine particulate matter, and sulfur dioxide as criteria pollutants, and established health-based air concentration standards for them, known as the National Ambient Air Quality Standards (NAAQS).

NYS Department of Environmental Conservation (NYSDEC) has the authority to require facilities to install pollution control technologies or to change operating practices that pollute the air. The air facility permit is one way to require pollution controls. Operating sources must comply with the terms of their NYSDEC permit, publicly report their emissions and may be required to monitor or test their emissions. For State and Title V permits, NYSDEC reviews and assesses a facility's emissions of criteria pollutants, hazardous air pollutants and carbon dioxide equivalents (a measure of climate warming potential) and appropriate control technologies before issuing a permit.

Through state and federal regulations, permitting, and enforcement, the air quality in New York has greatly improved over the last 40 years. As of 2018, all NYS counties met the fine particulate standard, however nine counties are still designated as non-attainment for ozone. When more stringent standards for ozone and fine particulate matter are adopted, it is possible for air quality to improve and yet have counties go into non-attainment and have more days with Air Quality Health Advisories. It is confusing, but it reflects continuing efforts to substantially improve outdoor air quality.

**Executive Order No. 166 (2017)** established the goal of reducing GHG emissions from all sources in New York State to 40 percent below levels emitted in 1990 by the year 2030. New York State is building a portfolio of programs and policies aimed at reducing GHG emissions. State programs use emission controls, technical assistance and financial incentives to ease the transition to cleaner energy generation. The health benefits of GHG reduction policies include: cleaner air (less ozone formation; fewer pollutants released), support for land-use planning that encourages more walking and cycling, and safer transportation through community design to accommodate alternative transportation. Policies to reduce GHG emissions, that also reduce emissions of criteria and hazardous pollutants will potentially result in greater benefits. Coordination of efforts to reduce GHGs and other harmful air pollutants, especially in low-income and minority communities, can provide an efficient and equitable approach to realize the health benefits anticipated with reductions in both GHGs and other air pollutants.

**Goal 2.1:** Reduce exposure to outdoor air pollutants

**Objective 2.1.a.** Reduce the annual number of days with Air Quality Index (AQI) >100 to 3 or less (reflecting unhealthy daily ozone or PM levels). (Baseline: 17 days; Baseline year: 2017; Target: 3; Intermediate Target (2021): 8. Data Source: NYSDEC Monitoring Data compared to current NAAQS; Available Data: State level)

**Objectives 2.1.b.** Implement policies that target vulnerable groups to reduce exposure to short-term increases in pollutant levels. (No data are available to measure)

**Interventions**

**2.1.1:** (Supporting Objective 2.1.a.)

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.

**Evidence Base:** The National Ambient Air Quality Standards (NAAQS) for Particle Pollution  
[https://www.epa.gov/sites/production/files/2016-04/documents/health\\_2012\\_factsheet.pdf](https://www.epa.gov/sites/production/files/2016-04/documents/health_2012_factsheet.pdf)  
US EPA Ozone Pollution

<https://www.epa.gov/ozone-pollution>

**Implementation Resources:**

NYSDEC AQI Forecast

[https://www.dec.ny.gov/cfm/xtapps/aqi/aqi\\_forecast.cfm](https://www.dec.ny.gov/cfm/xtapps/aqi/aqi_forecast.cfm)

US EPA AirNow

<https://www.airnow.gov/>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Transportation, Community Cohesion, Health Care, Natural Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies (State Health Department) and Natural Environmental Agencies (NYSDEC)

**Sectors Playing Contributing Role:** Governmental Agencies including Transportation, Child and Family Services, Office of the Aging, and Education Department; Employers, Businesses and Unions; Insurers; Media; Asthma Partners of New York; Healthcare Delivery System

**Intermediate Measures:** Number of air quality health advisories issued each year in NYS. Increase the number of counties in NYS that are in attainment of the National Ambient Air Quality Standards (NAAQS).

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (4) Chronic Disease Preventive Care and Management

### 2.1.2: (Supporting Objectives 2.1.b.)

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.

#### **Evidence Base:**

National Association of County and City Health Officials, Taking Action to Address the Public Health Impact of Wildfire Smoke

<https://nacchovoice.naccho.org/2018/05/03/taking-action-to-address-the-public-health-impact-of-wildfire-smoke/>

CDC Protect Yourself from Wildfire Smoke

<https://www.cdc.gov/features/wildfires/index.html>

CDC Wildfire Smoke

<https://www.cdc.gov/disasters/wildfires/smoke.html>

**Implementation Resources:** US EPA Guide for Public Health Officials – Wildfire Smoke

[https://www3.epa.gov/airnow/wildfire\\_may2016.pdf](https://www3.epa.gov/airnow/wildfire_may2016.pdf)

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Transportation, Community Cohesion, Health Care, Natural Environment, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies (NYSDOH), Natural Environmental Agencies (NYSDEC) and Transportation Agencies (NYSDOT).

**Sectors Playing Contributing Role:** Governmental Public Health Agencies (Local Health Departments), Emergency Preparedness, Policy Makers and Elected Officials, Media, Healthcare Delivery Systems, Schools, Community Based Organizations and Groups

**Intermediate Measures:** Enhance collaborations that will allow a weight of evidence approach (NYSDEC air monitoring data, NYSDOT or other public video feeds, reports of visible smoke impacts, and media reports) to track and monitor conditions to determine those events that warrant a local smoke advisory warning.

**Supporting Other Goals and Interventions from other Priorities: Prevent Chronic Diseases, (4)**  
Chronic Disease Preventive Care and Management

**2.1.3:** (Supporting Objectives 2.1.a. and 2.1.b.)

Implement policies that provide resources and guidance on ways individuals, communities, and governmental entities can work to reduce air pollution and CO<sub>2</sub> equivalent emissions.

Long term reductions in air pollutants and GHGs will hinge on government, community, and personal commitments. Knowing what to do and having the resources and support to accomplish the change is crucial. NYS energy, pollution control, and environmental protection laws and policies can be leveraged to achieve emission reductions. In addition, policies and programs that encourage and facilitate street and parkland tree planting, especially in urban environments, provides direct air quality improvements and indirectly reduces the urban heat island effect. Improving forest land management in rural areas can also mitigate pollution impacts and enhance carbon sequestration.

**Evidence Base:**

State and Territorial Air Pollution Program Administrators and Association of Local Air Pollution Control Officials, Reducing Greenhouse Gases and Air Pollution: A Menu of Harmonized Options

<http://www.oecd.org/environment/cc/2055676.pdf>

World Health Organization, Air Pollution Guidance

[http://www.who.int/ipcs/assessment/public\\_health/air\\_pollution/en/](http://www.who.int/ipcs/assessment/public_health/air_pollution/en/)

Journal of Urban Health, How can Urban Policies Improve Air Quality and Help Mitigate Global Climate Change: a Systematic Mapping Review

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4794467/>

**Implementation Resources:**

NYS Taking Action to Reduce Climate Change Pollution

<https://www.governor.ny.gov/sites/default/files/atoms/files/EO%20%23166.pdf>

US EPA Clean Air Act Overview

<https://www.epa.gov/clean-air-act-overview/benefits-and-costs-clean-air-act-1990-2020-second-prospective-study>

NYSDEC, Air

<https://www.dec.ny.gov/chemical/281.html>

NYSDEC, Tips to Keep Air Clean

<https://www.dec.ny.gov/public/43563.html>

NYSDEC, Executive Order 4

<https://www.dec.ny.gov/energy/71389.html>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Economic Stability, Housing, Transportation, Community Cohesion, Health Care Natural Environment, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies (NYSDOH), Natural Environmental Agencies (NYSDEC), and other Governmental Agencies (NYS Energy Research and Development Agency)

**Sectors Playing Contributing Role:** Governmental Public Health Agencies; Employers, Businesses and Unions; Community or Neighborhood Residents; Community Based Organizations; Human Service Agencies; Policy Makers and Elected Officials; Transportation Agencies; Urban Planning Agencies

**Intermediate Measure:** Reduce local government building GHG emissions to meet the Governor’s “40-by-30” goals (40% below 1990 levels by 2030). Reduce releases of pollutants from stationary sources (e.g., industrial, food service, residential heating) and mobile sources (e.g., rail, marine, and on and off- road vehicles) that contribute to local and regional pollutant levels.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases, (4)* Chronic Disease Preventive Care and Management

## Focus Area 3: Built and Indoor Environments

The 'built environment' focus area includes the outdoor and indoor environments of homes, schools, workplaces, public and commercial buildings, transit systems, roadways, multi-use trails, streetscapes and parks. How the built environment is designed and maintained can affect human health through the products and materials used and through land use, zoning, economic development and infrastructure decisions.

This area includes a diverse set of objectives and interventions covering increasing climate smart communities/projects/resilience and enhancing pedestrian opportunities; addressing *Legionella* in premise water in healthcare facilities and cooling towers; reducing exposure to lead, asthma triggers, and radon in the home environment; and reducing environmental exposures and improving the indoor and outdoor environments of early childcare centers and schools.

**Goal 3.1:** Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change.

Climate - Objective 3.1.a. Increase the percentage of the population that live in a certified Climate Smart Community by 15%. (Baseline: 7.5%; Baseline year: 2018; Target: 8.6%. Data Source: NYSDEC Climate Smart Communities program; Available Data: State/County level)

Climate - Objective 3.1.b. 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%. (Baseline as of end of 2017: 45.6%; Target: 47.9%. Data Source: US Census American Community Survey; Available Data: State/County level)

Climate - Objective 3.1.c. 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.)

Legionella - Objective 3.1.d. Increase the percentage of registered cooling towers in compliance with 10 NYCRR Subpart 4-1, Cooling Towers, to reach a goal of 93% compliance. (Baseline: 59%; Baseline year: 2018; Target: 93%; Intermediate target (2021): 78%. Data Source: NYS Cooling Tower Registry; Available Data: State excluding NYC/County level excluding NYC)

Legionella - Objective 3.1.e. 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.)

## Interventions

### 3.1.1: (Supporting Objective 3.1.a. and 3.1.b.)

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.

All communities in NYS can register to become a Climate Smart Community (CSC) by taking the CSC pledge. Becoming a certified Climate Smart Community goes beyond the CSC pledge by completing and documenting a suite of actions that mitigate and adapt to climate change at the local level. Besides the environmental and public health benefits, certification also facilitates better scores for some state funding programs, including NYSDEC's CSC grants.

#### **Evidence Base:**

Balbus, J.M et al. A wedge-based approach to estimating health co-benefits of climate change mitigation activities in the United States. *Climatic Change*. 2014; 127: 199-210.

Gao, J. et al. Public health co-benefits of greenhouse gas emissions reduction: A systematic review. *Sci Total Environ*. 2018; 627: 388-402.

#### **Implementation Resources:**

Certification process information

<https://climatesmart.ny.gov/>

NYSDEC Climate Smart Communities Pledge

<https://www.dec.ny.gov/energy/65494.html>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Community Cohesion, Health Care, Natural Environment, Built Environment, Transportation

**Sectors Playing a Lead Role:** Governmental Agencies (Local Government)

**Sectors Playing a Contributing Role:** Governmental Public Health Agencies; Community or Neighborhood Residents; Community Based Organizations and Human Service Agencies; Policy Makers and Elected Officials; Transportation Agencies; Economic Development Agencies; Natural Environment Agencies; Urban Planning Agencies

**Intermediate measures:** Number of certified communities. Number of communities working towards certification

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Disease*, (2) Physical Activity, (2.1) Create community environments for physical activity; (2.2) Promote school, child care and worksite environments that increase physical activity; (2.3) Facilitate access to safe and accessible places for physical activity

### 3.1.2 (Supporting Objective 3.1.c.)

Identify and promote the availability and use of cooling centers and other resources to prepare for extreme heat events.

NYS is experiencing increasing temperatures and extreme heat events. A few hours of air-conditioning during an extreme heat event can prevent or reduce the impact of heat on health. Cooling centers are one component of an overall strategy for preventing heat-related morbidity and mortality, by providing a cool location for people who do not have access to air-conditioning during a heat event. As of summer 2018, 37 counties reported cooling center information to the NYSDOH (NYC maintains a separate cooling center website). It would be prudent for all counties to prepare for extreme heat events by identifying locations that could be used as cooling centers if needed.

**Evidence Base:** The Use of Cooling Centers to Prevent Heat-Related Illness: Summary of Evidence and Strategies for Implementation (Climate and Health Technical Report Series Climate and Health Program, Centers for Disease Control and Prevention)

<https://www.cdc.gov/climateandhealth/docs/UseOfCoolingCenters.pdf>

**Implementation Resources:** NYSDOH Cooling Centers Information and Resources

<https://www.health.ny.gov/environmental/weather/cooling/>

NYSDOH interactive map application to identify nearest Cooling Center

[https://apps.health.ny.gov/statistics/environmental/public\\_health\\_tracking/tracker/#/CCMap](https://apps.health.ny.gov/statistics/environmental/public_health_tracking/tracker/#/CCMap)

NYSDOH Heat Vulnerability Index to assist local public health leaders and emergency planners identify areas with populations with greatest vulnerability to heat to mitigate the public health impact of heat in their area

[https://www.health.ny.gov/environmental/weather/vulnerability\\_index/](https://www.health.ny.gov/environmental/weather/vulnerability_index/)

NYSDOH County heat and health profile reports and summaries of county level temperature trends, heat-related health effects, and list some adaptation resources

<https://www.health.ny.gov/environmental/weather/profiles/>

**Target Population by Age:** New Yorkers of all Ages; certain populations are more vulnerable to heat than others including children and older adults

**Social Determinants of Health:** Community Cohesion; Health Care; Natural Environment; Built Environment

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (Local Health Departments, County Emergency Management Offices)

**Sectors Playing a Contributing Role:** Governmental Public Health Agencies; Employers, Businesses and Unions (e.g., shopping malls, grocery stores); Media; Colleges and Universities; Community or Neighborhood Residents; Community Based Organizations and Human Service Agencies; Policy Makers and Elected Officials; Transportation Agencies; Economic Development Agencies; Natural Environment Agencies; Urban Planning Agencies; Others: Public Libraries, Senior Centers, Fire Departments, Municipalities, Non-Profit Organizations (e.g., American Red Cross)

**Intermediate Measure:** Number of counties currently participating in the program. Number of designated cooling centers across NYS. Number of households receiving cooling assistance through HEAP. Number of people using cooling centers.

**Supporting Other Goals and Interventions from other Priorities:** Prevent Chronic Disease, (2) Physical Activity, (2.1) Create community environments for physical activity; (2.3) Facilitate access to safe and accessible places for physical activity

### **3.1.3: (Supporting Objective 3.1.b.)**

Enhance active transportation infrastructure by encouraging utilization and seeking opportunities to expand existing networks.

Encourage Utilization: Encourage public and private sector businesses to develop or adopt programs to utilize alternative commuting methods, and promote and participate in NYS's annual Green Your Commute Day. For state agencies, promote the use of 511NYRideShare within state government agencies. For the private sector, promote greater use of carpooling.

Seeking Funding Opportunities: Seek opportunities to enhance active transportation through funding. In 2016, the CSC Grant program was established to provide 50/50 matching grants to cities, towns, villages, and counties (or boroughs of New York City) of the State of New York for eligible climate adaptation and mitigation projects. Funds are available for two broad categories: The first category supports implementation projects related to climate change adaptation and the reduction of greenhouse gases outside the power sector. The second category supports planning projects related to CSC certification actions especially in the areas of climate change adaptation, land use, and municipal fleet management.

#### **Evidence Base:**

Community Preventive Services Task Force Recommendation for Built Environment Interventions to Increase Physical Activity

<https://www.thecommunityguide.org/content/combined-built-environment-features-help-communities-get-active>

#### **Implementation Resources:**

NYSDEC Green Your Commute Information

<https://www.dec.ny.gov/public/96405.html>

511NY Rideshare

<https://511nyrideshare.org/>

NYSDEC Climate Smart Community Grant Program

<http://www.dec.ny.gov/energy/109181.html#CSC>

NYSDEC Climate Smart Communities Certification Actions

<https://climatesmart.ny.gov/actions-certification/actions/>

NYS DOT Complete Streets

<https://www.dot.ny.gov/programs/completestreets>

Smart Growth America

Safer Streets, Stronger Economies: Complete Streets project outcomes from across the country

<https://www.smartgrowthamerica.org/app/uploads/2016/08/safer-streets-stronger-economies.pdf>

CDC Transportation Health Impact Assessment Toolkit

[https://www.cdc.gov/healthyplaces/transportation/promote\\_strategy.htm](https://www.cdc.gov/healthyplaces/transportation/promote_strategy.htm)

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Community Cohesion, Health Care, Natural Environment, Built Environment

**Sectors Playing a Lead Role:** Governmental Agencies (Local Governments)

**Sectors Playing a Contributing Role:** Governmental Public Health Agencies; Community or Neighborhood Residents; Community Based Organizations and Human Service Agencies; Policy Makers and Elected Officials; Transportation agencies; Economic Development Agencies; Natural Environment Agencies; Urban Planning Agencies

**Intermediate Measure:** Miles of active transportation opportunities within jurisdiction

Number of projects designed to enhance active transportation opportunities within jurisdiction

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Disease*, (2)

Physical Activity, (2.1) Create community environments for physical activity; (2.2) Promote school, child care and worksite environments that increase physical activity; (2.3) Facilitate access to safe and accessible places for physical activity

**3.1.4:** (Supporting Objective 3.1.d.):

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. If cooling towers are not operated and maintained properly, *Legionella* can grow inside of them and can be dispersed into the air in tiny water droplets or mist. 10 NYCRR Subpart 4-1 was developed in accordance with industry standards for cooling tower operating procedures, most notably ASHRAE Standard 188-2015 Legionellosis: Risk Management for Building Water Systems

**Evidence Base:** CDC Cooling Towers

[https://www.cdc.gov/healthywater/other/industrial/cooling\\_towers.html](https://www.cdc.gov/healthywater/other/industrial/cooling_towers.html)

**Implementation Resources:** NYSDOH Protection Against Legionella

<https://www.health.ny.gov/environmental/water/drinking/legionella/index.htm>

10 NYCRR Subpart 4-1 Cooling Towers Regulation

<https://regs.health.ny.gov/content/subpart-4-1-cooling-towers>

ASHRAE Standard 188-2015 Legionellosis: Risk Management for Building Water Systems p. 7-8

<https://www.ashrae.org/technical-resources/standards-and-guidelines#188>

**Target population by age:** New Yorkers of all Ages; Adults over 50 are at the highest risk for legionellosis

**Social determinants of health:** Built Environment

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (State and Local Health Departments)

**Sectors Playing a Contributing Role:** Employers, Businesses and Unions

**Intermediate measures:** Number of registered towers and the percent of towers in compliance. (By 2021: 78% compliance)

**Supporting Other Goals and Interventions from other Priorities:** NA

**3.1.5:** (Supporting Objective 3.1.e.):

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. CDC recommends that healthcare facilities develop and follow a water management program to minimize the growth and spread of *Legionella* and other waterborne pathogens in premise water systems.

**Evidence Base:** CDC Healthcare Water Management Program Frequently Asked Questions

<https://www.cdc.gov/legionella/wmp/healthcare-facilities/healthcare-wmp-faq.html>

**Implementation Resources:**

NYSDOH Protection Against *Legionella*: Residential and Health Care Facility Requirements

[https://www.health.ny.gov/environmental/water/drinking/legionella/hospitals\\_health\\_care.htm](https://www.health.ny.gov/environmental/water/drinking/legionella/hospitals_health_care.htm)

10 NYCRR Subpart 4-2 Health Care Facility Regulation

<https://regs.health.ny.gov/content/subpart-4-2-health-care-facilities>

CDC Guidance on *Legionella*

<https://www.cdc.gov/legionella/wmp/healthcare-facilities/healthcare-wmp-faq.html>

Federal Register, Centers for Medicare and Medicaid Services (CMS), 42 CFR 483.80

<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

CMS Survey and Certification Memo S&C 17-30-All, dated 6/2/2017 (revised 6/9/2017)

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-30.pdf>

**Target population by age:** New Yorkers of all Ages; Adults over 50 are at the highest risk for legionellosis and the most likely to be patients/residents of Article 28 facilities.

**Social determinants of health:** Built Environment

**Sectors Playing a Lead Role:** Healthcare Delivery System.

**Sectors Playing a Contributing Role:** Governmental Public Health Agencies (Federal and State)

**Intermediate measures:** Number of trainings and resources provided. Sampling and management plans (water management plan) submitted that contain evidence of effective facility water management practices.

**Supporting Other goals and Interventions from other Priorities:** *Prevent Communicable Diseases including HIV/STIs, Vaccine-Preventable Diseases and Antimicrobial Resistance, and Healthcare-Associated Infections*, (5) Antibiotic Resistance and Healthcare-Associated Infections, (5.1) Improve infection control in healthcare facilities

### **Goal 3.2:** Promote healthy home and school environments

**Objectives 3.2.a.** Increase health care provider's blood lead testing rates of children ages 0-6.

- One year old blood lead testing rates. (Baseline: 58.72%; Target 95%; Intermediate Target: 90%. Data Source: New York State Immunization Information System, 2017 Aggregate Clinical Performance Report; Available Data: State/County level)
- Two year old blood lead testing rates. (Baseline: 56.82%; Target 95%; Intermediate Target: 90%. Data Source: New York State Immunization Information System, 2017 Aggregate Clinical Performance Report; Available Data: State/County level)

**Objectives 3.2.b.** Increase the number of homes that are inspected for lead and other health hazards. (Baseline: 18,675 initial home visits completed; Baseline year: 2017; Target: 23,000 units annually. Data Source: NYSDOH Lead Poisoning Prevention Program reports, Childhood Lead Poisoning Primary Prevention Program reports, and Healthy Neighborhoods Program reports; Available Data: State level)

**Objective 3.2.c** 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.)

**Objective 3.2.d.** Increase the number of homes tested for radon and mitigating as needed. (Underdeveloped.) (Baseline: 37,563 tests annually (3-year average from 2015 through 2017); Target: 50,000 tests annual average (calculated over 3-years). Data Source: NYSDOH Radon Database/Application and Dataset per 10 NYCRR Part 16.130(b)(1)); Available Data: State level)

**Objective 3.2.e.** Increase the number of homes mitigated for radon as needed. (Baseline: 3,439 mitigation systems annually (3-year average from 2015 through 2017); Target: 3,700 mitigation systems annual average (calculated over 3-years). Data Source: Dataset per 10 NYCRR Part 16.130(b)(3)); Available Data: State level)

**Objective 3.2.f.** Increase the number of houses built with radon resistant features. (No data are available to measure this objective statewide.)

**Objective 3.2.g.** By 2024, 10% of NYS public, private, and charter schools enroll in the NYS Clean, Green, and Healthy Schools Program. (Baseline: 0.2%; Target: 10%; Intermediate: 5%; Data Source: NYSDOH database maintained by the Clean, Green, and Healthy Schools program as schools enroll; Available Data: State/County level)

(Goal of the above school objectives is improvements in other measures of school attendance, academic performance, and asthma/respiratory symptoms. This will cross reference the applicable Asthma-related objectives.)

**Objective 3.2.h.** 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.)

## Interventions

### 3.2.1: (Supporting Objectives 3.2.a)

Educate healthcare providers and parents about blood lead testing requirements and importance. Such activities may include:

- Promote point-of-care blood lead testing in healthcare provider offices.
- Create a blood lead testing “Report Card” and disseminate to healthcare providers.
- Educate HCPs to use the New York State Immunization Information System (NYSIIS) blood lead reports, e.g., Test Due List Report and Aggregate Clinical Performance Report
- Develop a media campaign targeting parents to discuss blood lead testing with their child’s healthcare provider.
- Educate healthcare providers to provide anticipatory guidance concerning lead poisoning prevention to parents and caregivers of children at child health visits.

**Evidence Base:** CDC guidance on lead action levels and follow-up

[https://www.cdc.gov/nceh/lead/acclpp/actions\\_blls.html](https://www.cdc.gov/nceh/lead/acclpp/actions_blls.html)

CDC Preventing Lead Poisoning in Young Children

<https://www.cdc.gov/nceh/lead/publications/books/plpyc/chapter7.htm>

**Implementation Resources:** NYSDOH Information for Health Care Providers on Lead Poisoning Prevention and Management

[https://www.health.ny.gov/environmental/lead/health\\_care\\_providers/index.htm](https://www.health.ny.gov/environmental/lead/health_care_providers/index.htm)

NYSDOH, Local Health Department Lead Poisoning Program (LPPP)

[https://www.health.ny.gov/environmental/lead/health\\_care\\_providers/local\\_health\\_departments.htm](https://www.health.ny.gov/environmental/lead/health_care_providers/local_health_departments.htm)

Regional Lead Resource Center (RLRC)

[https://www.health.ny.gov/environmental/lead/exposure/childhood/regional\\_lead\\_resource\\_centers.htm](https://www.health.ny.gov/environmental/lead/exposure/childhood/regional_lead_resource_centers.htm)

**Target Population by Age:** Infants and Toddlers up to age 5

**Social Determinants of Health:** Housing, Built Environment, Education, Economic Stability

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (State and Local Health Departments), Healthcare Delivery System (providers).

**Sectors Playing a Contributing Role:** Media, Community Based Organizations and Human Service Agencies

**Intermediate Measures:** Number of outreach materials distributed or training offered. Number of children screened.

**Supporting Other Goals and Interventions from other Priorities:** *Promote Healthy Women, Infants, and Children*, (2) Perinatal & Infant Health, (2.1) Reduce infant mortality & morbidity

### 3.2.2: (Supporting Objectives 3.2.b. and 3.2.c.)

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 (15 Programs cover 19 municipalities for home visits) and 19 Healthy Neighborhood Programs.

**Evidence Base:** A Cost-Benefit Analysis of a State-Funded Healthy Homes Program for Residents With Asthma: Findings From the New York State Healthy Neighborhoods Program.

<https://www.ncbi.nlm.nih.gov/pubmed/28121775>

**Implementation Resources:** NYSDOH Childhood Lead Poisoning Prevention Program

<https://www.health.ny.gov/environmental/lead/>

CDC, Lead

<https://www.cdc.gov/nceh/lead/default.htm>

NYSDOH, Healthy Neighborhood Program

[https://www.health.ny.gov/environmental/indoors/healthy\\_neighborhoods/](https://www.health.ny.gov/environmental/indoors/healthy_neighborhoods/)

**Target Population by Age:** New Yorkers of all Ages, children up to age 13, Adolescents (13-21)

**Social Determinants of Health:** Housing, Built Environment, Economic Stability

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (State and Local Health Departments), Managed Care Organizations, Health Care Providers, Community Based Organizations and Human Service Agencies.

**Sectors Playing a Contributing Role:** Managed Care Organizations, Other: Local Code Enforcement Agencies, Maternity and Early Childhood Foundation Inc, American Academy of Pediatrics, Local Level Medical Society

**Intermediate Measures:** Enhance referral network to make referrals to both the childhood lead primary prevention program for home assessment and/or the healthy neighborhood program. Increase the percentage of home visits for individual's with poorly controlled asthma under the Healthy Neighborhoods Program.

**Supporting Other Goals and Interventions from other Priorities:** *Promote Healthy Women, Infants, and Children*, (2) Perinatal & Infant Health, (2.1) Reduce infant mortality & morbidity. *Prevent Chronic Diseases* (4) Chronic Disease Preventive Care and Management, (4.3) Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular diseases diabetes and prediabetes and obesity (4.4) Improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

### **3.2.3:** (Supporting Objectives 3.2.d., 3.2.e, and 3.2.f.)

Conduct radon outreach and education programs for the public, applicable building construction contractors, and building officials and code inspectors. Component of outreach may include promotion of the NYSDOH's free and low-cost radon test kits, which includes providing test kits at half price to schools and daycares and free test kits as part of the NYSDOH's Healthy Neighborhoods Program and other State Indoor radon grant-funded programs.

**Evidence Base:** World Health Organization (WHO), Handbook on Indoor Radon

[http://apps.who.int/iris/bitstream/handle/10665/44149/9789241547673\\_eng.pdf;jsessionid=0FE3F65B7400BF681699BD5C5CAEBFF3?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/44149/9789241547673_eng.pdf;jsessionid=0FE3F65B7400BF681699BD5C5CAEBFF3?sequence=1)

National Academy of Science, Biological Effects of Ionizing Radiation (BEIR) VI Committee, Health Effects of Exposure to Radon

<https://www.nap.edu/read/5499/chapter/1>

US EPA, Assessment of Risks from Radon in Homes, EPA 402-R-03-003

<https://www.epa.gov/sites/production/files/2015-05/documents/402-r-03-003.pdf>

Agency for Toxic Substances and Disease Registry (ATSDR) toxicological profile for radon

<https://www.atsdr.cdc.gov/substances/toxsubstance.asp?toxid=71>

**Implementation Resources:**

NYSDOH Radon Information

[www.health.ny.gov/radon](http://www.health.ny.gov/radon)

CDC Radon

<https://www.cdc.gov/radon/>

US EPA Radon

[www.epa.gov/radon](http://www.epa.gov/radon)

US EPA Radon Guidance for Schools, Webinar: Radon in Schools

<https://www.epa.gov/iaq-schools/forms/webinar-radon-schools-what-you-need-know-properly-manage-radon-your-school>

Kansas State University, National Radon Program Services, Training and Resources

<https://sosradon.org/RRNC-Code-Officials>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Housing, Built Environment

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (State and Local Health Departments).

**Sectors Playing a Contributing Role:** Employers, Businesses and Unions, Media, Colleges and Universities, Schools (K-12), Community or Neighborhood Residents, Community Based Organizations and Human Service Agencies, Policy Makers and Elected Officials, Housing Agencies, Urban Planning Agencies

**Intermediate Measures:** Number of homes tested for radon.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases (4)*  
Chronic Disease Preventive Care and Management

**3.2.4:** (Supporting Objectives 3.2.g.)

Explore local level policy and/or code adoption to require radon resistant construction in high radon areas.

**Evidence Base:** WHO, Handbook on Indoor Radon

[http://apps.who.int/iris/bitstream/handle/10665/44149/9789241547673\\_eng.pdf;jsessionid=0FE3F65B7400BF681699BD5C5CAEBFF3?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/44149/9789241547673_eng.pdf;jsessionid=0FE3F65B7400BF681699BD5C5CAEBFF3?sequence=1)

National Academy of Science, Biological Effects of Ionizing Radiation (BEIR) VI Committee, Health Effects of Exposure to Radon

<https://www.nap.edu/read/5499/chapter/1>

US EPA, Assessment of Risks from Radon in Homes, EPA 402-R-03-003

<https://www.epa.gov/sites/production/files/2015-05/documents/402-r-03-003.pdf>

ATSDR toxicological profile for radon

<https://www.atsdr.cdc.gov/substances/toxsubstance.asp?toxid=71>

**Implementation Resources:**

NYS DOH, Radon Resistant New Construction information

<https://www.health.ny.gov/environmental/radiological/radon/rrnc/index.htm>

NYS Department of State, Division of Building Standards and Codes

<https://www.dos.ny.gov/dcea/>

Kansas State University, National Radon Program Services, Training and Resources

<https://sosradon.org/RRNC-Code-Officials>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Housing, Built Environment

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (State and Local Health Departments), State and Local Building Codes Officials.

**Sectors Playing a Contributing Role:** Policy Makers and Elected Officials, Housing Agencies, Economic Development Agencies, Urban Planning Agencies

**Intermediate Measures:** Number of building code officials that receive training on radon resistant construction methods. Number of policy makers/elected officials who are engaged.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases (4)*  
Chronic Disease Preventive Care and Management

**3.2.5:** (Supporting Objectives 3.2.d. and 3.2.e)

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. Add radon testing questions to routine electronic medical questionnaires.

**Evidence Base:** WHO, Handbook on Indoor Radon

[http://apps.who.int/iris/bitstream/handle/10665/44149/9789241547673\\_eng.pdf;jsessionid=0FE3F65B7400BF681699BD5C5CAEBFF3?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/44149/9789241547673_eng.pdf;jsessionid=0FE3F65B7400BF681699BD5C5CAEBFF3?sequence=1)

National Academy of Science, Biological Effects of Ionizing Radiation (BEIR) VI Committee, Health Effects of Exposure to Radon <https://www.nap.edu/read/5499/chapter/1>

US EPA, Assessment of Risks from Radon in Homes, EPA 402-R-03-003

<https://www.epa.gov/sites/production/files/2015-05/documents/402-r-03-003.pdf>

ATSDR toxicological profile for radon.

<https://www.atsdr.cdc.gov/substances/toxsubstance.asp?toxid=71>

**Implementation Resources:**

NYSDOH, Radon Awareness Through Physicians

[https://www.health.ny.gov/environmental/radiological/radon/md\\_campaign.htm](https://www.health.ny.gov/environmental/radiological/radon/md_campaign.htm)

Conference of Radiation Control Program Directors, Reducing the Risk from Radon: Information and Interventions, A Guide for Health Care Providers

[http://www.radonleaders.org/sites/default/files/HP\\_Radon\\_Guide\\_2018\\_FINAL\\_CRCPD%20E-18-2.pdf](http://www.radonleaders.org/sites/default/files/HP_Radon_Guide_2018_FINAL_CRCPD%20E-18-2.pdf)

Iowa Cancer Consortium, Breathing Easier Campaign videos and resources for physicians  
<http://canceriowa.org/BreathingEasier.aspx>

CDC Radon Toolkit

<https://www.cdc.gov/radon/toolkit/index.html>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Housing, Built Environment

**Sectors Playing a Lead Role:** Healthcare Delivery System (providers), Governmental Public Health Agencies (State and Local Health Departments).

**Sectors Playing a Contributing Role:** Community Based Organizations and Human Service Agencies; Policy Makers and Elected Officials

**Intermediate Measures:** Number of materials provided.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases (4)*  
Chronic Disease Preventive Care and Management

### 3.2.6: (Supporting Objectives 3.2.g.)

Implement the NYS Clean, Green, and Healthy Schools Program in schools across NYS.

The New York State Clean, Green, and Healthy Schools Program is a statewide school environmental health program developed through collaborative efforts by the NYSDOH in conjunction with over 40 state and federal agencies, and non-government organizations. The program helps schools improve the health and safety of their school environment, which may result in better health, attendance, productivity, and test scores. The program provides information for all school occupants on best practices, tools, knowledge, and resources in nine environmental health focus areas:

- 1) Indoor Air Quality (IAQ);
- 2) Energy and Resource Conservation;
- 3) Integrated Pest Management (IPM);
- 4) Mold/Moisture;
- 5) Chemical and Environmental Hazards;
- 6) Cleaning and Maintenance;
- 7) Transportation;
- 8) Construction/Renovation; and
- 9) Water Quality.

**Evidence Base:** E. Eitland, L. Klingensmith, P. MacNaughton, et al. Foundations for Student Success: How School Buildings Influence Student Health, Thinking, and Performance. Harvard T. H. Chan School of Public Health. 2018.

<https://www.hsph.harvard.edu/news/hsph-in-the-news/school-buildings-student-health-performance/>

**Implementation Resources:**

NYSDOH, New York State Clean, Green, and Healthy Schools

[https://www.health.ny.gov/environmental/indoors/healthy\\_schools/audience.htm#students](https://www.health.ny.gov/environmental/indoors/healthy_schools/audience.htm#students)

NYSDOH, New York State Clean, Green, and Healthy Schools Program Guide for Schools

[https://www.health.ny.gov/environmental/indoors/healthy\\_schools/docs/programguide.pdf](https://www.health.ny.gov/environmental/indoors/healthy_schools/docs/programguide.pdf)

NYSDEC School Chemical Management

<https://dec.ny.gov/education/105106.html>

**Target Population by Age:** School-aged children 5-17 years old; Adults who work in schools (Children up to age 13, Adolescents (13-21), and Adults (ages 21-60))

**Social Determinants of Health:** Education, Built Environment

**Sector Playing a Lead Role:** Schools (K-12)

**Sectors Playing a Contributing Role:** Governmental Public Health Agencies (State and Local Health Departments), Unions, Policy Makers and Elected Officials, NGOs, Natural Environment Agencies (NYDEC), Urban Planning Agencies

**Intermediate Measures:** Number of schools enrolled in the Clean, Green, and Healthy Schools Program (500 schools enrolled by December 31, 2022).

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases* (4) Chronic Disease Preventive Care and Management, (4.3) Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular diseases diabetes and prediabetes and obesity

### **3.2.7:** (Supporting Objectives 3.2.h.)

Promote outreach and increase education regarding environmental hazards among individuals leading and supporting the licensing of early care and education (ECE) programs.

In partnership with the Agency for Toxic Substances and Disease Registry's (ATSDR's) the NYSDOH is working on a 3-year project called "Choose Safe Places for Early Care and Education (CSPECE)." The overall mission of the CSPECE project is to ensure that early care and education programs are located where chemical hazards have been considered, addressed, and ruled out or mitigated to best protect children's health. The environmental hazards include but are not limited to: former uses of the property that may have residual harmful substances, migration of harmful substances onto the property from other sites, presence of naturally occurring harmful substances (i.e. radon), and access to safe drinking water. This program relies on the collaboration and assistance of stakeholders.

**Evidence Base:** US EPA, Drinking Water Best Management Practices for Schools & Child Care Facilities Served by Municipal Water Systems

<https://nepis.epa.gov/Exe/ZyPDF.cgi?Dockey=P100HGM8.txt>

US EPA, Drinking Water Best Management Practices for Schools and Child Care Facilities with Their Own Drinking Water Source

<https://nepis.epa.gov/Exe/ZyPDF.cgi/P100GOT8.PDF?Dockey=P100GOT8.PDF>

US EPA, School Siting Guidelines

[https://www.epa.gov/sites/production/files/2015-06/documents/school\\_siting\\_guidelines-2.pdf](https://www.epa.gov/sites/production/files/2015-06/documents/school_siting_guidelines-2.pdf)

American Academy of Pediatrics (AAP), Drinking Water from Private Wells and Risks to Children

<http://pediatrics.aappublications.org/content/pediatrics/123/6/1599.full.pdf>

**Implementation Resources:**

ATSDR's Choose Safe Places for Early Care & Education

<https://www.atsdr.cdc.gov/safeplacesforece/index.html>

Children's Environmental Health Network

<https://cehn.org/>

**Target Population by Age:** Children and Adolescents (ages 6 weeks to 13 years of age) and Adults (women of child bearing age).

**Social Determinants of Health:** Education, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies (State and Local including Early Childcare and Education Agencies and Health Departments).

**Sectors Playing Contributing Role:** Governmental Public Health Agencies (State and Local Health Departments), and State and Local Childcare Resource and Referral Agencies

**Intermediate Measures:** Number of annual trainings for OCFS staff (inspectors, fire & safety reps, licensors), Local Health Departments, and Day care providers.

**Supporting Other Goals and Interventions from other Priorities:** *Promote Healthy Women, Infants, and Children*, (2) Perinatal & Infant Health and *Prevent Chronic Diseases* (4) Chronic Disease Preventive Care and Management

## Focus Area 4: Water Quality

Challenges to drinking and recreational water quality can be viewed in the NYS Health Assessment *Contributing Causes of Health Challenges* Chapters:

[https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf)

**Goal 4.1:** Protect water sources and ensure quality drinking water

**Objective 4.1.a.** Increase the number of public water systems that apply for and are awarded infrastructure improvement assistance (e.g., Drinking Water State Revolving Fund (DWSRF), Water Infrastructure Improvement Act (WIIA), and Intermunicipal Water Infrastructure Grant Program (IMG)) to reduce exposure to regulated and emerging contaminants and public health impacts associated with aged infrastructure. (Annual Baseline: 28 annual average (calculated over 3-years (2015-2017)); Annual Target: 45 annual average (calculated over 3-years; with 6-year total target of 270). Short Term Financings are being used as to not double count projects as each project usually closes on both Short and Long-Term financing. Data Source: DWSRF Program data; Available Data: State/Public water system level)

**Objective 4.1.b.** 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.)

### Interventions

**4.1.1:** (Supporting Objective 4.1.a.)

Promote funding opportunities (e.g., DWSRF) through webinars and notices to stakeholders engaged in public water and public water infrastructure

#### **Evidence Base:**

The Associated General Contractors of America, Drinking Water and Wastewater Infrastructure

<https://www.agc.org/connect/agc-groups/utility-infrastructure-division/drinking-water-and-wastewater-infrastructure>

Hunter, P. R., MacDonald, A. M., & Carter, R. C. (2010). Water Supply and Health. *PLoS Medicine*, 7(11)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2976720/>

U.S. Environmental Protection Agency, Drinking Water Infrastructure Needs Survey and Assessment, Sixth Report to Congress

[https://www.epa.gov/sites/production/files/2018-10/documents/corrected\\_sixth\\_drinking\\_water\\_infrastructure\\_needs\\_survey\\_and\\_assessment.pdf](https://www.epa.gov/sites/production/files/2018-10/documents/corrected_sixth_drinking_water_infrastructure_needs_survey_and_assessment.pdf)

**Implementation Resources:**

NYS Environmental Facilities Corporation, DWSRF

<https://www.efc.ny.gov/DWSRF>

NYSDOH, DWSRF Information Sheet

[https://www.health.ny.gov/environmental/water/drinking/iup/information\\_sheet.htm](https://www.health.ny.gov/environmental/water/drinking/iup/information_sheet.htm)

NYS Environmental Facilities Corporation, Water Infrastructure Improvement Act

[www.efc.ny.gov/WIIA](http://www.efc.ny.gov/WIIA)

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies (State Health Department)

**Sectors Playing Contributing Role:** Public, Professional Societies (American Water Works Association NY Section, NYS Rural Water, American Society of Civil Engineers NY Section), Government Agencies (local) and Governmental Public Health Agencies (Local Health Departments), Private Sector Business Councils

**Intermediate Measure:** Number of short term financing projects. (By December 31, 2020, a total of 30 short-term financing projects.)

**Supporting Other Goals and Interventions from other Priorities:** NA

**4.1.2** (Supporting Objective 4.1.b.)

Develop and implement monitoring programs, source water assessments, and drinking water protection strategies. At the state level,

- Identify potential sources of drinking water contamination
- Develop a comprehensive statewide sustainable source water protection program

**Evidence Base:** Postel, S.L., and Thompson Jr., B.H. 2005. Watershed protection: Capturing the benefits of nature's water supply services. *Natural Resources Forum* 29:98-108.

<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.459.6538&rep=rep1&type=pdf>

**Implementation Resources:** US EPA Protect Sources of Drinking Water Information and Resources

<https://www.epa.gov/sourcewaterprotection>

Source Water Collaborative

<https://sourcewatercollaborative.org/>

American Water Works Association Source Water Protection Resource Community

<https://www.awwa.org/resources-tools/water-knowledge/source-water-protection.aspx>

Association of State Drinking Water Administrators Source Water Protection

<https://www.asdwa.org/source-water/>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Built Environment

**Sectors Playing Lead Role:** Natural Resource Agencies (NYSDEC), Governmental Public Health Agencies (State and Local Health Departments), Public Water Suppliers, Other Governmental Agencies (NYS Department of State, NYS Agriculture & Markets, and local municipalities)

**Sectors Playing Contributing Role:** Public, Professional Societies (American Water Works Association NY Section, NYS Rural Water, American Society of Civil Engineers NY Section) Governmental Agencies (local)

**Intermediate Measure:** Number of source water protection plans.

**Goal 4.2:** Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water

Objective 4.2.a. Increase access to information on water quality that affects the recreational use of NYS and marine waterbodies. (Underdeveloped; data may be developed and measured in the future.)

Objective 4.2.b. Reduce the annual average number of beach closure days due to HABS by 5% to 1,228 days. (Baseline (2018): 1,293 annual beach closure days; Target: overall 5% reduction in the cumulative annual average (2019-2024) number of beach closure days. Data Source: NYSDOH Bathing Beach closure tracking database; Available Data: State/County/Waterbody level)

## Interventions

### 4.2.1 (Supporting Objectives 4.2.a.)

Enhance the public's accessibility to real-time water quality information for recreational waters including beach status (open, closed) and other information.

Currently, the NYSDOH Beach Water Quality Information System includes details on bathing beaches in NYS on the Great Lakes and for marine waters. The data displayed are used by the public and other partner agencies. Information on NYS operated bathing beaches are displayed on NYS Parks, Recreation, and Historic Preservation's and other beach specific websites/pages. Centralizing and/or expanding the information available may help improve the usability and access to important information concerning bathing beaches.

Promotion of the NYSDOH Beach Water Quality Information System and other relevant sites could be implemented through outreach campaigns, press releases, and links from other web pages to promote public awareness.

**Evidence Base:** US EPA 2016 Recreational Water Conference

<https://www.epa.gov/sites/production/files/2016-06/documents/recreational-waters-session2-2016.pdf> (Page 21)

**Implementation Resources:** NYSDOH Beach Water Quality Information Site:

[http://ny.healthinspections.us/ny\\_beaches/](http://ny.healthinspections.us/ny_beaches/)

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Natural Environment, Built Environment

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (State and Local Health Departments), Natural Environment Agencies (NYSDEC, NYS State Parks, Recreation, and Historic Preservation)

**Intermediate Measure:** Number of waterbodies with bathing beach water quality information online.

#### 4.2.2 (Supporting Objective 4.2.b)

Adopt and implement best management practices to reduce nutrient loading through resource conservation, wastewater, and storm water infrastructure improvements (such as green infrastructure).

Increasing blooms of toxic cyanobacteria have affected not only NYS waterbodies, but have been found to be increasing around the world. Investigations suggest implementing nutrient loading reduction strategies can have a synergistic reduction effect on cyanobacteria blooms and populations. Sources of increased nutrients and increasingly eutrophic conditions in lakes in the US have been linked to storm water (Siegel, et al., 2011), sewage, atmospheric deposition, groundwater, and agriculture run-off (Anderson, et al. 2002). It is advisable to investigate and adopt best management practices for nutrient loading reduction to assist in the alleviation of harmful cyanobacteria blooms.

**Evidence Base:** Anderson, D. M., et al. 2002. Harmful algal blooms and eutrophication: Nutrient sources, composition, and consequences

<https://link.springer.com/article/10.1007/BF02804901>

<https://pdfs.semanticscholar.org/e5eb/9e1d2c50af255f71f1a435618a7df630f63a.pdf>

Siegel A, Cotti-Rausch B, Greenfield DI, Pinckney JL (2011) Nutrient controls of planktonic cyanobacteria biomass in coastal stormwater detention ponds. Mar Ecol Prog Ser 434:15-27. <https://doi.org/10.3354/meps09195>

**Implementation Resources:** NYSDEC Funding opportunities for non-point source pollution and water quality improvement

<https://www.dec.ny.gov/chemical/113733.html#Funding>

New York State DEC/EFC Wastewater Infrastructure Engineering Planning Grant - FAQs

<https://dec.ny.gov/pubs/83186.html>

NYSDEC examples of Green Infrastructure for Stormwater Management:

<https://www.dec.ny.gov/lands/58930.html>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Natural Environment, Built Environment

**Sectors Playing a Lead Role:** Governmental Agencies (local municipalities), Governmental Public Health Agencies (State and Local Health Departments), Natural Environment Agencies (NYSDEC, NYS State Parks, Recreation, and Historic Preservation)

**Sectors Playing a Contributing Role:** Urban Planning Agencies, Economic Development Agencies, Policy Makers and Elected Officials, Colleges and Universities, Community Based Organizations

**Intermediate Measure:** Number of jurisdictions that have implemented a watershed protection measure to address HABs (within 3 years, 7% of the waterbodies with HABs will have implemented some mitigation measures within respective watersheds).

## Focus Area 5: Food and Consumer Products

The Food and Consumer Products focus area is broad and covers reducing exposures to chemical or biological hazards in food and consumer products, and food safety. Challenges to food safety can be viewed in the NYS Health Assessment *Contributing Causes of Health Challenges* Chapters: [https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf)

This area includes a diverse set of objectives and interventions including improving gardening practices and garden environments to reduce the potential for exposures to contaminants in soil; promoting healthy fish consumption practices that reduce exposures to contaminants in fish; increasing the public's awareness of chemicals and contaminants in food and consumer products; and improving food safety management including reducing foodborne illness.

**Goal 5.1:** Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure.

Gardening - Objective 5.1.a. 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.)

Fish - Objective 5.1.b. 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.

By December 31, 2024, improve access to information for anglers and families eating fish from NYS waters by increasing the number of county or city maps from 8 to 20. These maps show better choice waterbodies; locations where fish have less contaminants.  
(Baseline: 8 maps; Baseline year: 2018; Target: 20 maps. Data Source: Fish Advisory Maps by County; Available Data: State/County/City level)  
[https://www.health.ny.gov/environmental/outdoors/fish/health\\_advisories/maps.htm](https://www.health.ny.gov/environmental/outdoors/fish/health_advisories/maps.htm)

Foods and Consumer Products - Objective 5.1.c. Increase public awareness of chemicals and/or contaminants in products. (Underdeveloped; data may be available to measure this objective in the future.)

## Interventions

### 5.1.1: (Supporting objective 5.1.a.)

Improve garden environments to reduce the potential for exposure to soil contaminants.

For young children, [studies](#) suggest that the greatest risk from a garden with soil contamination is direct contact with the soil and soil tracked into the home. For adults, including pregnant women, the greater risk may come from eating produce with adhered soil particles that are not readily removed by washing. Soil can be tested for common contaminants like lead to determine the importance of improving the garden environment to reduce the potential for exposure. Proactive improvements include installing a landscaping fabric barrier over contaminated soil, building [raised beds](#) and covering pathways with mulch. These improvements reduce the chances that gardeners and those who eat the garden's produce will be exposed to soil contaminants, without placing the responsibility on gardeners themselves to significantly change their practices. School districts, gardening groups, municipalities and other organizations can adopt practices, policies, or municipal codes that can support these changes by, for example, ensuring an adequate supply of locally available clean soil and amendments, keeping organized records of contaminant testing, and adopting maximum soil contaminant levels above which mitigative changes would be implemented. NYSDOH and its partners provide technical guidance and work to facilitate access to resources for community organizations to build capacity for informed decision-making about the benefits and risks associated with urban gardening.

**Evidence Base:** US EPA, Technical Review Workgroup Recommendations Regarding Gardening and Reducing Exposure to Lead-Contaminated Soils

<https://nepis.epa.gov/Exe/ZyPDF.cgi/P100JJS3.PDF?Dockey=P100JJS3.PDF>

CDC, Healthy Places: Community Gardens

<https://www.cdc.gov/healthyplaces/healthtopics/healthyfood/community.htm>

Urban Soils Institute, FAQ

<http://www.usi.nyc/soils-faq.html>

Environmental Geochemistry and Health, Estimated lead (Pb) exposures for a population of urban community gardeners

<https://link.springer.com/article/10.1007/s10653-016-9790-8>

Environmental Health Perspectives, Children's Lead Exposure: A Multimedia Modeling Analysis to Guide Public Health Decision-Making.

<https://www.ncbi.nlm.nih.gov/pubmed/28934096>

**Implementation Resources:** NYSDOH, Community Garden Raised Bed Tool Kit

<https://www.health.ny.gov/environmental/outdoors/garden/docs/toolkit.pdf>

NYSDOH, Healthy Gardening

<https://www.health.ny.gov/environmental/outdoors/garden/index.htm>

Cornell University College of Agriculture & Life Sciences, Healthy Soils, Healthy Communities

<http://blogs.cornell.edu/healthysoils/>

NYC Office of Environmental Remediation, NYC Clean Soil Bank

<http://home2.nyc.gov/html/oer/html/nyc-clean-soil-bank/nyc-clean-soil-bank.shtml>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Food Security, Community Cohesion, Natural Environment, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies, Colleges and Universities and Cooperative Extension

**Sectors Playing Contributing Role:** Colleges and Universities, Schools (K-12), Community or Neighborhood Residents, Policy Makers and Elected Officials, Housing Agencies, Economic Development Agencies, Natural Environment Agencies, Urban Planning Agencies

**Intermediate Measures:** Soil test results interpreted, garden soil covered/clean soil brought in.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (1) Healthy Eating and Food Security, (1.3) Reduce food insecurity

#### **5.1.2:** (Supporting objective 5.1.a)

Provide information to gardeners to help them produce healthy vegetables while minimizing exposure to contaminants for themselves and those with whom they share produce.

There are a number of [healthy gardening practices](#) that can reduce the likelihood of exposure to soil contaminants, such as planting fruiting vegetables instead of leafy or root vegetables, changing shoes before going indoors, washing hands after gardening, and washing and/or peeling vegetables before they are cooked or eaten. NYSDOH helps provide information to gardeners to make healthy choices and adopt healthy practices through evidence-based, culturally appropriate and balanced online content, distribution networks for printed materials (e.g., "Healthy Gardening" brochures), and indirectly, by working with partner organizations to convey these messages. NYSDOH and partners also participate in community outreach events called [soilSHOPS](#), where gardeners who might not be reached through other more traditional means are provided with lead screening results for their backyard soils. NYSDOH's community partners conduct trainings to foster peer education, build demonstration gardens, and engage in dialogue with policymakers to implement health-protective policies. Expanding partnerships will increase the number of gardeners empowered with information to make healthy gardening decisions.

**Evidence Base:** US EPA, Technical Review Workgroup for Lead recommendations

<https://nepis.epa.gov/Exe/ZyPDF.cgi/P100JJS3.PDF?Dockey=P100JJS3.PDF>

**Implementation Resources:**

NYSDOH, Healthy Gardening

<https://www.health.ny.gov/environmental/outdoors/garden/index.htm>

Cornell University College of Agriculture & Life Sciences, Healthy Soils, Healthy Communities

<http://blogs.cornell.edu/healthysoils/healthy-gardening/>

ATSDR, soilSHOP Tool Kit

<https://www.atsdr.cdc.gov/soilshop/index.html>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Food Security, Community Cohesion, Natural Environment, Built Environment

**Sectors Playing Lead Role:** Governmental Public Health Agencies (State or Local Health Departments), Colleges and Universities, and Cooperative Extension

**Sectors Playing Contributing Role:** Colleges and Universities, Schools (K-12), Community or Neighborhood Residents, Policy Makers and Elected Officials, Housing Agencies, Economic Development Agencies, Natural Environment Agencies, Urban Planning Agencies

**Intermediate Measures:** Soil test results interpreted, garden soil covered/ clean soil brought in.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (1) Healthy Eating and Food Security, (1.3) Reduce food insecurity

#### **5.1.3:** (Supporting Objective 5.1.b.)

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.

In NYS, fish and game health advisories are based primarily on information that NYSDEC collects and generates. In recent years, NYSDEC has annually collected approximately 1,500 fish from more than 50 locations/waters and analyzed these fish for various contaminants. NYSDEC also tests some game species (e.g., waterfowl, snapping turtles) that accumulate chemical contaminants. NYSDOH reviews the NYSDEC data for fish and game to determine if an advisory should be issued or revised for fish from specific waters, and game species. The NYSDEC expands their list of contaminants to test for in fish and game as new information on chemicals becomes available (specifically those chemicals that do not break down easily and have known or suspected health risks are of greatest interest). The NYSDOH and NYSDEC continue to work in collaboration to identify susceptible water bodies as new data become available related to emerging contaminants and their use and release.

**Evidence Base:** US EPA guidance on developing fish advisories

<https://www.epa.gov/fish-tech/epa-guidance-developing-fish-advisories>

Reducing Toxic Exposures from Fish Consumption in Women of Childbearing Age and Urban Anglers: Results of a Two-Year Diary Study

<https://ecommons.cornell.edu/bitstream/handle/1813/51499/HDRU%20Report%2016-3%20Version%202.pdf?sequence=2>

Tracking Declines in Mercury Exposure in the New York City Adult Population, 2004–2014, <https://link.springer.com/article/10.1007/s11524-018-0269-z#citeas>  
Fish Consumption and Breast Milk PCB Concentrations among Mohawk Women at Akwesasne, <https://academic.oup.com/aje/article/148/2/164/95863>

**Implementation Resources:**

US EPA guidance on developing fish advisories

<https://www.epa.gov/fish-tech/epa-guidance-developing-fish-advisories>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Food Security; Natural Environment

**Sectors Playing a Lead Role:** Governmental Public Health Agencies and Natural Environment Agencies (NYSDEC)

**Sectors Playing a Contributing Role:** NA

**Intermediate Measures:** Annual Sampling Request. By December 31<sup>st</sup> of each year, the NYSDOH will provide an annual fish sampling request to NYSDEC. This request will include information including but not limited to sampling requests for fish in those waterbodies with known or suspected contamination, popular fishing waters and waters where trends in fish contamination are being monitored. Additionally, the request will include those species that are most likely to be caught and eaten by sport anglers, as well as on waterbodies or fish species that the public have expressed concern about (if there is no available data).

**Supporting Other Goals and Interventions from other Priorities:** *Promote Healthy Women, Infants, and Children*, (2) Perinatal & Infant Health

**5.1.4** (Supporting Objective 5.1.b.)

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.

Inform the public about fish contamination in NYS water bodies to promote healthy fish consumption. Include advisory information in the NYSDEC Fresh Water Fishing Regulations guide. Provide online access and utilize social media and distribution networks, including entities that sell fishing licenses, environmental and community organizations, recreational facilities, food banks, and bait and tackle shops to distribute written materials. Translate regional materials into languages appropriate to the region, and utilize immigrant and refugee support networks, faith institutions, literacy, and other organizations to facilitate newcomers' access to this information.

Fishing is a fun outdoor activity and fish are an important part of a healthy diet. To promote healthy choices for recreational fish consumption, develop public-access county fishing maps that visually illustrate waters where families can eat the fish they catch, and waters where families should not eat fish. The county fishing maps offer local alternatives to contaminated waters for fish consumption without discouraging the practice of fishing nor

fish consumption. Develop fishing maps for additional counties and utilize online and distribution networks to distribute.

**Evidence Base:** US EPA guidance on developing fish advisories

<https://www.epa.gov/fish-tech/epa-guidance-developing-fish-advisories>

**Implementation Resources:** Reference for reaching out to sensitive subpopulations.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3709344/>

The Efficacy of Classroom Presentation in Spanish and English for Risk Communication on Fish Consumption Advisories.

[https://www.researchgate.net/publication/10606576\\_Evaluating\\_Risk\\_Communication\\_about\\_Fish\\_Consumption\\_Advisories\\_Efficacy\\_of\\_a\\_Brochure\\_versus\\_a\\_Classroom\\_Lesson\\_in\\_Spanish\\_and\\_English](https://www.researchgate.net/publication/10606576_Evaluating_Risk_Communication_about_Fish_Consumption_Advisories_Efficacy_of_a_Brochure_versus_a_Classroom_Lesson_in_Spanish_and_English)

Article from Atlantic States on communicating with multiethnic groups (see page 5).

[http://aslf.org/wp-content/uploads/2013/01/ASLF\\_Fish-Consumption-Communication-Strategy.pdf](http://aslf.org/wp-content/uploads/2013/01/ASLF_Fish-Consumption-Communication-Strategy.pdf)

**Target Population by Age:** New Yorkers of all Ages, with special emphasis on women under 50 (childbearing age) and children under 15 who are at higher risk from the contaminants in fish

**Social Determinants of Health:** Food Security, Natural Environment, Education

**Sectors Playing a Lead Role:** Community Based Organizations and Human Service Agencies, Governmental Public Health Agencies (State and Local Health Departments), Colleges and Universities, and Environmental Organizations

**Sectors Playing a Contributing Role:** Media, Schools (K-12); Community or Neighborhood Residents, Policy Makers and Elected Officials, Natural Environment Agencies, Others: Immigration Support Organizations, Food Banks and Faith Institutions

**Intermediate Measures:** By December 31, 2022, post three county public-access fishing maps online for regions of the state where contaminated waterbodies are heavily fished. Number of organizations participating and disseminating information.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (1) Healthy Eating and Food Security, (1.3) Reduce food insecurity, *Promote Healthy Women, Infants, and Children*, (1) Maternal and Women's Health (2) Perinatal & Infant Health (3) Child and Adolescent Health

#### 5.1.5: (Supporting objective 5.1.c.)

Expand access to chemical ingredient and other relevant product information.

- Promote existing disclosure venues to enhance public awareness.
- Expand chemical ingredient disclosure of products sold in NY through legislation or other.
- Enhance collaborations to investigate contaminants in products, share information, and alert the public.

**Evidence base:** Hore P, Ahmed M, Nagin D, and Clark N. 2014. Intervention Model for Contaminated Consumer Products: A Multifaceted Tool for Protecting Public Health. [Am J Public Health. 104\(8\):1377-83.](#)

**Implementation Resources:** NYSDEC Household Cleansing Product Information Disclosure Program

<https://www.dec.ny.gov/chemical/109021.html>

NYS Agriculture and Markets Food Safety Alerts

<https://www.agriculture.ny.gov/AD/alertList.asp>

US Food & Drug Administration Recalls, Market Withdrawals, and Safety Alerts

<https://www.fda.gov/Safety/Recalls/default.htm>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Food Security, Education, Community Cohesion

**Sectors Playing Lead Role:** Governmental Public Health Agencies (State and Local Health Departments, Poison Control Centers), Natural Environmental Agencies (NYSDEC), Policy Makers and Elected Officials, Media

**Sectors Playing Contributing Role:** Governmental Agencies: NYS Agriculture and Markets and NYS Food Laboratory; Community Based Organizations and Human Services Agencies; Employers, Businesses, and Unions; Healthcare Delivery System; Colleges and Universities

**Intermediate Measures:** Number of organizations participating and disseminating information.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (1) Healthy Eating and Food Security, (1.2) Increase skills and knowledge to support healthy food and beverage choices

## **Goal 5.2:** Improve food safety management

**Objective 5.2.a.** 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 Food safety regulations to provide modernized and uniform food safety requirements for operators across State and local jurisdictions. (This objective may be measured in the future.)

**Objective 5.2.b.** Identify the contributing factors in 56% of foodborne outbreaks on an annual basis. (Baseline (2017): 55.9%; Target 56%. Data Source: New York State Foodborne Disease Surveillance Data; Available Data: State level.)

## **Interventions**

**5.2.1:** (Supports Objective 5.2.a.)

Adopt Chapters 1-7 of the FDA 2017 Model Food into State Sanitary Code and provide implementation training and resources to Local Health Departments.

**Evidence Base:** US FDA Food Guidance, Regulation, and Food Code: Benefits Associated with Complete Adoption and Implementation of the FDA Food Code

<https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm494616.htm>

(The study associates the presence of a certified food manager (one of the requirements of the Model Food Code) with a reduction in the likelihood of having an outbreak.)

CDC and Partner Study on Food Safety

[https://www.cdc.gov/nceh/ehs/ehsnet/docs/JFP\\_Sys\\_Env\\_Eval\\_Id\\_Food\\_Safety\\_bw\\_OB\\_NOB\\_Rest.pdf](https://www.cdc.gov/nceh/ehs/ehsnet/docs/JFP_Sys_Env_Eval_Id_Food_Safety_bw_OB_NOB_Rest.pdf)

**Implementation Resources:**

US FDA Food Guidance Regulation and Food Code

<https://www.fda.gov/food/guidanceregulation/retailfoodprotection/foodcode/>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinant of Health addressed:** Built Environment

**Sectors playing lead role:** Governmental Public Health Agencies (State and Local Health Departments)

**Sectors playing contributing role:** Policy Makers; Employers, Businesses and Unions,

**Intermediate measures:** By December 31, 2022, publish for public comment, regulation amendments to Part 14 that incorporate Chapters 1-7 of FDA 2017 Model Food Code.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (1) Healthy Eating and Food Security, (1.1) Increase access to healthy and affordable foods and beverages.

**5.2.2:** (Supporting Objective 5.2.b)

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. Helping team members improve their skills to investigate outbreaks and to understand each other's roles and responsibilities as a team by building relationships among team members could protect additional people from getting sick. Providing training to Local Health Department staff will improve their ability to identify the root causes of foodborne disease outbreaks. With this information, education could be provided to the public to improve food safety and prevent future illnesses.

**Evidence Base:** National Center for Biotechnology Information (NCBI) Resources:

Biggerstaff, G. 2015. Improving Response to Foodborne Disease Outbreaks in the United States: Findings of the Foodborne Disease Centers for Outbreak Response Enhancement (FoodCORE), 2010–2012. *J Public Health Manag Pract.* 21(4): E18–E26.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629497/>

Gould, L.H., Rosenblum, I Nicholas, D., Phan, Q, Jones, T. 2013. Contributing Factors in Restaurant-Associated Foodborne Disease Outbreaks, FoodNet Sites, 2006 and 2007. J Food Prot. 76(11): 1824-1828.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4591533/>

CDC and partner study on Food Safety

[https://www.cdc.gov/nceh/ehs/ehsnet/docs/JFP\\_Sys\\_Env\\_Eval\\_Id\\_Food\\_Safety\\_bw\\_OB\\_NOB\\_Rest.pdf](https://www.cdc.gov/nceh/ehs/ehsnet/docs/JFP_Sys_Env_Eval_Id_Food_Safety_bw_OB_NOB_Rest.pdf)

CDC Environmental Health Services: NEARS Data and Foodborne Disease Outbreaks

<https://www.cdc.gov/nceh/ehs/publications/jeh-march-2018/march-cf-nears-h.pdf>

(These articles demonstrate that the application of targeted resources is an effective means to identify, implement, and document model practices that successfully improve the completeness and timeliness of foodborne disease outbreak response activities. The critical information learned from training and additional resources help resolve outbreaks quickly, remove contaminated foods from commerce, and protect additional people from getting sick.)

**Implementation Resources:** CDC: Foodborne Disease Outbreak Training and Resources

<https://www.cdc.gov/foodcore/practice/comms-training.html>

National Environmental Health Association Epi- Ready Team Training

<https://www.neha.org/professional-development/education-and-training/epi-ready-team-training>

CDC, Environmental Health Services: Environmental Assessment Training Series (EATS)

<https://www.cdc.gov/nceh/ehs/elearn/eats/index.html>

CDC, Food Safety Education Month

<https://www.cdc.gov/foodsafety/education-month.html>

CDC Burden of Foodborne Illness: Findings

<https://www.cdc.gov/foodborneburden/2011-foodborne-estimates.html>

NYS Agriculture and Markets Division of Animal Industry

<https://www.agriculture.ny.gov/AI/AIHome.html>

NYS Agriculture and Markets Division of Food Safety and Inspection

<https://www.agriculture.ny.gov/FS/FSHome.html>

NYS Agriculture and Markets Division of Milk Control and Dairy Services

<https://www.agriculture.ny.gov/DI/DIHome.html>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Education, Food Security

**Sectors Playing a Lead Role:** Governmental Public Health Agencies (State and Local Health Departments)

**Sectors Playing a Contributing Role:** Policy Makers and Elected Officials, Governmental Agencies (NYS Agriculture and Markets)

**Intermediate Measure:** Number of foodborne disease outbreaks with an identified etiologic agent or vehicle. Number of trained Local Health Department personnel to carry out foodborne outbreak investigations.

**Supporting Other Goals and Interventions from other Priorities:** *Prevent Chronic Diseases*, (1) Healthy Eating and Food Security, (1.2) Increase skills and knowledge to support healthy food and beverage choices.

**5.2.3:** (Supporting objective 5.2.b.)

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. The purpose of this procedure is to:

- 1) provide a standard protocol for enteric outbreak investigation and response;
- 2) enable stakeholders to work together effectively during outbreak investigations;
- 3) define roles and responsibilities of the outbreak investigation and control team; and
- 4) foster effective communication and data sharing among investigation team members.

**Evidence Base:** NCBI Resources:

Biggerstaff, G. 2015. Improving Response to Foodborne Disease Outbreaks in the United States: Findings of the Foodborne Disease Centers for Outbreak Response Enhancement (FoodCORE), 2010–2012. *J Public Health Manag Pract.* 21(4): E18–E26.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629497/>

Institute of Medicine (US) Forum on Emerging Infections, Public Health Systems and Emerging Infections: Assessing the Capabilities of the Public and Private Sectors: Workshop Summary.

<https://www.ncbi.nlm.nih.gov/books/NBK100248/>

(The application of targeted resources, documenting model practices and the critical information and efforts made by other State and Federal partners have improved the completeness and timeliness of foodborne disease outbreak response activities.)

**Implementation Resources:** US Council to Improve Foodborne Outbreak Response Guidelines

<http://cifor.us/downloads/clearinghouse/2nd%20edition%20CIFOR%20Guidelines%20Final.pdf>

WHO Guidelines for Investigation and Control of Foodborne Diseases Outbreak

[http://www.who.int/foodsafety/publications/foodborne\\_disease/outbreak\\_guidelines.pdf](http://www.who.int/foodsafety/publications/foodborne_disease/outbreak_guidelines.pdf)

Minnesota Department of Health Outbreak Response Protocol

<http://www.health.state.mn.us/divs/eh/food/pwdu/outbreakprotocol.pdf>

CDC Foodborne Disease Outbreak Training and Resources

<https://www.cdc.gov/foodcore/practice/comms-training.html>

National Environmental Health Association Epi- Ready Team Training

<https://www.neha.org/professional-development/education-and-training/epi-ready-team-training>

CDC Environmental Health Services: Environmental Assessment Training Series (EATS)

<https://www.cdc.gov/nceh/ehs/elearn/eats/index.html>

**Target Population by Age:** New Yorkers of all Ages

**Social Determinants of Health:** Education, Food Security

**Sectors Playing Lead Role:** Governmental Public Health Agencies (State and Local Health Departments)

**Sectors Playing Contributing Role:** Policy Makers and Elected Officials, Governmental Agencies (NYS Agriculture and Markets)

**Intermediate Measure:** Measure timeliness and completeness of foodborne disease outbreak investigation and reporting.

# New York State Prevention Agenda

## Promote Healthy Women, Infants, and Children Action Plan

Updated: June 30, 2023

### Introduction

*"Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system." - Healthy People 2020*

The health of women, infants, children, and their families is fundamental to population health. This Prevention Agenda priority aligns directly with the Maternal and Child Health Services Block Grant (Title V) Program, the core federal and state public health program for promoting the health and well-being of the nation's mothers, infants, and children, including children and youth with special health care needs, and their families.<sup>7</sup> As part of Title V, states are required to develop a Maternal and Child Health (MCH) State Action Plan that includes state priorities, objectives, and strategies, which are established based on data and stakeholder input obtained through a comprehensive and ongoing needs assessment process.<sup>8</sup>

Addressing these priorities requires strong partnerships and collaboration at all levels. Such partnership and collaboration are at the heart of the Prevention Agenda, providing a natural opportunity to align the Prevention Agenda 2019-2024 with NY's Title V State Action Plan. The Prevention Agenda goals, objectives, and interventions for Healthy Women, Infants, and Children were drawn from the state's Title V plan, with special consideration for those areas that would benefit from enhanced local action and cross-sector collaboration, and for which local data are available to track progress across the state.

Mirroring NY's Title V action plan, the Prevention Agenda Healthy Women, Infants, and Children (HWIC) priority focuses on health outcomes in three focus areas:

1. Maternal and Women's Health,
2. Perinatal and Infant Health, and
3. Child and Adolescent Health, including children with special health care needs (CSHCN).

#### **New York State Title V State Action Plan priorities (2016-2020)**

- Reduce maternal mortality and morbidity.
- Reduce infant mortality and morbidity.
- Support and enhance children's and adolescents' social-emotional development and relationships.
- Increase supports to address the special needs of children and youth.
- Increase use of primary and preventive health care services across the life course.
- Promote oral health and reduce tooth decay across the life course.
- Promote supports and opportunities that foster healthy home and community environments.
- Reduce racial, ethnic, economic and geographic disparities and promote health equity.

In addition, the HWIC plan includes a fourth cross-cutting focus area on social determinants of health and health equity, intended to address the entire MCH life course.

It is important to view these focus areas in the context of a life course perspective. Promoting healthy development, behaviors, and relationships early in life and during critical periods lays the groundwork for health promotion and disease prevention throughout the lifespan. Supporting the health and wellness of all women is essential to their current and lifelong well-being, regardless of their age, sexual or gender identity, pregnancy history, or future reproductive plans. Moreover, it requires a deep commitment to promoting health equity and eliminating racial, ethnic, economic, and other disparities, as reflected in the fourth cross-cutting focus area.

Guided by a life course framework, interventions must focus on mitigating risk factors, strengthening support for individuals and families, building resiliency, and addressing the broad social, economic, and environmental determinants of health. Interventions need to focus on critical periods of development (such as fetal development and early childhood), as well as the cumulative impact of exposures and adverse experiences over the life course and across generations. Public health efforts must include strategies that engage and support individuals, families, and providers across different settings and sectors and over time.<sup>9</sup>

The health of women, infants, and children is integral to other priorities addressed by the Prevention Agenda. Thus, information presented for this priority should be viewed in conjunction with, not separately from, other sections of the Prevention Agenda.

For additional information about the importance of promoting healthy women, infants and children and the life course perspective/framework, see the: *NYS Health Assessment Contributing Causes of Health Challenges*: [https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf)

## Focus Area 1: Maternal and Women's Health

**Goal 1.1:** Increase use of primary and preventive health care services among women of all ages, with a focus on women of reproductive age.

**Objective 1.1.1:** By December 31, 2024, increase the percentage of women ages 18-44 years with a past year preventive medical visit by 10% to 80.6%. (*Baseline: 73.3%, Year: 2016; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income), County (selected years).*)

**Objective 1.1.2:** By December 31, 2024, increase the percentage of women ages 45 years and older with a past year preventive medical visit by 2% to 85.0%. (*Baseline: 18-44 years: 83.3%, Year 2016; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income), County (selected years).*)

**Objective 1.1.3:** By December 31, 2024, 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%. (*Baseline: 34.6%; Year 2014; Source: Behavioral Risk Factor Surveillance System; Data availability: State (by race/ethnicity, income, and region), County (selected years).*)

### **Intervention 1.1.1: Incorporate strategies to promote health insurance enrollment, well-woman visits, and age-appropriate preventive health care across public health programs serving women**

**Description:** A well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including age-appropriate screenings, counseling, and immunizations, to support women's health across the life span.<sup>10</sup> The annual well-woman visit is endorsed by the American College of Obstetrics and Gynecologists (ACOG),<sup>11</sup> and is one of the preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost sharing.<sup>12</sup> NYS survey data show that women without health insurance are significantly less likely to report having a preventive visit in the past year, highlighting the importance of continuing to promote enrollment in affordable health insurance for all women.<sup>13</sup> For women of reproductive age (defined as ages 15-44 or 18-44 years, depending on the data source), well-woman visits provide a key opportunity for provision of reproductive health care (see Intervention 1.1.2 below). New York State survey data demonstrate that women ages 18-44 years are significantly less likely to receive annual preventive medical visits than older women. A recent review by the Women's and Children's Health Policy Center at Johns Hopkins University found strong evidence that patient reminders/invitations are effective in increasing use of preventive health care visits by women. Other interventions - including community-based group education, patient navigation supports, provider reminder/recall systems, provider education, designated clinics/extended hours, community-level media, and expansion of insurance coverage - also appear to be effective.<sup>14</sup>

## Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- [Evidence Analysis Report. NPM 1: Well-Woman Visit, Johns Hopkins University](#)
- [Evidence Brief. Well Woman Visits. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University](#)
- [Title V Transformation Tools. Recommendations to support NPM1 – Well Woman Visit. MCH Navigator](#)
- [Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit. Association of Maternal and Child Health Programs \(AMCHP\)](#)

[ACOG Committee Opinion on Well-Woman Visit. American College of Obstetricians and Gynecologists, Committee on Gynecologic Practice.](#)

[Maternal and Infant Community Health Collaboratives \(MICHC\) Initiative. New York State Department of Health.](#)

[New York State of Health: The Official Health Plan Marketplace. New York State Department of Health.](#)

[Technical Assistance Document: Implementing USPSTF Recommendations into Professional Education Programs. Agency for Healthcare Research and Quality \(AHRQ\).](#)

[Think Cultural Health. U.S. Department of Health & Human Services, Office of Minority Health.](#)

[Women’s Preventive Service Guidelines. U.S. Department of Health and Human Services, Health Resources and Services Administration \(HRSA\).](#)

**Age groups impacted by this intervention:** adolescents age 13-21 years; adults age 21-60 years; older adults age 60+ years

**Social determinants of health addressed by this intervention:** health care, *other:* social support, discrimination, health literacy

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Employers, businesses, and unions; Insurers; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Media; Colleges & universities; Community or neighborhood residents; Transportation agencies; Economic development agencies; Urban planning agencies.

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of strategies implemented by your organization to increase 1) women’s enrollment in health insurance 2) women’s use of preventive health care/ well woman visits.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Preventing Chronic Diseases – Preventive Care and Management

**Intervention 1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.**

**Description:** Both the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP) recommend that every health care visit should include a discussion of women’s reproductive life plan and pregnancy intentions. For women who desire pregnancy, discussion should address pregnancy risk factors including chronic disease management, how to prepare for a healthy pregnancy, and optimal birth spacing. For women, who wish to delay or prevent pregnancy, discussion should address contraceptive options, and effective contraception should be provided.<sup>15 16</sup> Reproductive life planning discussions and care should include adolescents.

Nearly half of all pregnancies in the United States are unplanned (either mistimed or not wanted), which underscores the importance of raising discussions about pregnancy planning and promoting women’s health across the lifespan, regardless of pregnancy intentions.<sup>17</sup> While over 70% of women ages 18-44 years report having a preventive medical visit in the past year, only 35% report that a health care provider had ever talked with them about ways to prepare for a healthy pregnancy.<sup>18</sup>

The NYS Partnership for Maternal Health (PMH), established in 2015, brings together key organizational partners committed to decreasing maternal mortality and morbidity (see Goal 1.2). The PMH has focused on preconception health as an initial priority, with several provider education projects, including a 2016 Commissioner’s letter, completed to date.<sup>19</sup>

**Resources**

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- [Evidence Analysis Report. NPM 1: Well-Woman Visit, Johns Hopkins University.](#)
- [Evidence Brief. Well Woman Visits. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools. Recommendations to support NPM1 – Well Woman Visit.](#)
- [Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit. Association of Maternal and Child Health Programs \(AMCHP\).](#)

[ACT for Youth. Act for Youth Center for Community Action \(2018\).](#)

[Action Plan for the National Initiative on Preconception health and Health Care \(2012-2014\). Centers for Disease Control and Prevention.](#)

[Bedsider and Bedsider Provider](#)

[Before, Between & Beyond pregnancy: Resource Guide for Clinicians \(2018\). Clinical Work Group of the National Preconception Health and Health Care Initiative.](#)

[IMPLICIT Interconception Toolkit. March of Dimes Foundation.](#)  
[Know Your Options, Get the Facts. New York State.](#)

Preconception Care webinars for Health Home Providers. New York State Department of Health

- [Well Woman Care and Preconception Care: Webinar for Health Home Providers.](#)
- [Preconception, Contraception and Conception for Women Living with HIV \(WLWH\): How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes. \(July 2018\).](#)
- [Postpartum Care for Women Living with HIV \(WLWH\) and their Newborns: How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes. \(August 2018\)](#)

[Preconception Health and Health Care: The Clinical Content of Preconception Care. American Journal of Obstetrics and Gynecology.](#)

[Preconception Health is Essential Well Woman Care – Webinar. New York State Partnership for Maternal Health. \(August 2018\).](#)

[Show Your Love Campaign. Centers for Disease Control and Prevention National Preconception Health Consumer Workgroup \(2013\).](#)

**Age groups impacted by this intervention:** adolescents, adults age 21-60 years

**Social determinants of health addressed by this intervention:** health care, *other:* social support, health literacy, discrimination, reproductive rights and justice.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers.
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Transportation agencies.

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of strategies developed to integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in primary health care visits for women of reproductive age.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Preventing Chronic Diseases – Preventive Care and Management

**Goal 1.2:** Reduce Maternal Mortality and Morbidity

- **Objective 1.2.1:** By December 31, 2024, decrease the maternal mortality rate by 22% to 16.0 maternal deaths per 100,000 live births. (*Baseline: 20.4; Year 2014-2016; Source: NYS Vital Statistics; Data availability: State (by race/ethnicity and region), County.*)
- **Objective 1.2.2:** By December 31, 2024, decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate) by 34% to 3.1. (*Baseline: 4.68; Year 2014-2016; Source: NYS Vital Statistics; Data availability: State.*)

- **Objective 1.2.3:** By December 31, 2024, decrease the rate of severe maternal morbidity to 79.3 per 10,000 delivery hospitalizations. (*Baseline: 80.0; Year 2016; Source: Healthcare Cost and Utilization Project – State Inpatient Database (HCUP-SID); Data availability: State.*)
- **Objective 1.2.4:** By December 31, 2024, 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%. (*Baseline: 76.1%; Year 2016; Source: PRAMS; Data availability: State (by race/ethnicity, income, and region)*)

**Intervention 1.2.1: Systematically review maternal deaths and several maternal morbidities and use results to inform maternal mortality and morbidity prevention efforts.**

**Description:** Maternal mortality – the death of a woman while pregnant or within six weeks of a pregnancy from causes related to her pregnancy – is a devastating outcome. While New York’s maternal mortality rate has been declining, it remains higher than many other states, with dramatic racial disparities. The most recent complete review of maternal deaths for New York State identified embolism, hemorrhage, infection, cardiomyopathy, and hypertensive disorders as the leading causes of maternal deaths. Severe Maternal Morbidity (SMM), also referred to as “near misses”, encompasses life threatening medical complications or the need for life-saving interventions during delivery-related hospitalizations. SMM is 50-100 times more common than maternal mortality, with similar racial and ethnic disparities. A study identifying and analyzing SMM cases in New York State was published in 2017 to expand knowledge of these events.<sup>20</sup>

The New York State Department of Health (NYSDOH) conducts comprehensive maternal mortality surveillance activities. Linked birth and death records, hospital in-patient and emergency department data, and a hospital-based adverse event reporting system are used to identify maternal deaths. All identified deaths are reviewed using a standardized tool. Data are analyzed and aggregated for review, discussion, and action. A multidisciplinary committee reviews the findings and provides recommendations for prevention, improvements in medical care and management, and education. The NYS Partnership for Maternal Health, established in 2015, brings together key organizational partners committed to decreasing maternal mortality and morbidity through collaboration.

In 2018, as part of the state’s comprehensive maternal mortality initiative (see Intervention 1.2.2), NYSDOH is implementing an enhanced process for maternal death reviews, developed in collaboration with the state’s chapter of the American College of Obstetricians and Gynecologists (ACOG). A formal multidisciplinary Maternal Mortality Review Board will have an active role in reviewing maternal death cases to assess causes of death, factors leading to death, preventability, and opportunities for intervention. Findings will be translated into issue briefs, Grand Rounds, quality improvement projects, and reports.

**Resources**

[New York State Maternal Mortality Review Report, 2012-13. New York State Department of Health.](#)

[New York City, 2008-2012 Severe Maternal Morbidity. \(2016\) New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health.](#)

[Pregnancy-Associated Mortality: New York City, 2006-2010 New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health.](#)

[Proceedings of the 2018 New York Maternal Mortality Summit.](#)

[Severe Maternal Morbidity in the United States. Centers for Disease Control and Prevention](#)

[Severe maternal morbidity: A population-based study of an expanded measure and associated factors.](#)

[Severe Maternal Morbidity: Screening and Review. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine.](#)

**Age groups impacted by this intervention:** adolescents, adults age 21-60 and their families

**Social determinants of health addressed by this intervention:** health care, community cohesion, *other:* social support, family support, discrimination, reproductive rights and justice.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system
- **Supporting:** Insurers; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of prevention strategies implemented by your organization based on state and local data about maternal morbidity and mortality.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Preventing Chronic Diseases – Preventive Care and Management

**Intervention 1.2.2: 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.**

**Description:** In April 2018, New York State launched a comprehensive initiative to target maternal mortality and reduce racial disparities in maternal health outcomes. Building on the state's established maternal mortality review process, this initiative encompasses a range of approaches to reducing maternal deaths and racial disparities, including:

- Creating a state Task Force on Maternal Mortality and Disparate Racial Outcomes
- Establishing a Maternal Mortality Review Board, building on the Department of Health's current maternal mortality review committee;
- Launching a Best Practice Summit with hospitals and obstetric providers;
- Piloting expansion of Medicaid coverage for doulas;
- Supporting *Centering Pregnancy* demonstration projects;
- Requiring Continuing Medical Education (CME) and curriculum development for health care practitioners and trainees;
- Expanding the New York State Perinatal Quality Collaborative (NYSPQC) clinical quality improvement activities; and,
- Convening a series of Commissioner listening sessions with women across the state.

These strategic activities should build on the rich array of existing clinical, community, and policy initiatives in the state. It is essential that a wide range of partners – including clinical providers and institutions, community-based organizations and leaders, and community members – be engaged in these efforts.

## Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 2 (Low-Risk Cesarean Delivery)

- Evidence Analysis Report NPM 2: Low-Risk Cesarean Deliveries. Johns Hopkins University
- [Evidence Briefs. Cesarean Births among Low Risk First Births. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools. Recommendations to support NPM 2 – Low-risk Cesarean Delivery](#)

[Alliance for Innovation on Maternal Health \(AIM\). Council on Patient Safety in Women's Health Care](#)

[Centering Pregnancy. Centering Healthcare Institute \(2018\).](#)

[Cochrane Systematic Review: Continuous Support for Women During Childbirth.](#)

[Home Visiting Evidence of Effectiveness \(HomVee\). U.S. Department of Health and Human Services and Administration for Children and Families.](#)

[Levels of Maternal Care. Obstetric Care Consensus. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine \(2016\).](#)

[Maternal and Infant Community Health Collaboratives \(MICH\) Initiative. New York State Department of Health.](#)

[New York State’s Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health](#)

[New York State Perinatal Quality Collaborative \(NYSPOC\). New York State Department of Health.](#)

[New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes.](#)

[Safe Motherhood Initiative \(SMI\). American College of Obstetricians and Gynecologists \(ACOG\) District II, New York State.](#)

[Training Modules for Community Health Workers.](#)

**Age groups impacted by this intervention:** adolescents, adults age 21-60 years and their families

**Social determinants of health addressed by this intervention:** community cohesion, economic stability, education, food security, health care, housing, transportation, *other:* family support, social support, health literacy, home environment, discrimination, reproductive rights and justice,

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies; *other:* Criminal justice system

**Intermediate-level measure that can be used by organizations to track progress toward**

**implementation of the intervention in the short term:** The number of strategies implemented in collaboration with partners to reduce disparities in maternal mortality and morbidity.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Preventing Chronic Diseases – Preventive Care and Management

**Intervention 1.2.3: Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.**

**Description:** Approximately 55% of pregnancies in New York State are unintended (not wanted or mistimed). Reducing unintended pregnancies is a fundamental public health approach to reducing maternal mortality and morbidity. Use of effective contraceptives is key to reducing unintended pregnancy. Long acting reversible contraceptives (LARC), which include Intrauterine Devices (IUDs) and subdermal hormonal implants, are the most effective reversible methods available. Patient and provider knowledge, contraceptive coverage, and acquisition costs and logistics are all important factors to address use of effective contraception.

Over the past several years, several national and New York State initiatives have focused on: provider reimbursement for postpartum LARC insertion and LARC acquisition costs; provider education and

training; integration of reproductive life planning in well-woman care; and, enhanced consumer outreach and pregnancy prevention education by Community Health Workers through the state's Maternal Infant Community Health Collaboratives (MICHC) program.

## Resources

[6 | 18 Initiative: Prevent Unintended Pregnancy. Centers for Disease Control and Prevention \(CDC\).](#)

[Bedsider](#) and [Bedsider Provider](#)

[Increasing Access to Contraception. Association of State and Territorial Health Officials \(ASTHO\).](#)

[Know Your Options, Get the Facts. New York State](#)

Long-Acting Reversible Contraception (LARC) Program. American College of Obstetricians and Gynecologists (ACOG).

- [National ACOG LARC Program](#)
- [New York State \(ACOG District II\) LARC Program](#)
- [ACOG District II LARC Resource Summary](#)

Medicaid Coverage of Long-Acting Reversible Contraception (New York State)

- [Medicaid Update \(September 2016\)](#)
- [eMedNY reimbursement guidance for physicians \(May 2014\)](#)

[New York State Family Planning Training Center.](#)

**Age groups impacted by this intervention:** adolescents, adults age 21-60 years and their families

**Social determinants of health addressed by this intervention:** education, health care, other: family support, social support, health literacy, discrimination, reproductive rights and justice.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Economic development agencies; Urban planning agencies; other: Criminal justice system

**Intermediate-level measure that can be used by organizations to track progress toward**

**implementation of the intervention in the short term:** The number of strategies implemented to discuss the use of effective contraception to prevent unwanted pregnancy and support optimal birth spacing as part of well care visits for women of reproductive age.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Preventing Chronic Diseases – Preventive Care and Management

**Intervention 1.2.4: Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.**

**Description:** Depression is the most common morbidity among postpartum women, affecting 10-20% of women during or within 12 months of pregnancy. Depression has implications for the well-being of the entire family and the development of infants and children. Legislation enacted for NYS in 2014 requires hospitals to educate patients about maternal depression and requires insurers to cover postpartum depression screening regardless of which health care provider performs the screening, when depression screening is a covered benefit.

The United States Preventive Services Task Force recommends screening for depression in pregnant and postpartum women. For screening to be effective, systems must be in place to ensure accurate diagnosis and effective treatment and follow-up for women with positive screening results. The USPSTF review identified a range of systems to support screening follow-up, from having designated nurses to implement protocols for facilitated referrals to more intensive systems that include: staff and clinician training (1- or 2-day workshops); clinician manuals; monthly training lectures; academic detailing; materials for clinicians, staff, and patients; an initial visit with a nurse specialist for assessment, education, and discussion of patient preferences and goals; a visit with a trained nurse specialist for follow-up assessment and ongoing support for medication adherence; a visit with a trained therapist for cognitive behavioral therapy (CBT); and a reduced copayment for patients referred for psychotherapy. Multidisciplinary team-based primary care that includes self-management support and care coordination has been shown to be effective in management of depression, as detailed in recommendations from the Community Preventive Services Task Force (CPSTF).

In a multi-year prenatal care quality improvement project conducted by the NYSDOH with Medicaid prenatal care providers, documentation of depression screening increased from 63% to 85% at initial prenatal visit and from 51% to 84% at postpartum visits (2009 to 2014 data) - although use of standardized screening tools was much lower. PRAMS data, which are based on an annual survey of a representative sample of women giving birth in New York State, show that approximately 76% of women report being asked about depression symptoms at their postpartum visit (2016 survey). While these data are encouraging, more efforts are needed to increase screening and strengthen supports and services for women with postpartum depression. A variety of collaborative initiatives have been implemented and are in progress to address this key issue, including updates to Medicaid coverage and reimbursement, the First 1000 Days on Medicaid initiative, the Healthy Steps program led by NYS Office of Mental Health, and the Early Childhood Comprehensive Systems (ECCS) Impact initiative led by NYS Council on Children and Families.

## Resources

[A Comprehensive Approach for Community-Based Programs to address Intimate Partner Violence and Perinatal Depression. Social Solutions International, Inc.](#)

[Depression in Adults: Screening. United States Preventive Services Task Force \(USPSTF\)](#)

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).

- [National ECCS CoIIN Coordinating Center](#)
- [New York State ECCS Impact Initiative](#)

[First 1000 Days on Medicaid Initiative.](#)

Healthy Steps.

- [National Healthy Steps](#)
- [New York Office of Mental Health Implementation of Healthy Steps](#)

[Maternal Depression: Information for Health Care Providers. New York State Department of Health.](#)

[Medicaid Update: NYS Medicaid Coverage of Postpartum Maternal Depression Screening. New York State Department of Health.](#)

[Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders. The Guide to Community Preventive Services. Community Preventive Services Task Force \(CPSTF\). June 2010.](#)

[Postpartum Depression Toolkit. American Academy of Family Physicians National Research Network.](#)

[Postpartum Resource Center of New York.](#)

**Age groups impacted by this intervention:** adolescents, adults age 21-60 and their families

**Social determinants of health addressed by this intervention:** community cohesion, health care, other: family support, social support, health literacy, home environment.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Employers, businesses, and unions; Media; Community or neighborhood residents; Community-based organizations and human service agencies;
- **Supporting:** Insurers; Media; Colleges & universities; Schools (K-12); Policymakers & elected officials; Transportation agencies; Economic development agencies; Urban planning agencies; other: Child care, Criminal justice system

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of strategies implemented to effectively screen pregnant and postpartum women for depression and provide appropriate follow up.  
**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Prevent Mental and SU Disorders

## Focus Area 2: Perinatal & Infant Health

### **Goal 2.1:** Reduce infant mortality and morbidity

- **Objective 2.1.1:** By December 31, 2024, decrease the infant mortality rate by 13% to 4.0 infant deaths per 1,000 live births.  
*(Baseline: 4.6; Year 2015; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)*
- **Objective 2.1.2:** By December 31, 2024, decrease the percentage of births that are preterm by 5% to 8.3 percent of live births.  
*(Baseline: 8.7; Year 2015; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)*
- **Objective 2.1.3:** By December 31, 2024, increase the percent of very low birthweight (VLBW) infants born in a Level III or higher hospital by 3% to 95.1%  
*(Baseline: 92.3; Year 2014; Source: National Vital Statistics System; Data availability: State (by race/ethnicity and region), County.)*
- **Objective 2.1.4:** By December 31, 2024, 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.  
*(Baseline: 10.1; Year 2016; Source: SPARCS; Data availability: State, Region, County.)*
- **Objective 2.1.5:** By December 31, 2024, decrease the Sudden Unexpected Infant Death (SUID) mortality rate by 17% to 0.5 per 1,000 live births.  
*(Baseline: 0.6; Year 2015; Source: Vital Statistics; Data availability: State (by race/ethnicity and region), County.)*

### **Intervention 2.1.1: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals and centers**

**Description:** There is strong evidence that very high risk infants – such as those with very low birth weight (VLBW) or extreme prematurity – are significantly more likely to survive and thrive when born in facilities with Level III Neonatal Intensive Care Units equipped to handle high-risk newborns.<sup>21</sup> For decades the American Academy of Pediatrics and others have recommended that VLBW and very preterm infants be delivered at hospitals with Level III/IV NICU facilities, designated based on uniform standards and organized within a statewide regionalized system of perinatal care.<sup>22</sup> More recently, there has been renewed attention on the importance of standards and systems for regionalized maternal care to ensure that high risk women receive care in facilities prepared to provide the required level of care to reduce maternal morbidity and mortality.<sup>23</sup>

The New York State Department of Health oversees a regionalized perinatal system in which every birthing hospital and birthing center in the state is designated at one of four levels based on the level of perinatal care it provides to women and newborns. Regional systems of Level I-III hospitals are led by Regional Perinatal Centers that provide or coordinate maternal-fetal and newborn transfers of high

risk patients from affiliate hospitals and birthing centers, and are responsible for support, education, consultation, and improvement in quality of care in their regional affiliates. A comprehensive process to update standards of care and designations, including incorporating midwife-led birthing centers in the system, is in progress. The New York State Perinatal Quality Collaborative (NYSPQC) initiative engages birthing hospitals and centers and other partners to translate evidence-based guidelines to clinical practice to improve outcomes for both mothers and infants.

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found that population-based systems level approaches— such as statewide policies and guidelines – are an important component of interventions to increase risk-appropriate perinatal care. Adding a hospital component – such as ongoing education of hospital staff and clinical providers - to these systems interventions appears to increase their effectiveness.<sup>24</sup> New York's systems-building and quality improvement approaches are consistent with this evidence base and serve as a strong foundation for continued work in this area.

## Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) NPM 3: Perinatal Regionalization:

- [Evidence Analysis Report. NPM 3: Risk-Appropriate Perinatal Care, Johns Hopkins University.](#)
- [Evidence Brief. Perinatal Regionalization. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools. Recommendations to support NPM3 – Perinatal Regionalization.](#)

[Levels of Neonatal Care Policy Statement. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine.](#)

[New York State Perinatal Quality Collaborative \(NYSPQC\).](#)

[Perinatal Regionalization. New York State Department of Health.](#)

[Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives. March of Dimes Foundation.](#)

**Age groups impacted by this intervention:** adolescents, adults age 21-60 years, infants and their families

**Social determinants of health addressed by this intervention:** health care, family support

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Transportation agencies;

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of local birthing hospitals that have been updated in accordance with perinatal designations.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote a Healthy and Safe Environment – Built and Indoor Environments

**Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs**

**Description:** Home visiting programs are a cornerstone of public health efforts to support pregnant and parenting families. An extensive body of research demonstrates that evidence-based home visiting programs improve numerous short- and long-term outcomes for mothers, infants, and families. As part of the national Maternal and Infant Early Childhood Home Visiting (MIECHV) program, the Home Visiting Evidence of Effectiveness (HomVee) project conducts ongoing in-depth analysis of research findings to identify evidence-based home visiting program models. In New York, MIECHV grant funds have supported the expansion of two specific evidence-based home visiting models: Nurse Family Partnership (NFP) and Healthy Families New York (HFNY). These complement other evidence-based programs operating in New York communities, including Early Head Start, Parents as Teachers, and Home Instruction for Parents of Preschool Youngers (HIPPY), as well as other traditional and emerging service models that include community outreach, home visit, and family support elements such as public health nursing, community health workers, and doulas.

Under New York State's MIECHV initiative, local home visiting programs have been engaged in a variety of efforts to build capacity and improve effectiveness in key areas, including: increasing referrals, client enrollment, and retention; extending the duration of breastfeeding; and increasing home visitors' knowledge and skills related to key topics such as intimate partner violence, substance use, mental health, smoking cessation, self-care, and post-partum/interconception care. Additionally, several local programs are working with the state to pilot the development of local coordinated intake and referral systems in communities with multiple home visiting programs.

**Resources**

[Community Health Workers Toolkit. NORC Walsh Center for Rural Health Analysis, University of Minnesota rural Health Resource Center, and Rural Health Information Hub.](#)

[First 1000 Days on Medicaid Initiative.](#)

[Home Visiting Evidence of Effectiveness \(HomVee\). U.S. Department of Health and Human Services and Administration for Children and Families.](#)

[Home Visiting Collaborative Improvement and Innovation Network \(CoIIN\).](#)

[Home Visiting – Your Partner in Helping Families. New York State Department of Health and University at Albany School of Public Health Center for Public Health Continuing Education. \(April 2018\).](#)

[Home is where the Start Is: Expanding Home Visiting to Strengthen All of New York’s Families. Schuyler Center for Analysis and Advocacy \(SCAA\).](#)

[New York State Home Visiting County Data Snapshots. Schuyler Center for Analysis and Advocacy \(SCAA\).](#)

[New York State’s Home Visiting Programs: Support for Pregnant and Parenting Families. New York State Department of Health. State](#)

[Training Modules for Community Health Workers.](#)

**Age groups impacted by this intervention:** adolescents, adults age 21-60, infants, children, and their families.

**Social determinants of health addressed by this intervention:** community cohesion, economic stability, education, food security, health care, housing, transportation, other: family support, social support, health literacy, learning environment, home environment, discrimination, reproductive rights and justice, incarceration, crime & violence

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials.
- **Supporting:** Health care delivery system; Employers, businesses, and unions; Insurers; Media; Colleges & universities; Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies; other: Child care, Criminal justice system

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of strategies implemented to increase capacity and competencies of maternal and infant home visiting programs.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

**Intervention 2.1.3: Engage in collaborative clinical and community-based strategies to reduce sleep-related infant deaths.**

**Description:** Sudden Unexpected Infant Deaths (SUID) - a classification that includes Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed, and sleep-related deaths of unknown cause - are the leading cause of infant death after the first month of life and one of the leading causes of infant death overall. Because infants placed to sleep on their sides or stomachs (prone) are at increased risk of SIDS, the American Academy of Pediatrics and other public health organizations have long recommended that infants be placed to sleep on their backs. In 2011, these

recommendations were expanded to address other risk factors for sleep-related deaths by promoting safe sleep environments, breastfeeding, and avoiding smoke exposure.

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found that national campaigns and interventions targeting caregivers, health care providers, and hospital levels appear to be effective at increasing exclusive back sleeping position in infants. There is less evidence to support interventions targeting only caregivers, health care providers, or child care providers alone. Researchers also noted substantial variation in following safe sleep recommendations by race and ethnicity, highlighting the need for interventions to consider these differences.<sup>25</sup> A variety of efforts to promote safe sleep and reduce sleep-related mortality have been completed or are underway in New York State, including community awareness campaigns and materials and several hospitals- and community-based quality improvement projects.

## Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 4: Safe Sleep:

- [Evidence Analysis Report. NPM 4: Safe Sleep, Johns Hopkins University.](#)
- [Evidence Brief. Safe sleep. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools – Safe Sleep](#)

[Building Integrated Systems for Address Sudden Unexpected Infant Death. National Center for Cultural Competence, Georgetown University](#)

[Caring for our Children – Safe Sleep Standards in Child Care Settings.](#)

[Collaborative Improvement and Innovation Network to Reduce Infant Mortality \(CoIIN\).](#)

[National Action Partnership to Promote Safe Sleep Improvement and Innovation Network \(NAPSS-IIN\) - Maternal and Child Health Bureau/ National Institute for Children's Health Quality \(NICHQ\).](#)

[New York State Perinatal Quality Collaborative \(NYSPQC\). New York State Department of Health.](#)

[Safe to Sleep Campaign®. Directed and managed by the National Institute of Child Health and Human Development.](#)

[SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. American Academy of Pediatrics](#)

[Sudden Unexpected Infant Death \(SUID\) and Sudden Infant Death Syndrome \(SIDS\) Gateway. National Center for Education in Maternal and Child Health, Georgetown University.](#)

[Toolkit for community health providers: Engaging ethnic media to inform communities about safe infant sleep. National Center for Cultural Competence, Georgetown University.](#)

**Age groups impacted by this intervention:** infants and their families.

**Social determinants of health addressed by this intervention:** community cohesion, health care, other: family support, social support, health literacy, home environment.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Media; Community or neighborhood residents; Community-based organizations and human service agencies; other: Child care.
- **Supporting:** Employers, businesses, and unions; Insurers; Colleges & universities; Schools (K-12); Policymakers & elected officials.

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of clinical or community-based strategies developed to reduce sleep related infant deaths.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

**Intervention 2.1.4: Engage in collaborative strategies to respond to increasing use of opioids among women, including pregnant women, and impact on infants.**

**Description:** Use of opioids among reproductive age women, including during pregnancy, has increased dramatically in recent years, paralleling the national and state opioid crisis. The rate of infants born with neonatal abstinence syndrome (withdrawal from opioids) increased by over 100% from 2008 to 2014, to nearly 6 infants per 1,000 delivery hospitalizations. Addressing the opioid epidemic is a public health priority in NYS. In 2014, the state established the Heroin and Opioid Task Force and enacted Combat Heroin legislation, establishing a multi-faceted response with a focus on prevention, harm reduction, treatment, recovery, and law enforcement. A collaborative approach is essential to addressing this complex issue. Several initiatives are in place and in process at the state level, including efforts focused specifically on pregnant women and families.

## Resources

[A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders. Substance Abuse and Mental Health Service Administration \(SAMHSA\).](#)

[Combating the Heroin and Opioid Crisis: Heroin and Opioid Task Force Report \(June 2016\). Report of NYS Task Force](#)

[Institute for Research, Education and Training in Addictions \(IRETA\).](#)

[National Collaborative for Maternal Opioid Use Disorders. Alliance for Innovation on Maternal Health.](#)

[National Registry of Evidence-Based Programs and Practices \(NREPP\). Substance Abuse and Mental Health Services Administration \(SAMHSA\).](#)

[New York State Opioid Overdose Prevention Program. New York State Department of Health Opioid Addiction Prevention & Management Collaborative. Health Care Association of New York State \(HANYS\).](#)

[Opioid-related Data in New York State. New York State Department of Health \(2018\).](#)

[During Pregnancy. National Institutes of Health \(NIH\) National Institute on Drug Abuse \(NIDA\).](#)

[Preventing Opioid Misuse in Pregnant Women and New Moms Challenge. Maternal and Child Health Bureau.](#)

**Age groups impacted by this intervention:** infants, adolescents, adults age 21-60 and their families.

**Social determinants of health addressed by this intervention:** community cohesion, economic stability, education, health care, other: family support, social support, health literacy, discrimination, incarceration, crime & violence

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Economic development agencies; Criminal justice system
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Transportation agencies; Housing agencies; Urban planning agencies;

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of strategies implemented by local health organizations to address the increase in opioid use among women as well as its effect on infants.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Prevent Mental and SU Disorders

**Goal 2.2:** Increase breastfeeding

- **Objective 2.2.1:** By December 31, 2024, increase the percentage of infants who are exclusively breastfed in the hospital by 10%:
    - from 47.0% (2016) to 51.7% among all infants
    - from 34.0% (2016) to 37.4% among Hispanic infants
    - from 34.9% (2016) to 38.4% among Black, non-Hispanic infants
    - from 34.7% (2016) to 38.2% among infants insured by Medicaid
- (Data Source: Vital Statistics)*

- **Objective 2.2.2:** By December 31, 2024, decrease the percentage of breastfed infants supplemented with formula in the hospital by 10%:
  - from 46.6% (2016) to 41.9% among all infants
  - from 62.6% (2016) to 56.3% among Hispanic infants
  - from 59.4% (2016) to 53.5% among Black, non-Hispanic infants
 (Data Source: Vital Statistics)
- **Objective 2.2.3:** By December 31, 2024, 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
  - from 37.7% (2016) to 41.5% among Black, non-Hispanic WIC infants
  - from 41.8% (2016) to 46.0% among Hispanic, WIC infants
 (Data Source: Pediatric Nutrition Surveillance System)

**Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes.**

**Description:** Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, CBOs and other stakeholders should collaboratively work to ensure increased awareness, availability and accessibility of culturally competent lactation consultants, and breastfeeding support prenatally and postpartum. This includes ensuring that culturally competent, professional lactation consultants (e.g., IBCLCs); peer support (e.g., WIC); and formal breastfeeding education is available in the local area, and that information and resources on accessing support and contacts is up-to-date and accessible.

**Resources**

Cochrane Systematic Review (2016). [Interventions for Promoting the Initiation of Breastfeeding](#)

U.S. Preventive Services Task Force (2016). [Primary Care interventions to Support Breastfeeding Recommendation Statement](#) and [Breastfeeding: Primary Care interventions](#)

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

U.S. Department of Agriculture (2018). [Partnering with WIC to Support Breastfeeding](#)

United States Breastfeeding Committee (2010). [Core Competencies in Breastfeeding Care and Services for All Health Professionals](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#)

Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 1, 2,3, 8 and 9: pgs. 38-40, 45-47).

Evans A, Marinelli KA, Taylor JS and The Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: "The Going Home Protocol," Revised 2014](#) doi: 10.1089/bfm.2014.9996.  
New York State Department of Health. [Women, Infants, and Children \(WIC\) Program Site Information Dataset](#)

New York State Department of Health. [Breastfeeding Friendly Practices by County](#)

**Age range(s):** Pregnant and Postpartum Women

**Social Determinant of Health addressed:** Health Care, Education, Community Cohesion

**Sector(s) playing lead role:** Healthcare Delivery System

**Sector(s) playing contributing role:** Insurers, Media, CBOs and Human Service Agencies

**Intermediate-level measure:** 1) Number of Supplemental Nutrition Program for Women, Infants and Children (WIC) local agencies or sites, hospitals, hospital-affiliated clinics, primary care practices) that provide professional support, peer support and formal education to change behavior and outcomes.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

### **Intervention 2.2.2: Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding.**

**Description:** Local health departments, health centers, insurers, businesses, CBOs and other stakeholders should work with hospitals to implement recommended maternity care practices and policies, and support hospitals in becoming certified as Baby Friendly. The goal is to increase the percent of mothers and newborns who are exposed to recommended maternity care practices, and the percent of infants born in Baby Friendly Hospitals.

### **Resources**

World Health Organization (1998). [Evidence for the Ten Steps to Successful Breastfeeding](#)

World Health Organization (2018). Revised Baby-Friendly Hospital Initiative [Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services](#)

Baby-Friendly USA, Inc. (2016). [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)

United States Lactation Consultant Association (2010). [International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting](#)

Nickel NC, Labbok MH, Hudgens MG, Daniels JL. [The Extent that Noncompliance with the Ten Steps to Successful Breastfeeding Influences Breastfeeding Duration](#)

J Hum Lact 2013;29(1): 59-70.

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#)

**Age range(s):** Pregnant and Postpartum Women

**Social Determinant of Health addressed:** Health Care, Education

**Sector(s) playing lead role:** Healthcare Delivery System

**Sector(s) playing contributing role:** Insurers, Media, CBOs and Human Service Agencies

**Intermediate-level measure:** 1) Number of hospitals that improve their maternity care practices towards consistency with the Ten Steps to Successful Breastfeeding.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

### **Intervention 2.2.3: Promote and implement early skin-to-skin contact in hospitals**

**Description:** Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, CBOs and other stakeholders should work to promote early skin-to-skin contact by educating women and their families of the benefits of skin-to-skin contact. Hospitals and health centers can ensure that providers and staff are knowledgeable and informed, and their policies, practices, and staff support skin-to-skin contact between mother and newborn immediately following birth (until the first breastfeeding is completed), and the first six hours.

**Resources:**

Cochrane Systematic Review (2016). [Early Skin-to-Skin Contact for Mothers and Their Health Newborn Infants](#)

Hung KJ & Berg O. [Early Skin-To-Skin after Cesarean to Improve Breastfeeding](#) MCN 2011;36(5):318-324.

Feldman-Winter L, Goldsmith JP, Committee on Fetus and Newborn, Task Force on Sudden Infant Death Syndrome. American Academy of Pediatrics (AAP). [Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns](#) Pediatrics 2016;138(3):e1-e10.

Association of Women’s Health, Obstetric and Neonatal Nurses. [Immediate and Sustained Skin-to-Skin Contact for the Healthy Term Newborn After Birth](#)

AWHONN Practice Brief Number 5. JOGNN 2016;45:842-844.

United States Institute for Kangaroo Care. [Kangaroo Care Resources](#)

Rosen-Carole C, Hartman S and The Academy of Breastfeeding Medicine. [ABM Clinical Protocol #19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015](#)

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#); questions A4, A5, A10, A11

**Age range(s):** Newborn infants up to 1 month; Pregnant and Postpartum Women

**Social Determinant of Health addressed:** Health Care, Education

**Sector(s) playing lead role:** Healthcare Delivery System, Governmental Public Health Agencies

**Sector(s) playing contributing role:** Healthcare Delivery System, Insurers, CBOs and Human Service Agencies

**Intermediate-level measure:** 1) Number of hospitals that improve their maternity care practices to promote and ensure early skin to skin contact 2) Number of staff (nurses, lactation consultant or other professionals, doulas, and/or WIC nutrition educators) trained in Kangaroo Care, who provide prenatal education and/or maternal support on early skin-to-skin contact after delivery.

**Related interventions, focus areas and goals from other priorities:** Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

#### **Intervention 2.2.4: Increase access to primary care practices that are supportive of breastfeeding.**

**Description:** Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work with primary care practices to support staff education and training, provide guidance in developing policies and procedures that are consistent with recommended guidelines, and that practices meet the criteria to become designated as a NYS Breastfeeding Friendly Practice. The goal is to increase the number of designated practices, and the number of patients who are supported and receive primary care in a Breastfeeding Friendly Practice.

#### **Resources**

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

The Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #14: [Breastfeeding Friendly Physician's Office](#), Part 1: Optimizing care for infants and children, Revised 2013. *Breastfeeding Med* 2006;1(2):115-119.

Shariff F, Levitt C, Kaczorowski J, et al. Workshop to implement the [Baby Friendly Office](#) initiative. Effect on community physicians' offices. *Can Fam Physician* 2000;46:1090-1097.

The American Academy of Pediatrics, Breastfeeding Initiatives. [How to Have a Breastfeeding Friendly Practice](#)

American College of Obstetricians and Gynecologists (ACOG). Optimizing Support for Breastfeeding as Part of Obstetric Practice. Committee Opinion. No. 756. *Obstet Gynecol* 2018;132:e187-196.

New York State Department of Health.

- [Breastfeeding Friendly Practice Designation](#)
- [NYS Breastfeeding Friendly Practice Designation Assessment Survey](#)
- [Breastfeeding Friendly Practices by County](#)

**Age range(s):** Infants and Young Children (0 - 3 years), Prenatal and Postpartum Women

**Social Determinant of Health addressed:** Health Care, Community Cohesion, Education

**Sector(s) playing lead role:** Healthcare Delivery System

**Sector(s) playing contributing role:** Insurers, Community or Neighborhood Residents, Governmental Public Health Agencies

**Intermediate-level measure:** 1) Number of health care practices that improve their policies and practices to support breastfeeding mothers and families. 2) Number of practices (pediatric, obstetric or family medicine) with breastfeeding office policies. 3) Number of practices that become designated as a NYS Breastfeeding Friendly Practice.

**Related interventions, focus areas and goals from other priorities:** Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

**Intervention 2.2.5: Increase access to community-based interventions that provide mothers with peer support via home visits in the prenatal and early postpartum period.**

**Description:** Local health departments, hospitals, health centers, insurers (including Medicaid Managed Care), businesses, and other stakeholders should establish partnerships with community-based organizations (i.e., trained community health workers, doulas and other peer support) to provide prenatal breastfeeding education, assistance, support, and facilitate coordination to community resources, and continuity of care post-discharge.

**Resources**

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

Cochrane Systematic Review (2017). [Schedules for Home Visits in the Early Postpartum Period](#)

U.S. Department of Health and Human Services. [Home Visiting Evidence of Effectiveness](#)

Centers for Disease Control and Prevention (2005). Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding interventions Atlanta: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

New York State Department of Health. [Find a Home Visiting Program](#) and [List of Home Visiting Programs in NYS](#)

**Age range(s):** Infants, Prenatal and Postpartum Women

**Social Determinant of Health addressed:** Health Care, Community Cohesion, Education

**Sector(s) playing lead role:** Governmental Public Health Agencies, Healthcare Delivery System

**Sector(s) playing contributing role:** Insurers, Community or neighborhood residents, CBOs and Human service agencies, Policy makers and other elected officials

**Intermediate-level measure:** 1) Number of community-based organizations that provide information, support and referrals to promote and support breastfeeding via home visits 2) Number of mothers that receive information, support and referrals to promote support breastfeeding via home visits.

**Related interventions, focus areas and goals from other priorities:** Promote evidence-based care to prevent and manage chronic diseases including obesity, reduce food insecurity, promote tobacco use cessation, eliminate exposure to secondhand smoke

**Intervention 2.2.6: Increase support for breastfeeding in the workplace.**

**Description:** Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should ensure their worksite has fully implemented the NY Nursing Mothers in the Workplace Act (NY Labor Law 206-c) and can work to assist other worksites to implement this Labor Law and adopt and implement policies and recommended multi-component worksite breastfeeding support programs. At the county or regional level, several health departments are working together to develop interventions to support local worksites, including educational materials, assessment tools, and guidelines to designate worksites as Breastfeeding Friendly.

**Resources**

Dinour L, Szaro J. Employer-Based Programs to Support Breastfeeding Among Working Mothers: A Systematic Review. *Breastfeeding Medicine* 2017;12(3).

New York State Department of Labor. [NYS Nursing Mothers in the Workplace Act](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#)  
Atlanta: U.S. Department of Health and Human Services (Strategy 5: Support for Breastfeeding in the Workplace pg. 23 - 28)

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 13: pg. 50).  
[Making It Work Toolkit](#)

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2008). [Business Case for Breastfeeding](#)

New York City Department of Health, Center for Health Equity (2018). [Breastfeeding Toolkit for Business Owners](#)

Niagara County Breastfeeding Friendly Employer Initiative  
<http://www.niagaracounty.com/health/Services/Lactation-and-Breastfeeding>

Centers for Disease Control and Prevention (2014). [The CDC Worksite Health Score Card: An Assessment Tool for Employers to Prevent Heart Disease, Stroke, & Related Health Conditions](#)  
Lactation Support Module (6 questions); page 21

Niagara County Department of Health. [Breastfeeding Friendly Workplace Assessment](#)

**Age range(s):** All Infants (0-3yrs), Women of Child-Bearing Age, Prenatal and Postpartum Women

**Social Determinant of Health addressed:** Economic Stability

**Sector(s) playing lead role:** Governmental Public Health Agencies; Policy Makers and Elected Officials

**Sector(s) playing contributing role:** Media; Insurers; Healthcare Delivery Systems

**Intermediate-level measure:** 1) Number of worksites that improve their policies and practices to support breastfeeding mothers and families.

**Related interventions, focus areas and goals from other priorities:** Healthy Eating and Food Security

**Intervention 2.2.7: Increase access to Early Care and Education programs that support breastfeeding families.**

**Description:** Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work to assist child care providers support breastfeeding families. This includes encouraging and supporting child care providers to receive training and education to support breastfeeding families, helping facilities develop breastfeeding friendly policies and working with day care centers and homes to meet the criteria to become designated as breastfeeding friendly.

## Resources

Batan M, Li R, Scanlon K. [Association of child care providers breastfeeding support with breastfeeding duration at 6 months](#). *Matern Child Health J.* 2012 doi: 10.1007/s10995-012-1050-7. Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services. (Strategy 6: Support for Breastfeeding in the Early Care and Education pg. 29 – 32)

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd Edition. Also available at <http://nrckids.org>

[Chapter 4: Nutrition and Food Service, 4.3 Requirements for Specials Groups or Ages of Children, 4.3.1 Nutrition for Infant](#)

[Breastfeeding and Early Care and Education – Centers for Disease Control and Prevention](#)

New York State Department of Health - [CACFP Breastfeeding Friendly Child Care Designation Program](#)

- [Child Care Center Breastfeeding Friendly Self-Assessment](#)

- [Day Care Home Breastfeeding Friendly Self-Assessment](#)
- [Day Care Home Breastfeeding Friendly Self-Assessment Spanish](#)
- [Breastfeeding Friendly Child Care Centers by County](#)
- [Breastfeeding Friendly Child Care Homes by County](#)

**Age range(s):** Infants and young children (6 weeks – 3 years), Women of Child-Bearing Age, Prenatal and Postpartum Women

**Social Determinant of Health addressed:** Economic Stability, Food Security, Community Cohesion

**Sector(s) playing lead role:** Governmental Public Health Agencies; Employers, Businesses and Unions; Policy Makers and Elected Officials

**Sector(s) playing contributing role:** Media; Insurers; Healthcare Delivery Systems

**Intermediate-level measure:** 1) Number of child care programs that improve their practices to support breastfeeding mothers and families.

**Related interventions, focus areas and goals from other priorities:** Healthy Eating and Food Security

**Intervention 2.2.8: 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.**

**Description:** Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders should work together to support and establish breastfeeding support groups in faith-based, community-based or health care organizations in communities. Support groups should provide access to lactation consultants (IBCLCs), other lactation professionals and peer support (pregnant and/or breastfeeding), their families, and other support persons).

## Resources

Fox, Rebekah & McMullen, Sarah & Newburn, Mary. (2015). [UK women’s experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services.](#) BMC Pregnancy and Childbirth. 15:147. DOI 10.1186/s12884-015-0581-5.

Evans, Marinelli, Taylor, Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: “The Going Home Protocol,” Revised 2014](#) Breastfeeding Med 2014; 9(1). DOI: 10.1089/bfm.2014.9996

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding.](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 3 and 11: pgs. 40 and 48).

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

Baby Café USA: <http://www.babycafeusa.org/> and [List of Baby Cafés in your state](#)

**Age range(s):** Infants and Young Children (0-3 years), Women of Child-Bearing Age, Prenatal and Postpartum Women

**Social Determinant of Health addressed:** Economic Stability, Food Security, Community Cohesion, Health Care

**Sector(s) playing lead role:** CBOs and Human Service Agencies, Community or Neighborhood Residents

**Sector(s) playing contributing role:** Media; Insurers; Healthcare Delivery Systems; Policy Makers and Elected Officials; Governmental Public Health Agencies

**Intermediate-level measure:** 1) Number of faith-based, community-based or health care organizations that provide peer and professional breastfeeding support by creating drop-in centers/Baby Cafés® 2) Number of mothers who received peer- and professional support at drop-in centers/Baby Cafés®.

**Related interventions, focus areas and goals from other priorities:** Healthy Eating and Food Security

## Focus Area 3: Child and Adolescent Health

**Goal 3.1:** Support and enhance children and adolescents' social-emotional development and relationships

- **Objective 3.1.1:** By December 31, 2024, 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%. (*Baseline: 17.5%; Year: 2016; Source: National Survey of Children's Health; Data availability: State*).
- **Objective 3.1.2:** By December 31, 2024, 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%. (*Baseline: 45.3%; Year: 2016; Source: National Survey of Children's Health; Data availability: State*).
- **Objective 3.1.3:** By December 31, 2024, 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% (*Baseline: 28.6%; Year: 2015; Source: Youth Risk Behavior Survey; Data availability: State (by race, grade, sex, sexual identity)*).
- **Objective 3.1.4:** By December 31, 2024, decrease the suicide mortality rate for youth ages 15-19 years by 6% to 4.7 per 100,000. (*Baseline: 5.0 deaths per 100,000 population ages 15-19 years; Year: 2014-16; Source: Vital Statistics; Data availability: State (by race), County*).

**Intervention 3.1.1: 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.**

**Description:** Supporting the healthy social-emotional development of children has emerged as a public health priority. Social-emotional development is foundational to children's development in other domains, school readiness and success, and lifelong health and well-being.<sup>26</sup> Adverse childhood experiences (ACEs) including abuse and neglect, parental mental illness and addiction, family separation, and other traumatic experiences can have profound impact on children's development. ACEs are associated with significantly increased risk for a wide range of chronic health conditions and risk factors later in life – as well as adverse pregnancy outcomes such as preterm birth.<sup>27 28 29</sup>

Strategies to increase individual foundational knowledge and skills for those working with children and families are a key element of building an effective capacity and response. A variety of state projects and national resources are available for individual practitioners and organizations to support this aspect of workforce development. Additional resources will be added as this emerging area of practice continues to grow.

## Resources

[Docs for Tots.](#)

[National Center of Trauma Informed Care \(NCTIC\). Supported by the federal Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)

[The Pyramid Model.](#)

[Trauma Informed Care: Perspectives and Resources. Developed by the National Technical Assistance Center for Children’s Mental Health at Georgetown University Center for Child and Human Development.](#)

[The Trauma Informed Care Project \(TCIP\).](#)

**Age groups impacted by this intervention:** infants, children, adolescents and their families

**Social determinants of health addressed by this intervention:** education, community cohesion, health care, family support, social support, incarceration, discrimination.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Colleges & universities; Schools (K-12); Community-based organizations and human service agencies; Media; Other: Child care, Criminal justice
- **Supporting:** Insurers; Policymakers & elected officials; Economic development agencies; Housing agencies

**Intermediate-level measure that can be used by organizations to track progress toward**

**implementation of the intervention in the short term:** The number of providers who have received training/professional development to improve knowledge and skills related to social emotional development, adverse childhood experiences, or trauma informed care.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

**Intervention 3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families.**

**Description:** As noted for Intervention 3.1.2, social-emotional development is foundational to children’s development in other domains, school readiness and success, and lifelong health and well-being.<sup>30</sup> Adverse childhood experiences (ACEs) including abuse and neglect, parental mental illness and addiction, family separation, and other traumatic experiences can have profound impact on children’s development and are associated with significantly increased risk for a wide range of chronic health conditions and risk factors later in life – as well as adverse pregnancy outcomes such as preterm birth.<sup>31 32 33</sup>

Collaborative strategies to promote positive development, build resiliency, and support safe, stable, and nurturing relationships and environments throughout childhood and adolescence have the potential to improve health outcomes across the life course.<sup>34</sup> Integrating basic trauma-informed approaches and practices can help recognize and respond to the impact of trauma on individuals and communities. While intensive behavioral health and trauma-informed care interventions are beyond the scope of some service settings and programs, strategies to promote positive social-emotional development and fundamental trauma-informed approaches should be integrated across all programs serving children, youth, and families. (See also Intervention 3.1.1)

## Resources

[Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention \(CDC\). First 1000 Days on Medicaid Initiative.](#)

Healthy Steps.

- [National Healthy Steps](#)
- [New York Office of Mental Health Implementation of Healthy Steps](#)

Help Me Grow.

- [Help Me Grow National Center](#)
- [Help Me Grow New York](#)

[Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals \(2017\). Joint Task Force on Social-Emotional Development: New York State Department of Health Early Intervention Coordinating Council and New York State Early Childhood Advisory Council.](#)

[The National Center for Pyramid Model Interventions \(NCPMI\).](#)

[The Resilience Project. American Academy of Pediatrics.](#)

[The Search Institute.](#)

[Supporting Social-Emotional Learning with Evidence-Based Programs. Annie E. Casey Foundation.](#)

[Teaching Students to Prevent Bullying: Curriculum and Resources. National Education Association.](#)

**Age groups impacted by this intervention:** infants, children, adolescents and their families

**Social determinants of health addressed by this intervention:** education, community cohesion, health care, family support, social support, incarceration, discrimination.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Schools (K-12); Community-based organizations and human service agencies; Other: Child care, Criminal justice system
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community residents; Policymakers & elected officials; Housing agencies; Economic development agencies; Natural environment agencies; Urban planning agencies

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of strategies implemented that promote social-emotional wellness among children, youth, and families through public health programs.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

### **Intervention 3.1.3: Engage in collaborative strategies to increase developmental screening of young children in accordance with professional medical guidelines.**

**Description:** Early identification of developmental delays and disabilities is critical to the well-being of children and their families. Routine developmental screening at specified intervals, combined with ongoing developmental surveillance, is an integral component of children’s health care. The American Academy of Pediatrics recommends that developmental screening using standardized tools be completed at the 9, 18, and 30 (or 24) month well-child visits, but screening rates have remained low. Based on the 2016 National Survey of Children’s Health (NSCH), only 30.4% of children ages 9 to 35 months nationally, and 17.5% in New York State, received a parent-completed standardized developmental screening in the previous year. National data also reveal disparities in screening rates, with lower rates among black and Asian children, children living in poverty, and children whose parents have lower education.<sup>35</sup> A study published in *Pediatrics* found that disparities in age at diagnosis for autism spectrum disorders (ASD) between white and Latino children may be due in part to lack of language-appropriate screenings, culturally appropriate materials for families, and access to developmental specialists.<sup>36</sup>

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found evidence that structured quality improvement activities (e.g., Plan-Do-Study-Act cycles) in health care settings appear to be effective. Quality improvement initiatives that include additional systems-level approaches - such as collaboration with health departments, insurance coding or payment changes, or involvement in larger systems-change initiatives or improvement partnerships - also appear to be effective. Other interventions, including health care provider training and home visiting programs may be effective, but because the number of published studies is limited, further evidence is needed to fully assess these.<sup>37</sup>

## Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 6: Developmental Screening:

- [Evidence Analysis Report. NPM 6: Developmental Screening, Johns Hopkins University.](#)
- [Evidence Brief. Developmental Screening. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools.](#)

American Academy of Pediatrics - clinical guidelines:

- [Recommendations for preventive pediatric health care \(periodicity schedule\)](#)
- [Policy statement: Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening.](#)
- [Bright Futures Tool and Resource Kit.](#)

[Birth to Five: Watch me Thrive.](#)

Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).

- [National ECCS CoIIN Coordinating Center](#)
- [New York State ECCS Impact Initiative](#)

[First 1000 Days on Medicaid Initiative.](#)

Healthy Steps.

- [National Healthy Steps](#)
- [New York Office of Mental Health Implementation of Healthy Steps](#)

Help Me Grow.

- [Help Me Grow National Center](#)
- [Help Me Grow New York](#)

[Learn the Signs, Act Early. Centers for Disease Control and Prevention](#)

**Age groups impacted by this intervention:** infants, children

**Social determinants of health addressed by this intervention:** economic stability, education, health care

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Other: Child care
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Schools (K-12); Policymakers & elected officials; Economic development agencies; Urban planning agencies.

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** Number of strategies implemented to increase developmental screening in young children.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Chronic Disease - Preventive Care & Management

**Goal 3.2:** Increase supports for children and youth with special health care needs

- **Objective 3.2.1:** By December 31, 2024, increase the percentage of infants who fail their initial hearing screening who have a documented follow-up by 60% to 50.0% (*Baseline: 31.0%; Year 2015; Source: Early Hearing Detection and Intervention Program; Data availability: State, County*).
- **Objective 3.2.2:** By December 31, 2024, 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%. (*Baseline: 17.5%; Year: 2016; Source: National Survey of Children's Health; Data availability: State (by race, income, insurance, other child & family factors)*). [same as Objective 3.1.1]
- **Objective 3.2.3:** By December 31, 2024, 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% (*Baseline: 61.6; Year 2015-16; Source: Early Intervention Program Data; Data availability: State, County*).
- **Objective 3.2.4:** By December 31, 2024, 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%. (*Baseline: 11.0; Year 2016; Source: National Survey of Children's Health; Data availability: State*).
- **Objective 3.2.5:** By December 31, 2024, 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%. (*Baseline: 15.3; Year 2016; Source: National Survey of Children's Health; Data availability: State*).

**Intervention 3.2.1: Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families.**

**Description:** Children with special health care needs (CSHCN) are those who have chronic physical, developmental, behavioral, or emotional conditions and require health and related services beyond that which generally is required by most children – nearly one in five children ages birth to 17 years in New York State. Families of children with special health care needs (CSHCN) face unique challenges and bring tremendous knowledge, experience, and strengths to the care of their children that is an asset to both individual and population-based public health efforts. Systems must be designed and implemented to meet the needs of families, and to engage them in meaningful roles as their children's most important caregivers.

The New York State Department of Health Children with Special Health Care Needs (CSHCN) Program recently completed a Systems Mapping project to engage families from across the state in identifying successes, gaps, and barriers to services for CSHCN, using tools and technical support from the Maternal Child Health Workforce Development Center at the University of North Carolina (UNC). Through this process, over 130 family members of CSHCN from all regions of the state and diverse demographics participated in facilitated discussions. The resulting qualitative data (system maps) will inform the future practices of the CSHCN Program.

Throughout this systems mapping process and other ongoing needs assessments, parents and providers of CSHCN in New York State have emphasized the fragmentation of services for CSHCN, the complexity of finding providers and accessing the myriad of services needed, and disparities in care – with some families getting what they need for their children and others “going without”.<sup>38</sup> Parents are seeking better information about their child’s diagnosis and service systems, and they want more connections to other families who have had similar experiences. Partnering with and supporting families who reflect the diversity of our communities is essential to improving these service systems and experiences.

Family engagement may help to improve the quality and efficiency of the health care and public health systems at all levels, from direct care to organizational design to policy.<sup>39</sup> There are opportunities for parents to receive leadership training and participate in state and local advisory and workgroups through several core programs.

## Resources

### [Children and Youth with Special Health Care Needs \(CYSCHN\) Program Early Intervention Program.](#)

Early Intervention Family Outcomes Project.

- [Child and Family Outcomes Survey](#)
- [Early Intervention Family Outcomes & the State Systemic Improvement Plan](#)
- [Improving Family Centeredness Together](#)
- [Early Intervention Partners Training Project.](#)

### [Families Together in New York State.](#)

Hands and Voices.

- National organization: <http://www.handsandvoices.org>
- New York State chapter: <http://www.handsandvoicesny.org/>

### [Parent to Parent of New York State.](#)

### [National Center for Family/ Professional Partnerships \(NCFPP\).](#)

**Age groups impacted by this intervention:** infants, children, adolescents and their families

**Social determinants of health addressed by this intervention:** community cohesion, economic stability, education, health care, family support, social support

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Child care; Criminal justice
- **Supporting:** Employers, businesses, and unions; Insurers; Media; Colleges & universities; Transportation agencies; Housing agencies; Economic development agencies; Urban planning agencies.

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** Number of families of CSHCN participating in the development or improvement of family centered services for CSHCN.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

**Intervention 3.2.2.: 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).**

**Description:** NYS Public Health Law requires all maternity hospitals and birthing centers to administer newborn hearing screening programs, which is consistent with national public health goals and guidelines for early detection of hearing loss. Infants are screened shortly after birth in the hospital or birthing facility. Infants that do not pass their initial screenings are referred for follow up, which may include a second screening and, when needed, a full diagnostic hearing assessment. Infants with hearing loss are referred to the NYS Early Intervention Program for appropriate intervention services. Providers at each step in this process are required to report screening and follow-up test results in the state's Early Hearing Detection and Intervention Information System (NYEHDI-IS). Timely follow up of infants with hearing loss is critical to optimizing their development. Documentation of follow up in NYEHDI-IS is essential to tracking progress and informing public health improvement efforts.

Over 97% of infants born in New York State in 2016, had a documented initial hearing screening after birth. Of those infants who failed this initial screening, only 37.5% had follow-up test results documented in the NYEHDI-IS system. Although this percentage has improved significantly from the baseline of 9% in 2014, there is still substantial need for improvement. For the past several years, the New York State Department of Health has been engaged in a variety of efforts to improve newborn hearing screening and follow up, including enhancements to the data system to make it more useful for providers, dissemination of data to hospitals and other partners to reinforce the need for reporting, and convening structured quality improvement collaboratives with health care providers and families to improve follow up services, including linkage to the Early Intervention Program. There is a need to build on these efforts and engage more partners to ensure that all babies who fail their initial hearing screening receive timely and appropriate follow up.

## Resources

[Early Hearing Detection and Intervention Program \(EHDI\). New York State Department of Health.](#)

Hands and Voices.

- National organization: <http://www.handsandvoices.org>
- New York State chapter: <http://www.handsandvoicesny.org/>

[Joint Committee on Infant Hearing.](#)

[National Center on Birth Defects and Developmental Disabilities \(NCBDD\). \(2018\). Centers for Disease Control and Prevention.](#)

[National Center for Hearing Assessment and Management \(NCHAM\).](#)

[Program to Enhance the Health & Development of Infants and Children \(PEHDIC\): Early Hearing Detection & Intervention \(2018\). American Academy of Pediatrics \(AAP\).](#)

**Age groups impacted by this intervention:** Infants, children and their families

**Social determinants of health addressed by this intervention:** education, health care, family support, social support

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Policymakers & elected officials;
- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Community or neighborhood residents; Community-based organizations and human service agencies;

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** Number of health care providers that are consistently reporting results of newborn hearing screening and follow up.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Chronic Disease - Preventive Care & Management

### **Intervention 3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.**

**Description:** Care coordination is the purposeful organization of care activities and information sharing among patients and those involved in their care to improve efficiency, quality of care, health outcomes, and patient satisfaction. The Institute of Medicine has identified care coordination as a key strategy with the potential to improve the effectiveness, safety, and efficiency of the U.S. health care system, improving outcomes for patients, providers, and payers.<sup>40</sup>

Children with special health care needs (CSHCN) may require specialty medical services across multiple providers and service settings. They may experience multiple transitions as they develop and “age out” of specific programs or services (e.g., from Early Intervention to Special Education, elementary to

secondary school, pediatric to adult health care) and move across service and community settings (e.g., hospital to community, home to school).

Both formal care coordination/ care management services and more informal transition supports can be critical for CSHCN and their families to manage their health and family needs during key periods of change and overtime. The 2016 National Survey of Children’s Health found that about 73% of children age birth to 17 years in New York State who needed care coordination services received effective services, while about 15% of youth with special health care needs received services necessary to transition to adult health care.<sup>41</sup>

## Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 12: Transition to Adulthood:

- [Evidence Analysis Report. NPM 12: Transition, Johns Hopkins University.](#)
- [Evidence Brief. Transition to Adulthood. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools - Transition.](#)

[Care Coordination for CSHCN Challenge. Maternal and Child Health Bureau](#)

[Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease. New York State Department of Health](#)

[Got Transition. Maternal and Child Health Bureau/ National Alliance to Advance Adolescent Health](#)

Medicaid Health Homes Serving Children. New York State Department of Health.

- [New York State Health Homes Serving Children Website](#)
- [Find a Health Home](#)

[National Technical Assistance Center on Transition \(NTACT\). U.S. Department of Education’s Office of Special Education Programs \(OSEP\)/ Rehabilitation Services Administration \(RSA\).](#)

[State Department of Health Early Intervention Program to the State Education Department Preschool Special Education Program or Other Early Childhood Services.](#)

**Age groups impacted by this intervention:** infants, children, adolescents and their families

**Social determinants of health addressed by this intervention:** community cohesion, economic stability, education, food security, health care, housing, transportation, family support, social support

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Health care delivery system; Insurers; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; Economic development agencies; Policymakers & elected officials; other: child care

- **Supporting:** Employers, businesses, and unions; Media; Colleges & universities; Transportation agencies; Housing agencies; Urban planning agencies; other: Criminal justice system

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of strategies implemented to enhance care coordination or transition services.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

**Goal 3.3:** Reduce dental caries among children

- **Objective 3.3.1:** By December 31, 2024, increase the percentage of New York State residents served by community water systems that have optimally fluoridated water by 9% to 77.5% (*Baseline: 71.1; Year 2016; Source: Safe Drinking Water Information System (SDWIS); Data availability: State, County*).
- **Objective 3.3.2:** By December 31, 2024, decrease the percentage of children ages 1-17 years who had decayed teeth or cavities in the past year by 20% to 6.7%. (*Baseline: 8.4; Year 2016; Source: National Survey of Children’s Health; Data availability: State*).
- **Objective 3.3.3:** By December 31, 2024, 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%. (*Baseline: 77.6; Year 2016; Source: National Survey of Children’s Health; Data availability: State*).

**Intervention 3.3.1: Maintain and expand community water fluoridation.**

**Description:** The US Surgeon General’s Reports have emphasized oral health as a critical aspect of overall individual and population health. Research demonstrates the large number of lost school and work hours attributed to oral health problems. Dental cavities (also called dental caries or tooth decay) are one of the most common chronic diseases of childhood.

Drinking fluoridated water keeps teeth strong and reduces cavities by about 25% in children and adults. By preventing cavities, community water fluoridation has been shown to save money for families and for the US health care system. Community water fluoridation is the most cost-effective way to deliver fluoride to people of all ages, education levels, and income levels who live in a community. Most water has some natural levels of fluoride, but usually not enough to prevent cavities. Community water systems can add the right amount of fluoride to the local drinking water to prevent cavities. Community water fluoridation is recommended by nearly all public health, medical, and dental organizations. It is recommended by the American Dental Association, American Academy of Pediatrics, US Public Health Service, World Health Organization, and the Community Preventive Services Task Force. Grant funds are available from the New York State Department of Health to support implementation and maintenance of fluoridation systems in communities.

## Resources

[Best Practice Approach Reports - Use of Fluoride: Community Water Fluoridation. Association for State and Territorial Dental Directors.](#)  
[Community Water Fluoridation. Centers for Disease Control and Prevention.](#)

[Community Water Fluoridation. National Association of County and City Health Officials.](#)  
[Dental Caries \(Cavities\): Community Water Fluoridation. Community Preventive Services Task Force.](#)

[Drinking Water Fluoridation Grant Program. New York State Department of Health.](#)

[Patient Engagement About Fluoride and Fluoridation. New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation.](#)

**Age groups impacted by this intervention:** infants, children, adolescents, adults age 21-60 years, older adults

**Social determinants of health addressed by this intervention:** economic stability, education, food security, health care, built environment

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Media; Community or neighborhood residents; Community-based organizations and human service agencies; Policymakers & elected officials; Urban planning agencies; other: Community water systems
- **Supporting:** Health care delivery system; Employers, businesses, and unions; Insurers; Colleges & universities; Schools (K-12); Economic development agencies.

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** Number of strategies implemented to expand or maintain community water fluoridation.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote a Healthy and Safe Environment - Water Quality

**Intervention 3.3.2: Increase delivery of evidence-based preventive dental services across key settings, including school-based and community-based primary care clinics.**

**Description:** Access to oral (dental) health care is critical to maintain oral health throughout the life course. Early dental visits teach children that oral health is important and improve children's positive attitudes about oral health professionals and dental visits. Pregnant women who receive dental care are more likely to take their children to get oral health care, and untreated maternal dental caries may increase the odds of her children developing cavities.<sup>42 43</sup> Children should be taught proper oral hygiene, including daily teeth brushing, at an early age.

Preventive dentistry encompasses several practices to keep teeth healthy and prevent cavities, gum disease, enamel wear, and tooth loss. It includes personal oral hygiene practices (including daily tooth brushing), dental cleanings, the application of sealants, and fluoride supplementation. To maintain optimal oral health, the American Dental Association (ADA) recommends visits to the dentist at regular intervals determined by a dentist. The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride, and that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. The Community Preventive Services Task Force (CPSTF) recommends school-based programs to deliver dental sealants and prevent tooth decay among children (see also Intervention 3.3.1).

A recent review by the Women’s and Children’s Health Policy Center at Johns Hopkins University found evidence that school-based oral health services, preschool interventions (participation in Head Start), enrollment in public health insurance programs (Medicaid or CHIP/Child Health Plus), and Medicaid reforms (e.g., increased provider reimbursements, enhanced benefits, administrative changes, and health plan incentives) appear to be effective. Caregiver education/counseling, home visits, and outreach to recruit dental practices to provide care may be effective but there is currently insufficient evidence to assess their effectiveness.<sup>44</sup> There is also insufficient evidence currently to assess the effectiveness of interventions to increase dental visits of women during pregnancy.<sup>45</sup> Of note, this particular review did not look at other promising strategies to increase use of preventive oral health services such as integration of oral health in primary medical care settings, co-location of dental and medical services, enhanced patient outreach and reminder systems (which have been found effective in increasing use of other preventive health services), or delivery of oral health services through other community-based programs.

## Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 13: Oral Health:

- Evidence Analysis Reports (2017) Johns Hopkins University. Reports include detailed tables of interventions reviewed with citations for individual studies.
  - [NPM 13A – Oral Health in Pregnancy](#)
  - [NPM 13B – Oral Health in Childhood.](#)
- [Evidence Brief. Oral Health. National Center for Education in Maternal and Child Health \(NCEMCH\), Georgetown University.](#)
- [Title V Transformation Tools – Oral Health.](#)

Best Practice Approach Reports. Association for State and Territorial Dental Directors.

- [School-Based Dental Sealant Programs \(2017\)](#)
- [Use of Fluorides in Schools. \(2018\)](#)
- [Prevention and Control of Early Childhood Tooth Decay \(2011\).](#)

[Dental Sealants. Centers for Disease Control and Prevention.](#)

[Dental Caries \(Cavities\): School-Based Dental Sealant Delivery Programs. Community Preventive Services Task Force.](#)

[Medical-Dental Integration New York State Department of Health and University at Albany School of Public Health.](#)

[Patient Engagement About Fluoride and Fluoridation. New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation.](#)

[Smiles for Life: A National Oral Health Curriculum, Third Edition.](#)

**Age groups impacted by this intervention:** all ages (focus on infants, children, adolescents)

**Social determinants of health addressed by this intervention:** community cohesion, economic stability, education, food security, health care, housing, transportation, natural environment, build environment, family support, social support

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; Employers, businesses, and unions; Health care delivery system; Insurers; Schools (K-12); Community-based organizations and human service agencies; other: Child care
- **Supporting:** Media; Colleges & universities; Community or neighborhood residents; Policymakers & elected officials; Transportation agencies; Economic development agencies; Urban planning agencies

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of schools or community centers providing preventive dental care in the community.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Chronic Disease - Preventive Care & Management

**Intervention 3.3.3: Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.**

**Description:** Integrating oral health messages and prevention strategies in other public health programs has the potential to increase awareness, knowledge, and preventive oral hygiene practices among children and their families. Home visiting programs, nutrition programs, child care, and other early care and education programs are examples of community-based programs that may have opportunities to reinforce oral health promotion.

## Resources

Best Practice Approach Reports. Association for State and Territorial Dental Directors.

- [Improving Children’s Oral Health through the Whole School, Whole Community, Whole Child \(WSCC\) Model. \(March 2017\)](#)
- [Oral Health of Children, Adolescents and Adults with Special Health Care Needs. \(August 2007\)](#)

- [Perinatal Oral Health. \(October 2012\).](#)

Caring for Our Children: National Health and Safety Performance Standards for Early Care and Education Programs – Oral Health

- [Routine Oral Hygiene Activities](#)
- [Toothbrushes and toothpaste](#)
- [Oral Health Education](#)
- [Oral Health Policy](#)

[Cavity Free Kids.](#)

[Oral Health Educational Resources for Home Visitors and Families: Environmental Scan. \(2018 update\). Association of State and Territorial Dental Directors, Early Childhood Committee.](#)

**Age groups impacted by this intervention:** infants, children age 2-12, adolescents age 13-21 years; pregnant women.

**Social determinants of health addressed by this intervention:** community cohesion, economic stability, education, health care, other: family support, social support, health literacy, learning environment.

**Sectors that can play lead and contributing roles in implementing this intervention:**

- **Lead:** Governmental public health agencies; employers, businesses, and unions; Schools (K-12); Community or neighborhood residents; Community-based organizations and human service agencies; other: Child care.
- **Supporting:** Health care delivery system; Insurers; Media; Colleges & universities; Policymakers & elected officials; Economic development agencies.

**Intermediate-level measure that can be used by organizations to track progress toward implementation of the intervention in the short term:** The number of community-based programs serving women, infants, and children, that incorporate oral health promotion messages.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** Promote Well-Being and Prevent Mental & SU Disorders - Promote Well-Being

## **Focus Area 4: Cross Cutting Healthy Women, Infants, & Children (applicable to all HWIC focus areas and goals)**

**Goal:** *Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.*

**Intervention 4.1: 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.**

**Description:** The focus within public health increasingly is on addressing social determinants of health: the conditions in which people are born, grow, live, work, and age. Social factors such as food insecurity, homelessness, employment conditions, poverty, adverse neighborhood environments, inadequate health care, lack of educational opportunities, social exclusion, racism and discrimination, lack of social support, and gender-based inequities are important forces that influence MCH outcomes, both directly and through their impact on other individual risk factors. These social determinants help explain why rates of key indicators – such as infant mortality and maternal mortality – are worse in the United States compared to other countries. They also help to explain the persistent racial, economic, and other disparities we see across virtually all key indicators of maternal and child health.

A dedicated focus on social determinants of health across the life course is consistent with input received from youth, families, and service providers as part of New York's needs assessment activities over the past three years. Stakeholders repeatedly identified factors that influence their use of health care services: health insurance coverage, accessibility of health care, provider diversity and cultural competence, transportation, stigma and confidentiality concerns, language barriers, cost, inability to take time off from work, and competing life responsibilities (cite: Title V applications for 2017 and 2019). Additionally, stakeholders noted lack of social support, unsafe neighborhoods, lack of affordable housing, limited access to affordable, healthy food, and lack of opportunities for physical activity as key barriers to good health.

While these factors may be addressed in the context of other topic-specific interventions described throughout this plan, it is essential that public health organizations and practitioners partner with other sectors to address them directly as foundational influences on all aspects of health and well-being. For this reason, the stakeholder group contributing to this action plan endorsed the inclusion of this cross-cutting goal and intervention to underpin other sections of the plan.

Healthy People 2020 has emphasized the need to address social determinants of health by including a new goal to “create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.<sup>46</sup> Achieving this goal in New York State will require new approaches, partnerships, and collaborations across a wide range of sectors, at both the community and state level.

**Resources:**

[Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Centers for Disease Control and Prevention \(CDC\).](#)

[The EveryONE Project™. American Academy of Family Physicians.](#)

[The Guide to Community Preventive Services: Health Equity Reviews. Community Preventive Services Task Force.](#)

[Health Impact in 5 Years \(HI-5\). Centers for Disease Control and Prevention.](#)

[Healthy People 2020: Social Determinants of Health Interventions & Resources. Office of Disease Prevention and Health Promotion](#)

[National Center for Cultural Competence \(NCCC\). Georgetown University Center for Child and Human Development.](#)

[Paid Family Leave – New York State.](#)

[Policy Resources to Support Social Determinants of Health. Centers for Disease Control and Prevention](#)

[Sources for Data on Social Determinants of Health. Centers for Disease Control and Prevention](#)

[Technical Packages for Violence Prevention. Centers for Disease Control and Prevention.](#)

[Think Cultural Health. U.S. Department of Health & Human Services, Office of Minority Health.](#)

Tools for Putting Social Determinants of Health into Action. Centers for Disease Control and Prevention:

- [At-a-Glance: 10 Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities.](#)
- [Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health.](#)

**Age groups impacted by this intervention:** All

**Social determinants of health addressed by this intervention:** All

**Sectors that can play lead and contributing roles in implementing this intervention:** All

**Intermediate-level measure that can be used by organizations to track progress toward**

**implementation of the intervention in the short term:** The number of collaborations with partners that address social determinants of health impacting women, infants, children, and families.

**Related interventions, focus areas, or goals from other Prevention Agenda priorities:** All

## **Healthy Women, Infants, and Children Action Plan Appendix**

This appendix provides additional detail on resources to support the evidence base and implementation for each intervention in the Healthy Women, Infants, and Children Action Plan for the 2019-2024 New York State Prevention Agenda.

## Focus Area 1: Maternal and Women’s Health

**Goal 1.1:** Increase use of primary and preventative health care services among women of all ages, with a focus on women of reproductive age.

**Intervention 1.1.1:** Incorporate strategies to promote health insurance enrollment, well-woman visits, and age-appropriate preventive health care across public health programs serving women

### Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- **Evidence Analysis Report. NPM 1: Well-Woman Visit**, Johns Hopkins University. [https://www.mchevidence.org/documents/reviews/npm\\_1\\_well\\_woman\\_visit\\_evidence\\_review\\_brief\\_june\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_1_well_woman_visit_evidence_review_brief_june_2017.pdf)
- **Evidence Brief. Well Woman Visits**. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-1-well-woman.php>
- **Title V Transformation Tools**. Recommendations to support NPM1 – Well Woman Visit. <https://www.mchnavigator.org/transformation/npm-1.php>
- **Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit**. Association of Maternal and Child Health Programs (AMCHP). Summary bulletin highlights specific promising practices from the AMCHP Innovation Station related to well woman visits. <http://www.amchp.org/Calendar/Webinars/Documents/NPM%20State%20Action%20Plan%201.pdf>.

**ACOG Committee Opinion on Well-Woman Visit**. American College of Obstetricians and Gynecologists, Committee on Gynecologic Practice. (2014). Describes the importance of the annual health assessment for women and provides clinical guidelines related to important elements of the annual examination at defined ages. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Well-Woman-Visit>

**Care Women Deserve**. Information and resources on preventive health services for women of all ages. Developed by a coalition dedicated to educating people about the women’s preventive services available at no out-of-pocket costs under the Affordable Care Act. <http://carewomendeserve.org/>

**Health Care Innovations Exchange**. [Agency for Healthcare Research and Quality \(AHRQ\)](https://www.ahrq.gov/). (2016) A resource for health professionals and researchers on evidence-based and promising innovations and tools for health care delivery. Includes searchable databases of innovations and quality tools and other resources. <https://innovations.ahrq.gov/>

**Health Communication and Social marketing: Campaigns that Include Mass Media and Health-Related Product Distribution**. The Guide to Community Preventive Services. Community Preventive

Services Task Force (CPSTF). December 2010. <https://www.thecommunityguide.org/findings/health-communication-and-social-marketing-campaigns-include-mass-media-and-health-related>

**Maternal and Infant Community Health Collaboratives (MICHC) Initiative.** New York State Department of Health. The MICHC initiative addresses outcomes for women of reproductive age, infants, and families through a combination of individual, family, community, and organizational strategies, including Community Health Workers (CHWs). Site provides an overview of the MICHC initiative, link to on-line CHW training, and list of current projects.  
[https://www.health.ny.gov/community/adults/women/maternal\\_and\\_infant\\_comm\\_health\\_collaboratives.htm](https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm)

**New York State of Health: The Official Health Plan Marketplace.** NYS' marketplace to help people shop for and enroll in health insurance coverage. Individuals, families, and small businesses can use the Marketplace to compare insurance options, calculate costs, and select coverage. The Marketplace uses a single application that helps people to check eligibility and enroll in health care programs like [Medicaid](#), [Child Health Plus](#), and the [Essential Plan](#), and provides information on [financial assistance](#). Options for [online](#), [in-person](#), [over the phone](#) or mail applications.  
<https://info.nystateofhealth.ny.gov/what-ny-state-health>

**Technical Assistance Document: Implementing USPSTF Recommendations into Professional Education Programs (2010).** Developed as part of an Agency for Healthcare Research and Quality (AHRQ) initiative. Includes examples of lesson plans and activities from academic institutions that have integrated the USPSTF recommendations in their curricula.  
<https://www.ahrq.gov/sites/default/files/wysiwyg/cpi/centers/ockt/kt/tools/impuspstf/impuspstf.pdf>

**Think Cultural Health.** U.S. Department of Health & Human Services, Office of Minority Health. Dedicated to advancing health equity, site features information, continuing education opportunities, and resources for health professionals to learn about culturally and linguistically appropriate services (CLAS). Includes link to CLAS standards and resources for implementation.  
<https://www.thinkculturalhealth.hhs.gov/>

**Women's Preventive Service Guidelines.** U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). Updated December 2016.  
<https://www.hrsa.gov/womens-guidelines-2016/index.html>

## Focus Area 1: Maternal and Women’s Health

**Intervention 1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.**

### Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 1: Well-Woman Visit:

- **Evidence Analysis Report. NPM 1: Well-Woman Visit**, Johns Hopkins University. [https://www.mchevidence.org/documents/reviews/npm\\_1\\_well\\_woman\\_visit\\_evidence\\_review\\_brief\\_june\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_1_well_woman_visit_evidence_review_brief_june_2017.pdf)
- **Evidence Brief. Well Woman Visits**. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-1-well-woman.php>
- **Title V Transformation Tools**. Recommendations to support NPM1 – Well Woman Visit. <https://www.mchnavigator.org/transformation/npm-1.php>
- **Title V National Performance Measure Resource Sheet. NPM 1: Well-Women Visit**. Association of Maternal and Child Health Programs (AMCHP). <http://www.amchp.org/Calendar/Webinars/Documents/NPM%20State%20Action%20Plan%201.pdf>. This is a 2-page summary bulletin. It highlights specific promising practices from the AMCHP Innovation Station related to well woman visits.

**ACT for Youth**. Act for Youth Center for Community Action (2018). NYSDOH-funded center to support evidence-based practice for youth-serving programs in NYS. Comprehensive website for positive youth development initiatives and resources focuses on connecting research to practice and youth engagement. Includes resources on adolescent sexual health and development. <http://actforyouth.net/>

**Action Plan for the National Initiative on Preconception health and Health Care (2012-2014)**. CDC report outlines objectives, strategies and action steps to improve preconception care with a renewed vision for achieving change in maternal and child health. <https://stacks.cdc.gov/view/cdc/31755>

**Bedsider**. A non-profit organization and web-based resource providing in-depth information, decision and reminder tools, and other resources related to contraception for consumers. <https://www.bedsider.org>. Companion site for providers <https://providers.bedsider.org> provides contraception information and tools for health care providers.

**Before, Between & Beyond Pregnancy: Resource Guide for Clinicians (2018)**. Designed to help primary care providers meet their patient’s needs based on the response to the “vital sign” key question “Would you like to become pregnant in the next year?” Developed by the Clinical Work Group of the National Preconception Health and Health Care Initiative, recommendations in the guide are evidence-based and reflect national and professional recommendations for routine preventive care. Site also includes a link to a new “At Your Fingertips” Mobile app for clinicians. <https://beforeandbeyond.org/toolkit/about-this-toolkit/>

**Before Pregnancy.** Centers for Disease Control and Prevention (CDC). Site provides information on preconception health and health care for women and men, including a pregnancy planning checklist <https://www.cdc.gov/preconception/index.html>

**Health Communication and Social marketing: Campaigns that Include mass Media and Health-Related Product Distribution.** The Guide to Community Preventive Services. Community Preventive Services Task Force (CPSTF). December 2010. <https://www.thecommunityguide.org/findings/health-communication-and-social-marketing-campaigns-include-mass-media-and-health-related>

**IMPLICIT Interconception Toolkit.** March of Dimes Foundation. The IMPLICIT (Interventions to Minimize Preterm and Low birth weight Infants using Continuous Improvement Techniques) Network is a family medicine maternal child health learning collaborative focused on improving care for women, infants and families through faculty, resident, and student development and quality improvement. The toolkit provides the background, evidence, and resources to implement the IMPLICIT ICC model in the context of well-child visits, tailored to the needs of individual clinic sites, practice settings, and populations. <https://www.prematurityprevention.org/Toolkits-Reports/IMPLICIT-interconception-care-toolkit>

**Know Your Options, Get the Facts.** New York State initiative to connect women with comprehensive family planning services delivered by quality health care providers licensed in NYS and meeting high standards of care for the NYS Family Planning Program. Information and links for consumers on contraception, preconception care, infertility services, and pregnancy options including prenatal care, adoption, and abortion services. <https://www.ny.gov/programs/pregnancy-know-your-options-get-facts>

**One Key Question®.** A strategic initiative developed by the [Power to Decide](#) to transform women’s health care experience with a routine question: “would you like to become pregnant in the next year?” Site offers information about consulting services, training, and technical assistance for provider networks and community organizations interested in becoming certified as One Key Question® providers or institutions. <https://powertodecide.org/select360-consulting>

**Power to Decide** (formerly the National Campaign to Prevent Teen and Unplanned Pregnancy). A public, nonprofit and nonpartisan organization and national campaign to prevent unplanned pregnancy. Website offers variety of information, resources, and services for health care providers, organizations, and consumers related to pregnancy prevention methods, programs, and policies. <https://powertodecide.org/>

**Preconception Health and Health Care: The Clinical Content of Preconception Care.** 2008 supplement to the *American Journal of Obstetrics and Gynecology*. Documents the evidence base for preconception care, with recommendations across 14 areas of clinical services. [https://www.ajog.org/issue/S0002-9378\(08\)X0011-0](https://www.ajog.org/issue/S0002-9378(08)X0011-0)

[Preconception interventions.](#) 2014 supplement to *Reproductive Health* journal that includes a series of systematic reviews regarding the impact of public health interventions during the preconception

period on maternal and child health. <https://reproductive-health-journal.biomedcentral.com/articles/supplements/volume-11-supplement-3>

**Recommendations to Improve Preconception Health and Health Care – United States.** A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. Includes 10 recommendations with key action steps.

<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>

**Technical Assistance Document: Implementing USPSTF Recommendations into Professional Education Programs (2010).** Developed as part of an Agency for Healthcare Research and Quality (AHRQ) initiative. Includes examples of lesson plans and activities from academic institutions that have integrated the USPSTF recommendations in their curricula.

<https://www.ahrq.gov/sites/default/files/wysiwyg/cpi/centers/ockt/kt/tools/impuspstf/impuspstf.pdf>

**Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives.** March of Dimes Foundation. 2010 report explores the elements that are essential to improving quality, safety and performance across the continuum of perinatal care. Includes chapter on preconception and interconception care (must create free registration to download report).

<https://www.prematurityprevention.org/>

Preconception Care webinars for Health Home Providers. New York State Department of Health. A series of webinars developed to address aspects of preconception health for Health Home providers working with women with multiple chronic medical and behavioral health conditions and care coordination needs. Includes a set of webinars specifically for women living with HIV.

- *Well Woman Care and Preconception Care: Webinar for Health Home Providers.* New York State Department of Health (October 2017). Addresses the importance of well woman and preconception care to prevent unintended pregnancy and improve pregnancy outcomes for women, including women with chronic medical issues.  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/webinars/docs/2017/2017-10-11\\_preconception\\_care\\_for\\_hhcm.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2017/2017-10-11_preconception_care_for_hhcm.pdf)
- *Preconception, Contraception and Conception for Women Living with HIV (WLWH): How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes.* (July 2018).  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/webinars/docs/2018/preconception\\_contraception\\_conception\\_for\\_wlwh\\_7\\_16\\_2018.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2018/preconception_contraception_conception_for_wlwh_7_16_2018.pdf)
- *Postpartum Care for Women Living with HIV (WLWH) and their Newborns: How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes.* (August 2018)  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/webinars/docs/2018/hh\\_webinar\\_pp\\_nb\\_bf\\_retention\\_8\\_15\\_2018.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2018/hh_webinar_pp_nb_bf_retention_8_15_2018.pdf)

Preconception Health is Essential Well Woman Care - Webinar. New York State Partnership for Maternal Health. (August 2018). Addresses preconception health as key component of preventing maternal morbidity and mortality. Health practitioners serving women of reproductive age will learn how to incorporate “every woman, every time” into their practice to improve women’s health and

birth outcomes. Link to archived webinar from this page (users will need to register first):

<https://www.health.ny.gov/community/adults/women/>

**Show Your Love Campaign.** Developed by the CDC’s National Preconception Health Consumer Workgroup. National campaign designed to improve the health of women and babies by promoting preconception health and healthcare. This evidence-based social marketing campaign is seeking to elevate preconception health to same level of awareness and significance as prenatal health. Includes links to an implementation tool kit and other resources.

[http://www.nationalhealthystart.org/what we do/show your love preconception social marketing campaign](http://www.nationalhealthystart.org/what_we_do/show_your_love_preconception_social_marketing_campaign)

## **Focus Area 1: Maternal and Women’s Health**

**Goal 1.2:** Reduce maternal mortality and morbidity

**Intervention 1.2.1: Systematically review maternal deaths and severe maternal morbidities and use results to inform maternal mortality and morbidity prevention efforts.**

### **Resources**

**New York State Maternal Mortality Review Report, 2012-13.** New York State Department of Health.

[https://www.health.ny.gov/community/adults/women/docs/maternal\\_mortality\\_review\\_2012-2013.pdf](https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_2012-2013.pdf)

**New York City, 2008-2012 Severe Maternal Morbidity.** (2016) New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health. Report focuses on severe maternal morbidity in New York City from 2008-2012. Report provides background information on SMM, highlights summary and detailed findings, and provides recommendations.

<https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>

**Pregnancy-Associated Mortality: New York City, 2006-2010.** New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant and Reproductive Health. Report provides estimates and examines characteristics and causes of death for women within one year of pregnancy in New York City from 2006-2010. <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf>

**Proceedings of the 2018 New York Maternal Mortality Summit.** February 14, 2018. This 2018 Summit convened stakeholders from New York State to: assess statewide progress in addressing maternal mortality; understand the factors in maternal health inequity; and discuss outstanding challenges to reducing maternal mortality, disparities, and strategies to address them. Convened by the New York Academy of Medicine with funding from Merck and Company and in collaboration with the New York State Department of Health, New York City Department of Health and Mental Hygiene, American College of Obstetricians and Gynecologists District II, Greater New York Hospital Association, and the

Healthcare Association of New York State. [https://nyam.org/media/filer\\_public/f3/be/f3beda7e-44d0-4a59-b403-80c980f33454/mm\\_summit\\_proceedings\\_final\\_062118.pdf](https://nyam.org/media/filer_public/f3/be/f3beda7e-44d0-4a59-b403-80c980f33454/mm_summit_proceedings_final_062118.pdf)

**Severe Maternal Morbidity in the United States.** Centers for Disease Control and Prevention. Includes an overview of the issue, summary national data trends, and links to lists of indicators and corresponding ICD codes used to identify SMM.

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

**Severe maternal morbidity: A population-based study of an expanded measure and associated factors.** 2017 study by Lazariu et al discusses identification and analysis of severe maternal morbidity cases in New York State. Identifying and analyzing SMM cases in New York State

<https://doi.org/10.1371/journal.pone.0182343>

**Severe Maternal Morbidity: Screening and Review.** American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. Obstetric Care Consensus. Outlines a two-step screen and review process intended to efficiently detect severe maternal morbidity in women and to ensure that each case undergoes a review to determine whether there were opportunities for improvement in care. <https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Severe-Maternal-Morbidity-Screening-and-Review>

## Focus Area 1: Maternal and Women’s Health

**Goal 1.2:** Reduce maternal mortality and morbidity

**Intervention 1.2.2:** 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.

### Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 2 (Low-Risk Cesarean Delivery) and NPM 3 (Perinatal Regionalization):

- **Evidence Analysis Reports.** Johns Hopkins University:
  - **NPM 2: Low-Risk Cesarean Deliveries** [https://www.mchevidence.org/documents/reviews/npm\\_2\\_low\\_risk\\_cesarean\\_delivery\\_evidence\\_review\\_brief\\_feb\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_2_low_risk_cesarean_delivery_evidence_review_brief_feb_2017.pdf)
  - **NPM 3: Risk-Appropriate Perinatal Care,** [https://www.mchevidence.org/documents/reviews/npm\\_3\\_riskappropriate\\_perinatal\\_care\\_brief\\_feb\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_3_riskappropriate_perinatal_care_brief_feb_2017.pdf)
- **Evidence Briefs.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University.
  - **Cesarean Births among Low Risk First Births** <https://www.ncemch.org/evidence/NPM-2-cesarean.php>
  - **Perinatal Regionalization** <https://www.ncemch.org/evidence/NPM-3-VLBW.php>

- **Title V Transformation Tools.**
  - **Recommendations to support NPM 2 – Low-risk Cesarean Delivery**  
<https://www.mchnavigator.org/transformation/npm-2.php>
  - **NPM3 – Perinatal Regionalization.** <https://www.mchnavigator.org/transformation/npm-3.php>

**Alliance for Innovation on Maternal Health (AIM).** Council on Patient Safety in Women's Health Care. AIM is a national alliance to promote consistent and safe maternity care to reduce maternal mortality and severe maternal morbidity funded through the federal Maternal and Child Health Bureau, AIM is a data-driven improvement initiative focusing on the use of best practice safety bundles for maternity care. <https://safehealthcareforeverywoman.org/aim-program/>

**Centering Pregnancy. Centering Healthcare Institute (2018).** Site provides information on the evidence-based Centering group prenatal care model, with a variety of implementation resources including an organizational readiness assessment tool, facilitator certification, technical assistance and implementation grants. <https://www.centeringhealthcare.org/what-we-do/centering-pregnancy>.

**Community Health Workers Toolkit.** Toolkit created by the NORC Walsh Center for Rural Health Analysis, University of Minnesota rural Health Resource Center, and Rural Health Information Hub. Designed to help rural communities evaluate opportunities for developing a CHW program and provide resources and best practices developed by successful CHW programs. Modules focus on different aspects of CHW programs, with resources for developing local CHW programs. <https://www.ruralhealthinfo.org/toolkits/community-health-workers>

**Cochrane Systematic Review: Continuous Support for Women During Childbirth.** Doulas are individuals who provide continuous physical, emotional, and informational support to women during pregnancy, childbirth, and/or postpartum periods. There are a number of organizations offering training, certification, and continuing education for doulas. A pilot of Medicaid coverage for doulas is an element of the New York State's maternal mortality reduction initiative. A 2017 review of 26 studies from 17 countries published in the Cochrane Database of Systemic Reviews concluded that women who received continuous labor during labor may be less likely to have cesarean births, use pain medications, have low Apgar scores at birth, and have negative feelings about childbirth, and more likely to have spontaneous vaginal deliveries. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003766.pub6/full?highlightAbstract=doul&highlightAbstract=doula>

**Home Visiting Evidence of Effectiveness (HomVee).** U.S. Department of Health and Human Services and Administration for Children and Families. Review of the home visiting research literature assessing the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5. Provides information about which home visiting program models have evidence of effectiveness, as well as detailed information about the samples of families who participated in the research, the outcomes measured in each study, and the implementation guidelines for each model. <https://homvee.acf.hhs.gov/>.

**Institute for the Advancement of Family Support Professionals.** Funded in part through a federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Innovation Grant, the Institute offers Family Support Professionals everywhere the opportunity to learn new skills and grow their careers. Through engaging, online modules and a personalized learning map feature, professionals take charge of their growth and advancement. <https://institutefsp.org/modules>

**Levels of Maternal Care.** Obstetric Care Consensus. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine (2016). Calls for standards and regionalized systems of maternal hospital care to reduce maternal morbidity and mortality. <https://www.acog.org/-/media/Obstetric-Care-Consensus-series/oc002.pdf?dmc=1&ts=20180802T1643258695>

**Maternal and Infant Community Health Collaboratives (MICHC) Initiative.** New York State Department of Health. The MICHC initiative addresses outcomes for women of reproductive age, infants, and families through a combination of individual, family, community, and organizational strategies, including Community Health Workers (CHWs). Site provides an overview of the MICHC initiative, link to on-line CHW training, and list of current projects. [https://www.health.ny.gov/community/adults/women/maternal\\_and\\_infant\\_comm\\_health\\_collaboratives.htm](https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm)

**New York State Home Visiting County Data Snapshots.** Schuyler Center for Analysis and Advocacy (SCAA). Snapshots for each county in New York State designed to illustrate current home visiting services and community needs that could be addressed through expansion of home visiting programs. <http://www.scaany.org/policy-areas/maternal-infant-and-early-childhood/numbers-tell-a-story-new-york-state-home-visiting-data-snapshots/>

**New York State's Home Visiting Programs: Support for Pregnant and Parenting Families.** New York State Department of Health. State website includes information for providers and families, including a searchable list of home visiting programs in New York State by county. [https://www.health.ny.gov/community/pregnancy/home\\_visiting\\_programs/](https://www.health.ny.gov/community/pregnancy/home_visiting_programs/)

**New York State Perinatal Quality Collaborative (NYSPQC).** New York State Department of Health. Site includes materials, reports, archived presentations, and other resources from multiple NYSPQC quality improvement projects related to improving pregnancy outcomes for women and infants. [https://www.albany.edu/sph/cphce/mch\\_nyspqc.shtml](https://www.albany.edu/sph/cphce/mch_nyspqc.shtml).

**Remote Pregnancy Monitoring Challenge.** Sponsored by the federal Maternal and Child Health Bureau, this challenge will support the development and testing of low-cost, scalable, technology-based innovations to help prenatal care providers remotely monitor the health and well-being of pregnant women, and to place health data into the hands of pregnant women as a tool to monitor their own health and make informed decisions about care. The design phase for this challenge will launch in September 2018, with subsequent development, small-scale testing, and scaling phases through Winter 2019. <https://mchbgrandchallenges.hrsa.gov/challenges/remote-pregnancy-monitoring>

**Safe Motherhood Initiative (SMI).** American College of Obstetricians and Gynecologists (ACOG) District II, New York State. Collaborative initiative to develop and implement standard approaches for handling obstetric emergencies associated with maternal mortality and morbidity. Focuses on the three leading causes of maternal death – obstetric hemorrhage (severe bleeding), venous thromboembolism (blood clots), and severe hypertension in pregnancy (high blood pressure). Site includes information, patient materials, clinician tools, and other resources. <https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Safe-Motherhood-Initiative>

**Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives.** March of Dimes Foundation. 2010 report explores the elements that are essential to improving quality, safety and performance across the continuum of perinatal care (must create free registration to download report). <https://www.prematurityprevention.org/>

**Training Modules for Community Health Workers.** Six modules provide introductory training for community health workers on maternal and child health information, resources and strategies. Four webinars are also available for supervising community health workers. [https://www.health.ny.gov/community/adults/women/chw\\_training/](https://www.health.ny.gov/community/adults/women/chw_training/)

## Focus Area 1: Maternal and Women’s Health

**Goal 1.2:** Reduce maternal mortality and morbidity

**Intervention 1.2.3:** Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.

### Resources

**6 | 18 Initiative: Prevent Unintended Pregnancy.** Centers for Disease Control and Prevention (CDC). Information on national initiative led by CDC to target unintended pregnancies as one of six common and costly health conditions through the expansion of 18 initial evidence-based interventions to engage purchasers, payers, and providers in improving health outcomes and controlling health costs. Includes information and resource links for three specific evidence-based interventions related to reimbursement for contraceptives, including LARC. <https://www.cdc.gov/sixteen/pregnancy/index.htm>

**Bedsider.** A non-profit organization and web-based resource providing in-depth information, decision and reminder tools, and other resources related to contraception for consumers. <https://www.bedsider.org>. Companion site for providers <https://providers.bedsider.org> provides contraception information and tools for health care providers.

**Increasing Access to Contraception.** Association of State and Territorial Health Officials (ASTHO). Information, tools, and resources to drive the work of states and territories to increase access to contraception. Includes links to ROI calculation and monitoring tools, fact sheets, recorded

presentations, and publications. <http://www.astho.org/Maternal-and-Child-Health/Increasing-Access-to-Contraception-Resources-from-States-Partners-and-ASTHO/>

**Know Your Options, Get the Facts.** New York State initiative to connect women with comprehensive family planning services delivered by quality health care providers licensed to practice in NYS and meeting high standards of care for the NYS Family Planning Program. Information and links for consumers on contraception, preconception care, infertility services, and pregnancy options including prenatal care, adoption, and abortion services. <https://www.ny.gov/programs/pregnancy-know-your-options-get-facts>

**Long-Acting Reversible Contraception (LARC) Program.** American College of Obstetricians and Gynecologists (ACOG). ACOG's LARC Program works to lower the unintended pregnancy rate in the US by connecting providers, patients, and the public with the most up-to-date information and resources on LARC methods and increasing access to the full range of contraceptive methods.

- **National ACOG LARC Program:** Comprehensive site includes clinical guidelines, education, and training resources; billing, coding, and reimbursement guidance; a technical assistance “help desk”; patient resources; and more. <https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception>
- **New York State (ACOG District II) LARC Program:** Site includes information on LARC methods, clinical practice considerations, insertion considerations, and system and reimbursement barriers, along with complex case studies to test providers' knowledge. Links to patient education materials and waiting room posters, fact sheets, quick guides, and other practical resources for providers. <https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Long-Acting-Reversible-Contraception-LARC>
- **ACOG District II LARC Resource Summary:** 2-page resource document includes links to multiple ACOG and other organizational resources and sites for LARC. [https://www.acog.org/-/media/Districts/District-II/Public/PDFs/FINAL\\_LARC\\_RESOURCE\\_SUMMARY\\_Web\\_2Updated\\_July\\_2018.pdf?dmc=1&ts=20180909T1118306705](https://www.acog.org/-/media/Districts/District-II/Public/PDFs/FINAL_LARC_RESOURCE_SUMMARY_Web_2Updated_July_2018.pdf?dmc=1&ts=20180909T1118306705)

Medicaid Coverage of Long-Acting Reversible Contraception. Key resources for Medicaid providers related to coverage and reimbursement for LARC, including updates to carve-out LARC from FQHC prospective payment system (PPS) rates and unbundle payment for post-partum LARC from inpatient delivery rates.

- **Medicaid Update** (September 2016): [https://www.health.ny.gov/health\\_care/medicaid/program/update/2016/2016-09.htm#larc\\_coverage](https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-09.htm#larc_coverage)
- **eMedNY reimbursement guidance for physicians** (May 2014): [https://www.emedny.org/listserv/physician/physician\\_reimbursement\\_for\\_larc\\_provided\\_as\\_a](https://www.emedny.org/listserv/physician/physician_reimbursement_for_larc_provided_as_a)

[n\\_inpatient\\_post-partum\\_service\\_05-28-14.pdf](#)

New York State Family Planning Training Center. JSI Research and Training Institute, Inc. (2018). New York State Department of Health-funded training center to support family planning providers to deliver quality reproductive health services across New York State. Website includes training, events, and wide array of provider resources. <https://nysfptraining.org>

**One Key Question®.** A strategic initiative developed by the [Power to Decide](#) to transform women's health care experience with a routine question: *"would you like to become pregnant in the next year?"* Site offers information about consulting services, training, and technical assistance for provider networks and community organizations interested in becoming certified as One Key Question® providers or institutions. <https://powertodecide.org/select360-consulting>

**Power to Decide** (formerly the National Campaign to Prevent Teen and Unplanned Pregnancy). A public, nonprofit and nonpartisan organization and national campaign to prevent unplanned pregnancy. Website offers variety of information, resources, and services for health care providers, organizations, and consumers related to pregnancy prevention methods, programs, and policies. <https://powertodecide.org/>

## Focus Area 1: Maternal and Women's Health

**Goal 1.2:** Reduce maternal mortality and morbidity

**Intervention 1.2.4: Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.**

### Resources

**A Comprehensive Approach for Community-Based Programs to address Intimate Partner Violence and Perinatal Depression.** This toolkit was produced for the U.S. Department of Health and Human Services Health Resources and Services Administration by Social Solutions International, Inc. The goal of the toolkit is to highlight innovative state and community-based strategies and provide a resource that assists community-based organizations with addressing the intersection of intimate partner violence and perinatal depression. The target audience is community-based organizations working with women, children and families.

[https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthTopics/maternal-womens-health/A\\_COMPREHENSIVE\\_APPROACH\\_FOR\\_COMMUNITY-BASED\\_PROGRAMS\\_TO\\_ADDRESS\\_INTIMATE\\_PARTNER\\_VIOLENCE\\_AND\\_PERINATAL\\_DEPRESSION\\_JANUARY\\_2013\\_%281%29.pdf](https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthTopics/maternal-womens-health/A_COMPREHENSIVE_APPROACH_FOR_COMMUNITY-BASED_PROGRAMS_TO_ADDRESS_INTIMATE_PARTNER_VIOLENCE_AND_PERINATAL_DEPRESSION_JANUARY_2013_%281%29.pdf)

**Depression in Adults: Screening. United States Preventive Services Task Force (USPSTF)** (January 2016). Summarizes USPSTF evidence-based recommendation for depression screening in the general adult population, including pregnant and postpartum women, with adequate systems in place to

ensure accurate diagnosis, effective treatment, and appropriate follow up.

<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1>

**Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).** Multiyear initiative funded by federal Maternal and Child Health Bureau to improve early childhood service systems in 12 states, including New York State, to increase age-appropriate developmental skills and reduce developmental disparities among 3-year old children. *See also **Help Me Grow** resource.*

- **National ECCS CoIIN Coordinating Center** led by National Institute for Children’s Health Quality (NICHQ) supports state teams through quality improvement and innovation. Site includes information about the initiative, approach, and resources. <https://www.nichq.org/project/early-childhood-comprehensive-systems-collaborative-improvement-and-innovation-network-eccs>
- **New York State ECCS Impact Initiative** led by the NYS Council on Children and Families is working with community teams in Nassau County and Western New York. Site includes an overview of the NYS initiative and resources related to project implementation. <http://ccf.ny.gov/council-initiatives/early-childhood-comprehensive-systems-impact-initiative-eccs-impact/>

**Emergency Resources for Women in Crisis.** New York State Office of Mental Health. Includes suicide prevention and parental stress hot lines and a crisis text line. <https://omh.ny.gov/omhweb/maternal-depression/>

**First 1000 Days on Medicaid Initiative.** Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child’s first three years of development, and seeks to ensure that New York’s Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. [https://health.ny.gov/health\\_care/medicaid/redesign/first\\_1000.htm](https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm)

**Healthy Steps.** Evidence-based primary care program model that integrates child development professional (“specialist”) to primary care practice teams to enhance screening, family engagement and communication, and coordination of family support and follow up services.

- **National Healthy Steps** site includes an overview of the model and evidence base, materials for families, and resources for providers, including information on how to become a HealthySteps site. <https://www.healthysteps.org/>
- **New York Office of Mental Health Implementation of Healthy Steps** includes 2016 Request for Proposals to support implementation of Healthy Steps in primary care medical care practices across New York State. <https://omh.ny.gov/omhweb/rfp/2016/healthy-steps/>

**Help Me Grow.** A system model that works to promote cross-sector collaboration to build early childhood systems that mitigate the impact of adversity and support protective factors among families, so that all children can grow, develop, and thrive to their full potential. Help Me Grow is not a stand-alone program, but a system model that leverages and builds on programs and resources already in place to develop and enhance early childhood system building in any given community. Core components of the model include Centralized Access Point, Family & Community Outreach, Child Health Care Provider Outreach, and Data Collection.

- **Help Me Grow National Center** site includes information on the model and the role of the national center to support local programs, links to its affiliate network of local programs, and other resources. <https://helpmegrownational.org/>
- **Help Me Grow New York** includes information on Western New York and Long Island Help Me Grow networks, partners, events, and other resources. <http://helpmegrownny.org/> See also *ECCS Impact Initiative resource*.

**Maternal Depression: Information for Health Care Providers.** New York State Department of Health. Includes information on maternal depression, overview and links to screening recommendations and tools, treatment guidelines, links to implementation toolkits, and additional national and state resources for providers and families. [https://www.health.ny.gov/community/pregnancy/health\\_care/perinatal/maternal\\_depression/providers/](https://www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_depression/providers/)

**Medicaid Update: NYS Medicaid Coverage of Postpartum Maternal Depression Screening.** New York State Department of Health. (July 2015). Provides guidance on billing for postpartum screening reimbursement effective August 2015. [https://www.health.ny.gov/health\\_care/medicaid/program/update/2015/2015-07.htm#pmd](https://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-07.htm#pmd)

**Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders.** The Guide to Community Preventive Services. Community Preventive Services Task Force (CPSTF). June 2010. <https://www.thecommunityguide.org/findings/mental-health-and-mental-illness-collaborative-care-management-depressive-disorders>

**Mom's Mental Health Matters.** National Child & Maternal Health Education Program, *Eunice Kennedy Shriver* National Institute of Child Health and Human Development. Information for women and their partners, family, and friends related to depression and anxiety around pregnancy. <https://www1.nichd.nih.gov/ncmhpep/initiatives/moms-mental-health-matters/moms/Pages/default.aspx>

**Paid Family Leave.** Research studies have shown that new mothers who take paid leave have fewer postpartum depression symptoms, higher rates of breastfeeding, less stress, and stronger parent-child bonding. Website includes information on New York State's Paid Family Leave law and benefits to support bonding with a new child. <https://paidfamilyleave.ny.gov/>

**Postpartum Depression Toolkit.** American Academy of Family Physicians National Research Network. Site includes documents, slide sets, clinical tools for screening and follow up, and other resources used as part of the Translating Screening and Management of Postpartum Depression (TRIPPD) study. The TRIPPD study (2005-2010) was designed to assess the impact of a universal postpartum depression (PPD) screening and follow-up management program on patient-oriented outcomes and practice-based process measures associated with PPD, and to explore the impact of practice characteristics on the translation of research regarding a PPD screening and follow-up management program. <https://www.aafp.org/patient-care/nrn/studies/all/trippd/ppd-toolkit.html>

**Postpartum Resource Center of New York.** The Postpartum Resource Center of New York offers support and education around perinatal mood and anxiety disorders for individuals and health care providers. Site includes a searchable statewide resource directory. <https://postpartumny.org/>

## Focus area 2: Perinatal & Infant Health

**Goal 2.1:** Reduce infant mortality and morbidity

**Intervention 2.1.1: Implement updated perinatal regionalization standards, designations, and structured clinical quality improvement initiatives in birthing hospitals**

### Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) NPM 3: Perinatal Regionalization:

- **Evidence Analysis Report. NPM 3: Risk-Appropriate Perinatal Care**, Johns Hopkins University. [https://www.mchevidence.org/documents/reviews/npm\\_3\\_riskappropriate\\_perinatal\\_care\\_brief\\_feb\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_3_riskappropriate_perinatal_care_brief_feb_2017.pdf)
- **Evidence Brief. Perinatal Regionalization.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-3-VLBW.php>
- **Title V Transformation Tools.** Recommendations to support NPM3 – Perinatal Regionalization. <https://www.mchnavigator.org/transformation/npm-3.php>

**Levels of Maternal Care.** Obstetric Care Consensus. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. Statement adopted in 2015 and reaffirmed in 2016 calling for standards and regionalized systems of maternal hospital care to reduce maternal morbidity and mortality. <https://www.acog.org/-/media/Obstetric-Care-Consensus-series/oc002.pdf?dmc=1&ts=20180802T1643258695>

**Levels of Neonatal Care Policy Statement.** American Academy of Pediatrics Committee on Fetus and Newborn. (2012). Update policy statement summarizing review of data supporting evidence for a

tiered provision of care and reaffirming the need for uniform definitions and standards of care and designation of facilities that provide hospital care for newborns on the basis of functional capabilities, organized within a regionalized system of perinatal care.

<http://pediatrics.aappublications.org/content/130/3/587.full>

New York State Perinatal Quality Collaborative (NYSPQC). New York State Department of Health. Site includes materials, reports, archived presentations, and other resources from multiple NYSPQC quality improvement projects related to improving pregnancy outcomes for women and infants.

[https://www.albany.edu/sph/cphce/mch\\_nyspgc.shtml](https://www.albany.edu/sph/cphce/mch_nyspgc.shtml).

**Perinatal Regionalization. New York State Department of Health.** Site includes overview of the state’s regionalized perinatal system and materials related to process launched in 2017 review and update the standards for perinatal hospital level requirements, conduct site visits, assign new designations, and development of performance measures for perinatal hospitals and birthing centers in New York State.

[https://www.health.ny.gov/community/pregnancy/health\\_care/perinatal/regionalization\\_descrip.htm](https://www.health.ny.gov/community/pregnancy/health_care/perinatal/regionalization_descrip.htm)

**Toward Improving the Outcome of Pregnancy III: Enhancing Perinatal Health Through Quality, Safety and Performance Initiatives.** March of Dimes Foundation. 2010 report explores the elements that are essential to improving quality, safety and performance across the continuum of perinatal care (must create free registration to download report). <https://www.prematurityprevention.org/>

## Focus Area 2: Perinatal & Infant Health

**Goal 2.1:** Reduce infant mortality and morbidity

**Intervention 2.1.2:** Increase capacity and competencies of local maternal and infant home visiting programs

### Resources

**Community Health Workers Toolkit.** NORC Walsh Center for Rural Health Analysis, University of Minnesota rural Health Resource Center, and Rural Health Information Hub. Designed to help rural communities evaluate opportunities for developing a CHW program and provide resources and best practices developed by successful CHW programs. Modules focus on different aspects of CHW programs and include resources for developing local CHW programs.

<https://www.ruralhealthinfo.org/toolkits/community-health-workers>

**Doula Support.** Doulas are individuals who provide continuous physical, emotional, and informational support to women during pregnancy, childbirth, and/or postpartum periods. There are a number of organizations offering training, certification, and continuing education for doulas. A pilot of Medicaid coverage for doulas is an element of the state’s maternal mortality reduction initiative. A 2017 review of 26 studies from 17 countries published in the Cochrane Database of Systemic Reviews concluded

that women who received continuous labor during labor may be less likely to have cesarean births, use pain medications, have low Apgar scores at birth, and have negative feelings about childbirth, and more likely to have spontaneous vaginal deliveries.

<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003766.pub6/full#CD003766-sec1-0001>

**First 1000 Days on Medicaid Initiative.** Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child's first three years of development and seeks to ensure that New York's Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. [https://health.ny.gov/health\\_care/medicaid/redesign/first\\_1000.htm](https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm)

**Home Visiting Evidence of Effectiveness (HomVee).** *U.S. Department of Health and Human Services and Administration for Children and Families.* Review of the home visiting research literature assessing the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5. Provides information about which home visiting program models have evidence of effectiveness, as well as detailed information about the samples of families who participated in the research, the outcomes measured in each study, and the implementation guidelines for each model. <https://homvee.acf.hhs.gov/>.

**Home Visiting Collaborative Improvement and Innovation Network (CoIIN).** A national quality improvement initiative launched in 2013 to support the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Specific areas for improvement include breastfeeding, developmental assessments and interventions, screening and follow up for maternal depression, and retention of enrolled families. Site includes links to toolkits developed for each area. <http://hv-coiin.edc.org/>

**Home Visiting – Your Partner in Helping Families.** New York State Department of Health and University at Albany School of Public Health Center for Public Health Continuing Education. (April 2018). Webcast for health care providers, local public health professionals, and local community-based agencies working with families discusses the benefits of home visiting to the clients and to referring agencies, including improved adherence to immunization schedules, reinforcement of health messages delivered during pregnancy and early childhood, and screening for maternal depression and child developmental delays. Archived at: [https://www.albany.edu/sph/cphce/phl\\_0418.shtml](https://www.albany.edu/sph/cphce/phl_0418.shtml)

**Home is where the Start Is: Expanding Home Visiting to Strengthen All of New York's Families.** Schuyler Center for Analysis and Advocacy (SCAA). 2016 report describes the benefits of home visiting, evidence-based and evidence-informed programs currently operating in New York State, and recommendations for expanding maternal, infant and early childhood home visiting in the state. [http://www.scaany.org/wp-content/uploads/2016/08/Home\\_Is\\_Where\\_the\\_Start\\_Is-Expanding\\_HV-06-2016.pdf](http://www.scaany.org/wp-content/uploads/2016/08/Home_Is_Where_the_Start_Is-Expanding_HV-06-2016.pdf)

**Institute for the Advancement of Family Support Professionals.** The Institute offers Family Support Professionals everywhere the opportunity to learn new skills and grow their careers. Through engaging, online modules and a personalized learning map feature, professionals take charge of their growth and advancement. <https://institutefsp.org/modules>

**New York State Home Visiting County Data Snapshots.** Schuyler Center for Analysis and Advocacy (SCAA). Snapshots for each county in New York State designed to illustrate current home visiting services and community needs that could be addressed through expansion of home visiting programs. <http://www.scaany.org/policy-areas/maternal-infant-and-early-childhood/numbers-tell-a-story-new-york-state-home-visiting-data-snapshots/>

**New York State’s Home Visiting Programs: Support for Pregnant and Parenting Families.** New York State Department of Health. State website includes information for providers and families, including a searchable list of home visiting programs in New York State by county. [https://www.health.ny.gov/community/pregnancy/home\\_visiting\\_programs/](https://www.health.ny.gov/community/pregnancy/home_visiting_programs/)

**Training Modules for Community Health Workers.** Six modules provide introductory training for community health workers on maternal and child health information, resources and strategies. Four webinars are also available for supervising community health workers. [https://www.health.ny.gov/community/adults/women/chw\\_training/](https://www.health.ny.gov/community/adults/women/chw_training/)

## Focus Area 2: Perinatal & Infant Health

**Goal 2.1:** Reduce infant mortality and morbidity

**Intervention 2.1.3: Engage in collaborative clinical and community-based strategies to reduce sleep-related infant deaths.**

### Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 4: Safe Sleep:

- **Evidence Analysis Report. NPM 4: Safe Sleep,** Johns Hopkins University. [https://www.mchevidence.org/documents/reviews/npm\\_5\\_safe\\_sleep\\_evidence\\_review\\_brief\\_feb\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_5_safe_sleep_evidence_review_brief_feb_2017.pdf)
- **Evidence Brief. Safe sleep.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-5-safe-sleep.php>
- **Title V Transformation Tools.** Skills and knowledge recommendations for the MCH workforce to support NPM5 – Safe Sleep. <https://www.mchnavigator.org/transformation/npm-5.php>

**Building Integrated Systems for Address Sudden Unexpected Infant Death.** National Center for Cultural Competence, Georgetown University [https://nccc.georgetown.edu/documents/MI\\_BL.pdf](https://nccc.georgetown.edu/documents/MI_BL.pdf)

**Caring for our Children - National Health and Safety Performance Standards for Early Care and Education Programs – Safe Sleep.** Health and safety standards on sleep safety in out of home child care settings developed by the American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education, in consultation with panels of experts. <http://nrckids.org/CFOC/Database/3.1.4.1>

**Collaborative Improvement and Innovation Network to Reduce Infant Mortality (CoIIN).** A public-private partnership developed by the Maternal and Child Health Bureau to reduce infant mortality and improve birth outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks. Site includes information on Infant Mortality CoIIN and link to an interactive [infant mortality prevention toolkit](#). Promoting infant safe sleep practices is one of five priorities selected by CoIIN participants.

<https://mchb.hrsa.gov/maternal-child-health-initiatives/collaborative-improvement-innovation-networks-coiins>

**National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN).** Funded by the federal Maternal and Child Health Bureau and based at the National Institute for Children's Health Quality (NICHQ). (2017-2022). NAPPSS-IIN is an initiative to make infant safe sleep and breastfeeding the national norm by aligning stakeholders to test safety bundles in multiple care settings to improve the likelihood that infant caregivers and families receive consistent, evidence-based instruction about safe sleep and breastfeeding. The project is currently working with five pilot hospitals in five states, including New York Presbyterian Lawrence Hospital in Westchester County representing New York State. Site includes information and tools related to the project.

<https://www.nichq.org/project/national-action-partnership-promote-safe-sleep-improvement-and-innovation-network-nappss>

**New York State Perinatal Quality Collaborative (NYSPQC).** New York State Department of Health. Site includes materials, reports, archived presentations, and other resources from multiple NYSPQC quality improvement projects related to improving pregnancy outcomes for women and infants.

[https://www.albany.edu/sph/cphce/mch\\_nyspqc.shtml](https://www.albany.edu/sph/cphce/mch_nyspqc.shtml).

**Psychosocial interventions for supporting women to stop smoking in pregnancy (2017).** Systematic review of interventions from Cochrane Database. <http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD001055.pub5/full>

**Safe to Sleep Campaign®.** Directed and managed by the National Institute of Child Health and Human Development. National campaign aimed at health professionals, child care providers, and families about ways to reduce the risk for SIDS and other sleep-related causes of infant death. Includes outreach materials in English and Spanish and online curricula for nurses and pharmacists. Includes

information about outreach activities in specific communities informed by research and experience.  
<https://www1.nichd.nih.gov/sts/Pages/default.aspx>

**SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment.** American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome 2011 policy statement on safe sleep.  
<http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284>

**Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS) Gateway.** National Center for Education in Maternal and Child Health, Georgetown University. Resources for states, communities, health and social services professionals, child care providers, and families to reduce SUID and SIDS, promote healthy outcomes, and cope with grief when losses occur. Resources related to infant sleep environments include a resource page, training toolkit, infant safe sleep campaigns and materials, resources to support AAP's policy statement on SIDS and other sleep-related infant deaths, and other implementation support materials. <https://www.ncemch.org/suid-sids/index.php>

**Toolkit for community health providers: Engaging ethnic media to inform communities about safe infant sleep.** National Center for Cultural Competence, Georgetown University.  
<https://nccc.georgetown.edu/engaging-ethnic-media/Engaging-Ethnic-Media.pdf>

## **Focus Area 2: Perinatal & Infant Health**

**Goal 2.1:** Reduce infant mortality and morbidity

**Intervention 2.1.4:** Engage in collaborative strategies to respond to increasing use of opioids among women, including pregnant women, and impact on infants.

### **Resources**

**A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders.** Substance Abuse and Mental Health Service Administration (SAMHSA). 2016. Manual offers best practices to states, tribes, and local communities on collaborative treatment approaches for pregnant women living with opioid use disorders, and the risks and benefits associated with medication-assisted treatment. [https://ncsacw.samhsa.gov/files/Collaborative\\_Approach\\_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)

**Combating the Heroin and Opioid Crisis: Heroin and Opioid Task Force Report** (June 2016). Report of NYS Task Force, informed by series of statewide listening sessions and other public input. Provides recommendations in four areas: Prevention, Treatment, Recovery, and Enforcement.  
[https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/HeroinTaskForceReport\\_3.pdf](https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/HeroinTaskForceReport_3.pdf).

**Institute for Research, Education and Training in Addictions (IRETA).** Non-profit organization that works with national, state, and local partners to improve recognition, prevention, treatment, research,

and policy related to addiction and recovery. Includes evidence-based and best practice resources for the substance abuse field including descriptions of intervention implementation, technical assistance resources, information on fidelity measurement and staff training, and evidence-based practice references. <https://ireta.org/>

**National Collaborative for Maternal Opioid Use Disorders.** Alliance for Innovation on Maternal Health. As part of the larger AIM initiative (see Intervention 1.2.3), this collaborative seeks to optimize the care of mothers with opioid use disorder and their infants during the prenatal and postpartum periods through improvements to care in hospitals, outpatient settings, and in the community. Includes a number of clinical and quality improvement resources.

<https://safehealthcareforeverywoman.org/national-collaborative-on-maternal-oud/>

**National Registry of Evidence-Based Programs and Practices (NREPP).** Substance Abuse and Mental Health Services Administration (SAMHSA). Developed to increase awareness and promote the adoption of scientifically established behavioral health interventions. Site includes a searchable database of interventions and a learning center with resources to support the selection, adoption, implementation, and evaluation of evidence-based programs and practices.

<https://www.samhsa.gov/nrepp>

**New York State Opioid Overdose Prevention Program.** New York State Department of Health to support community programs for administration of Naloxone to prevent opioid overdose fatalities. Includes information on registration, resources for providers and the public, program locator, and calendar of training events. <https://www.nyoverdose.org/>

**Opioid Addiction Prevention & Management Collaborative.** Health Care Association of New York State (HANYS). Statewide collaborative launched by HANYS to help members prevent opioid addiction and manage the care of patients in crisis. Includes education, networking opportunities, and resources for health care providers and to advance community dialogue around opioid addiction.

[https://www.hanys.org/quality/collaboratives\\_and\\_learning\\_networks/opioids/](https://www.hanys.org/quality/collaboratives_and_learning_networks/opioids/)

**Opioid-related Data in New York State.** New York State Department of Health (2018). website designed to provide comprehensive and useful data and information regarding opioid use and misuse to support statewide prevention efforts. Site provides the most up-to-date summary opioid summary reports as well as prescription monitoring program, overdose death, hospital and emergency department visits, and other data at state, regional, and county level where available.

<https://www.health.ny.gov/statistics/opioid/>

**Preventing Opioid Misuse in Pregnant Women and New Moms Challenge.** Sponsored by the federal Maternal and Child Health Bureau, this challenge will support the development and testing of low-cost, scalable, technology-based innovations to improve access to quality health care, including substance use disorder (SUD) treatment, recovery, and support services for pregnant women with opioid use disorders (OUD), their infants, and families, especially those in rural and geographically isolated areas. The design phase for this challenge will launch in September 2018, with subsequent development, small-scale testing, and scaling phases through Winter 2019.

<https://mchbgrandchallenges.hrsa.gov/challenges/addressing-opioid-use-disorder-pregnant-women-and-new-moms>

**Treating Opioid Use Disorder During Pregnancy.** National Institutes of Health (NIH) National Institute on Drug Abuse (NIDA). July 2017. Brief provides overview of risk of opioid use during pregnancy, evidence-based treatment options including considerations for breastfeeding, and considerations for improving engagement in treatment, with links to additional citations and resources.

<https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy>

## **Focus Area 2: Perinatal & Infant Health**

**Goal 2.2:** Increase breastfeeding

**Intervention 2.2.1:** Increase access to professional support, peer support, and formal education to change behavior and outcomes.

### **Resources**

#### **Evidence base:**

Cochrane Systematic Review (2016). [Interventions for Promoting the Initiation of Breastfeeding](#)

U.S. Preventive Services Task Force (2008). [Primary Care Interventions to Promote Breastfeeding](#)

U.S. Preventive Services Task Force (2016). [Primary Care interventions to Support Breastfeeding Recommendation Statement](#) and [Breastfeeding: Primary Care interventions](#)

AHRQ (2007). [Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries](#)

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

#### **Implementation Resources:**

U.S. Department of Agriculture (2018). [Partnering with WIC to Support Breastfeeding](#)

United States Breastfeeding Committee (2010). [Core Competencies in Breastfeeding Care and Services for All Health Professionals](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 1, 2,3, 8 and 9: pgs. 38-40, 45-47).

Hannula L, Kaunonen M, Tarkka MT. [A Systematic Review of Professional Support Interventions for Breastfeeding](#). *J Clin Nurs*. 2008;17(9):1132-1143.

Evans A, Marinelli KA, Taylor JS and The Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: “The Going Home Protocol,” Revised 2014](#) doi: 10.1089/bfm.2014.9996.

**Evaluation Resources:**

New York State Department of Health. [Women, Infants, and Children \(WIC\) Program Site Information Dataset](#)

New York State Department of Health. [Breastfeeding Friendly Practices by County](#)

Baby-Friendly USA. [Designated Facilities by State](#)

**Focus Area 2: Perinatal & Infant Health**

**Goal 2.2:** Increase breastfeeding

**Intervention 2.2.2:** Promote and implement maternity care practices consistent with the Baby Friendly Hospital Initiative - Ten Steps to Successful Breastfeeding.

*Resources*

**Evidence base:**

World Health Organization (1998). [Evidence for the Ten Steps to Successful Breastfeeding](#)

World Health Organization (2018). Revised Baby-Friendly Hospital Initiative [Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services](#)

**Implementation Resources:**

Baby-Friendly USA, Inc. (2016). [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)

Baby-Friendly USA, Inc. Final Report (2004). [Overcoming Barriers to Implementing The Ten Steps to Successful Breastfeeding](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#). Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 7: pg. 44).

United States Lactation Consultant Association (2010). [International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting](#)

Nickel NC, Labbok MH, Hudgens MG, Daniels JL. [The Extent that Noncompliance with the Ten Steps to Successful Breastfeeding Influences Breastfeeding Duration](#)

J Hum Lact 2013;29(1): 59-70.

**Evaluation Resources:**

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#)

## Focus Area 2: Perinatal & Infant Health

**Goal 2.2:** Increase breastfeeding

**Intervention 2.2.3:** Promote and implement early skin-to-skin contact in hospitals

### Resources

#### Evidence base:

Cochrane Systematic Review (2016). [Early Skin-to-Skin Contact for Mothers and Their Health Newborn Infants](#)

#### Implementation Resources:

Hung KJ & Berg O. [Early Skin-To-Skin after Cesarean to Improve Breastfeeding](#) MCN 2011;36(5):318-324.

Feldman-Winter L, Goldsmith JP, Committee on Fetus and Newborn, Task Force on Sudden Infant Death Syndrome. American Academy of Pediatrics (AAP). [Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns](#) Pediatrics 2016;138(3):e1-e10.

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). [Immediate and Sustained Skin-to-Skin Contact for the Healthy Term Newborn After Birth](#)

AWHONN Practice Brief Number 5. JOGNN 2016;45:842-844.

United States Institute for Kangaroo Care. [Kangaroo Care Resources](#)

Centers for Disease Control and Prevention (CDC), Division of Nutrition, Physical Activity, and Obesity (2015). [Maternity Practices in Infant Nutrition & Care \(mPINC\) Survey](#)

American Congress of Obstetricians and Gynecologists (ACOG). [Optimizing Support for Breastfeeding as Part of Obstetric Practice](#) Committee Opinion No. 658. Obstet Gynecol 2016;127:e86-92.

Baby-Friendly USA, Inc. [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#) 2016 Edition, Updated 06/30/16.

Rosen-Carole C, Hartman S and The Academy of Breastfeeding Medicine. [ABM Clinical Protocol #19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015](#)

#### Evaluation Resources:

Baby-Friendly USA, Inc. (2016).

- [The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation](#)
- [Baby-Friendly Hospital Initiative: Facility Self-Appraisal Tool](#)
- [Designated Facilities by State](#)

Centers for Disease Control and Prevention (2015). [Maternity Practices in Infant Nutrition and Care \(mPINC\) Survey](#); questions A4, A5, A10, A11

## **Focus Area 2: Perinatal & Infant Health**

**Goal 2.2:** Increase breastfeeding

**Intervention 2.2.4:** Increase access to primary care practices that are supportive of breastfeeding.

### **Resources**

#### **Evidence base:**

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

#### **Implementation Resources:**

The Academy of Breastfeeding Medicine Protocol Committee. ABM Clinical Protocol #14: [Breastfeeding Friendly Physician's Office](#), Part 1: Optimizing care for infants and children, Revised 2013. *Breastfeeding Med* 2006;1(2):115-119.

Shariff F, Levitt C, Kaczorowski J, et al. Workshop to implement the [Baby Friendly Office](#) initiative. Effect on community physicians' offices. *Can Fam Physician* 2000;46:1090-1097.

The American Academy of Pediatrics, Breastfeeding Initiatives. [How to Have a Breastfeeding Friendly Practice](#)

New York State Department of Health. [Breastfeeding Friendly Practice Designation](#)

#### **Evaluation Resources:**

New York State Department of Health.

- [NYS Breastfeeding Friendly Practice Designation Assessment Survey](#)
- [Breastfeeding Friendly Practices by County](#)

## Focus Area 2: Perinatal & Infant Health

**Goal 2.2:** Increase breastfeeding

**Intervention 2.2.5:** Increase access to community-based interventions that provide mothers with peer support via home visits in the prenatal and early postpartum period.

### Resources

#### Evidence base:

AHRQ: Breastfeeding Programs and Policies, Breastfeeding Uptake, and Maternal Health Outcomes in Developed Countries (2018). [Full Report](#) and [Evidence Summary](#)

Cochrane Systematic Review (2017). [Schedules for Home Visits in the Early Postpartum Period](#)

U.S. Department of Health and Human Services. [Home Visiting Evidence of Effectiveness](#)

#### Implementation Resources:

Centers for Disease Control and Prevention (2005). Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to Breastfeeding interventions Atlanta: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 4 and 8: pgs. 41 and 45).

New York State Department of Health. [Find a Home Visiting Program](#)

#### Evaluation Resources:

New York State Department of Health. [List of Home Visiting Programs in NYS](#)

## Focus Area 2: Perinatal & Infant Health

**Goal 2.2:** Increase breastfeeding

## **Intervention 2.2.6: Increase support for breastfeeding in the workplace.**

### **Resources**

#### **Evidence base:**

Dinour L, Szaro J. Employer-Based Programs to Support Breastfeeding Among Working Mothers: A Systematic Review. *Breastfeeding Medicine* 2017;12(3).

#### **Implementation Resources:**

New York State Department of Labor. [NYS Nursing Mothers in the Workplace Act](#)

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services (Strategy 5: Support for Breastfeeding in the Workplace pg. 23 - 28)

U.S. Department of Health and Human Services (2011). [The Surgeon General's Call to Action to Support Breastfeeding](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 13: pg. 50).  
[Making It Work Toolkit](#)

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2008). [Business Case for Breastfeeding](#)

New York City Department of Health, Center for Health Equity (2018). [Breastfeeding Toolkit for Business Owners](#)

Niagara County Breastfeeding Friendly Employer Initiative  
<http://www.niagaracounty.com/health/Services/Lactation-and-Breastfeeding>

#### **Evaluation Resources:**

Centers for Disease Control and Prevention (2014). [The CDC Worksite Health Score Card: An Assessment Tool for Employers to Prevent Heart Disease, Stroke, & Related Health Conditions](#) Lactation Support Module (6 questions); page 21

Niagara County Department of Health. [Breastfeeding Friendly Workplace Assessment](#)

New York State Department of Health. Contact [promotebreastfeeding@health.ny.gov](mailto:promotebreastfeeding@health.ny.gov) for an additional worksite assessment tool

## **Focus Area 2: Perinatal & Infant Health**

**Goal 2.2:** Increase breastfeeding

**Intervention 2.2.7:** Increase access to Early Care and Education programs that support breastfeeding families.

**Resources**

**Evidence base:**

Batan M, Li R, Scanlon K. [Association of child care providers breastfeeding support with breastfeeding duration at 6 months](#). Maternal Child Health J. 2012 doi: 10.1007/s10995-012-1050-7.

**Implementation Resources:**

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services. (Strategy 6: Support for Breastfeeding in the Early Care and Education pg. 29 – 32)

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd Edition. Also available at <http://nrckids.org>

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding](#). Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Action 16: pg. 53).

[Caring for our children: National health and safety performance standards; Guidelines for early care and education programs](#). Chapter 4: Nutrition and Food Service, 4.3.1 Nutrition for Infant (pp. 162-173).

New York State Department of Health. [CACFP Breastfeeding Friendly Child Care Designation Program](#)

**Evaluation Resources:**

New York State Department of Health.

- [Child Care Center Breastfeeding Friendly Self-Assessment](#)
- [Day Care Home Breastfeeding Friendly Self-Assessment](#)
- [Day Care Home Breastfeeding Friendly Self-Assessment Spanish](#)
- [Breastfeeding Friendly Child Care Centers by County](#)
- [Breastfeeding Friendly Child Care Homes by County](#)

**Focus Area 2: Perinatal & Infant Health**

**Goal 2.2:** Increase breastfeeding

**Intervention 2.2.8:** 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.

**Resources**

**Evidence base:**

Fox, Rebekah & McMullen, Sarah & Newburn, Mary. (2015). [UK women’s experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services.](#) BMC Pregnancy and Childbirth. 15:147. DOI 10.1186/s12884-015-0581-5.

**Implementation Resources:**

Evans, Marinelli, Taylor, Academy of Breastfeeding Medicine (2014). [ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: “The Going Home Protocol,” Revised 2014](#) Breastfeeding Med 2014; 9(1). DOI: 10.1089/bfm.2014.9996

U.S. Department of Health and Human Services (2011). [The Surgeon General’s Call to Action to Support Breastfeeding.](#) Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. (Actions 3 and 11: pgs. 40 and 48).

Centers for Disease Control and Prevention (2013). [Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies](#) Atlanta: U.S. Department of Health and Human Services.

Baby Café USA: <http://www.babycafeusa.org/>

**Evaluation Resources:**

Baby Café USA. [List of Baby Cafés in your state](#)

## Focus Area 3: Child and Adolescent Health

**Goal 3.1:** Support and enhance children and adolescents’ social-emotional development and relationships

**Intervention 3.1.1: 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.**

### Resources

**Docs for Tots.** A non-profit, non-partisan organization led by pediatricians to promote practices, policies, and investments that will enable young children to thrive. Docs for Tots offers resources, tools, technical assistance and training to ensure that social-emotional health is addressed by doctors and in all early childhood settings. Site includes resources related to social-emotional health and other related topics, organized for doctors, early childhood providers, families, and advocates.

<http://docsfortots.org/>

**National Center of Trauma Informed Care (NCTIC).** Supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), NCTIC supports interest in developing approaches to eliminate the use of seclusion, restraints, and other coercive practices and to further advance the knowledge base related to implementation of trauma-informed approaches. NCTIC offers consultation and technical assistance, education and outreach, and resources to support a broad range of service systems, including systems providing mental health and substance abuse services, housing and homelessness services, HIV services, peer and family organizations, child welfare, criminal justice, and education. <https://www.samhsa.gov/nctic>

**The Pyramid Model.** The Pyramid Model is an evidence-based framework for implementing a multi-level system of support for children ages birth to six years and their families in diverse settings. It is a relationship-based, child and family-centered professional development model that addresses the drivers outlined in implementation science research: competency, leadership, and organization. In New York State, the *New York State Pyramid Model Partnership* was established to promote statewide use of the Pyramid Model to build social and emotional competence in early care and education programs.

<http://www.nysecac.org/ecac-initiatives/pyramid-model/>

**Trauma Informed Care: Perspectives and Resources.** Developed by the National Technical Assistance Center for Children’s Mental Health at Georgetown University Center for Child and Human Development. A comprehensive web-based, video-enhanced resource tool to support leaders and decision makers at all levels (national, state, tribal, territorial, and local) in becoming “trauma informed”. <https://gucchdtacenter.georgetown.edu/TraumaInformedCare/>

**The Trauma Informed Care Project (TCIP).** Trauma Informed Care (TIC) is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. It emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment. The Trauma Informed

Care Project (TIC), based at Orchard Place/Child Guidance Center in Iowa, provides a variety of resource links to publications, trainings, and other tools for practitioners.

<http://traumainformedcareproject.org/index.php>

### **Focus Area 3: Child and Adolescent Health**

**Goal 3.1:** Support and enhance children and adolescents' social-emotional development and relationships

**Intervention 3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families.**

#### **Resources**

**Bright Futures Tool and Resource Kit.** American Academy of Pediatrics. This kit provides forms and tools for health care professionals, patients, and families to complete before, during, or after well-child visits. These items help pediatricians and other health care professionals support and implement the guidance provided in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition*. Providers can use or adapt these materials to meet the needs of their practices and ensure they are following the recommendations presented in the *Guidelines* when delivering care to patients. An update to the kit is anticipated in the near future.

<https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx>

**Center for Integrated Health Solutions - Children and Youth.** The CIHS, supported by the Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA), reviews the latest resources and research related to integrated care for children and youth, and compiles links to useful resources for providers.

<https://www.integration.samhsa.gov/integrated-care-models/children-and-youth>

**Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children.** Centers for Disease Control and Prevention (CDC). This framework outlines strategies communities can consider to promote relationships and environments that help children grow up to be healthy and productive citizens. The framework is intended for communities committed to the positive development of children and families, and specifically to the prevention of child abuse and neglect. The framework has four goal areas and suggests strategies based on best available evidence to achieve each goal. Site includes link to full framework and a number of related resources. <https://www.cdc.gov/violenceprevention/childabuseandneglect/essentials.html>.

**Evidence-based Bullying Programs, Curricula and Practices.** Oklahoma State Department of Education. Provides a list of evidence-based bullying prevention programs examined and approved by federal agencies to assist schools in prevention efforts, with links to additional resources for each program.

<http://sde.ok.gov/sde/bullying-prevention-curriculum>

**First 1000 Days on Medicaid Initiative.** Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child's first three years of development and seeks to ensure that New York's Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. [https://health.ny.gov/health\\_care/medicaid/redesign/first\\_1000.htm](https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm)

**Fostering Cultural Competence: Using Children's Literature to Talk about Difficult Issues in K-12 Classrooms.** Center for Safe Schools. 2015 Webinar focuses on strategies for broaching sensitive topics with students and for examining one's own assumptions about others. <http://www.safeschools.info/bullying-prevention/professional-development/429>

**Healthy Steps.** Evidence-based primary care program model that integrates child development professional ("specialist") to primary care practice teams to enhance screening, family engagement and communication, and coordination of family support and follow up services.

- **National Healthy Steps** site includes an overview of the model and evidence base, materials for families, and resources for providers, including information on how to become a HealthySteps site. <https://www.healthysteps.org/>
- **New York Office of Mental Health Implementation of Healthy Steps** includes 2016 Request for Proposals to support implementation of Healthy Steps in primary care medical care practices across New York State. <https://omh.ny.gov/omhweb/rfp/2016/healthy-steps/>

**Help Me Grow.** A system model that works to promote cross-sector collaboration to build early childhood systems that mitigate the impact of adversity and support protective factors among families, so that all children can grow, develop, and thrive to their full potential. Help Me Grow is not a stand-alone program, but a system model that leverages and builds on programs and resources already in place to develop and enhance early childhood system building in any given community. Core components of the model include Centralized Access Point, Family & Community Outreach, Child Health Care Provider Outreach, and Data Collection.

- **Help Me Grow National Center** site includes information on the model and the role of the national center to support local programs, links to its affiliate network of local programs, and other resources. <https://helpmegrownational.org/>
- **Help Me Grow New York** includes information on Western New York and Long Island Help Me Grow networks, partners, events, and other resources. <http://helpmegrownny.org/> See also **ECCS Impact Initiative** resource.

**Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals** (2017). Joint Task Force on Social-Emotional

Development: New York State Department of Health Early Intervention Coordinating Council and New York State Early Childhood Advisory Council. This guidance document is geared towards early childhood health, development specialists, and early care and learning professionals to partner with families to promote and support healthy social emotional development in infants and toddlers, including those in the State's Early Intervention Program.

<https://www.health.ny.gov/publications/4226.pdf>

**The National Center for Pyramid Model Interventions (NCPMI).** The NCPMI aims to assist states and programs in their implementation of sustainable systems for the implementation of the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (Pyramid Model) within early intervention and early education programs. The focus is on promoting the social, emotional, and behavioral outcomes of young children birth to five, reducing the use of inappropriate discipline practices, promoting family engagement, using data for decision-making, integrating early childhood and infant mental health consultation and fostering inclusion. <http://challengingbehavior.cbcs.usf.edu/>

**The Resilience Project.** American Academy of Pediatrics. Website clearinghouse for resources developed for pediatricians and medical home teams to more effectively identify and care for children and youth exposed to violence. Includes links to a variety of resources including websites, toolkits, and practice guides. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Prevention.aspx>

**The Search Institute.** The Search Institute bridges research and practice to help young people be and become their best selves. The Institute supports a wide range of research-based resources including its Developmental Assets®, one of the foundational frameworks in positive youth development that has become among the most frequently cited and widely utilized frameworks in the world. Site includes a wide array of resources and tools for schools, youth and family serving programs, and community coalitions. [www.search-institute.org](http://www.search-institute.org)

**Supporting Social-Emotional Learning with Evidence-Based Programs. Annie E. Casey Foundation.** This brief shares nine strategies for implementing and sustaining evidence-based programs to support students' social and emotional health. Situated within a four-stage framework, these strategies consider the costs, resource allocations, funding streams, infrastructure and partnerships that are necessary for effective implementation. Input from administrators in seven school districts — each with a track record of delivering and sustaining social-emotional learning (SEL) programs — helped shape the strategies identified. <https://www.aecf.org/resources/supporting-social-emotional-learning-with-evidence-based-programs/>

**Teaching Students to Prevent Bullying: Curriculum and Resources.** National Education Association. Curriculum resources to prevent, identify, and confront bullying. Site includes lesson plans, activities, games, and other resources for elementary through high school grade levels. <http://www.nea.org/tools/lessons/teaching-students-to-prevent-bullying.html>

## Focus Area 3: Child and Adolescent Health

**Goal 3.1:** Support and enhance children and adolescents' social-emotional development and relationships

**Intervention 3.1.3:** Engage in collaborative strategies to increase developmental screening of young children in accordance with professional medical guidelines.

### Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 6: Developmental Screening:

- **Evidence Analysis Report. NPM 6: Developmental Screening**, Johns Hopkins University. Report includes detailed tables of interventions reviewed with citations for individual studies. [https://www.mchevidence.org/documents/reviews/npm\\_6\\_developmental\\_screening\\_evidence\\_review\\_april\\_2018.pdf](https://www.mchevidence.org/documents/reviews/npm_6_developmental_screening_evidence_review_april_2018.pdf)
- **Evidence Brief. Developmental Screening**. National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-6-developmental-screening.php>
- **Title V Transformation Tools**. Recommendations to support NPM6 – Developmental Screening. <https://www.mchnavigator.org/transformation/npm-6.php>

**American Academy of Pediatrics.** Clinical guidelines for pediatric health care providers:

- **Recommendations for preventive pediatric health care** (periodicity schedule) - [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)
- **Policy statement: Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening.** <http://pediatrics.aappublications.org/content/118/1/405.long>
- **Bright Futures Tool and Resource Kit.** <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx>

**Birth to Five: Watch me Thrive.** This initiative of the Early Childhood Development office of the Administration for Children and Families is a coordinated federal effort to encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them. The website includes a list of research-based [developmental screening tools](#) for use across a wide range of settings. Its [Families page](#) offers resources families can use to track their child's development and know how to take action when needed. <https://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive>

**Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN).** Multiyear initiative funded by federal Maternal and Child Health Bureau to improve early childhood service systems in 12 states, including New York State, to increase age-appropriate developmental skills and reduce developmental disparities among 3-year old children. *See also **Help Me Grow** resource.*

- **National ECCS CoIIN Coordinating Center** led by National Institute for Children’s Health Quality (NICHQ) supports state teams through quality improvement and innovation. Site includes information about the initiative, approach, and resources. <https://www.nichq.org/project/early-childhood-comprehensive-systems-collaborative-improvement-and-innovation-network-eccs>
- **New York State ECCS Impact Initiative** led by the NYS Council on Children and Families is working with community teams in Nassau County and Western New York. Site includes an overview of the NYS initiative and resources related to project implementation. <http://ccf.ny.gov/council-initiatives/early-childhood-comprehensive-systems-impact-initiative-eccs-impact/> *See also **Help Me Grow** resource.*

**First 1000 Days on Medicaid Initiative.** Launched in 2017 as a new focus for Medicaid Redesign in New York State, the First 1,000 Days on Medicaid Initiative recognizes the crucial importance of a child’s first three years of development and seeks to ensure that New York’s Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve. A stakeholder workgroup was charged with developing a ten-point agenda to focus on enhancing access to services and improving outcomes for children on Medicaid in their first 1,000 days of life. Website includes information on the initiative and materials from workgroup and advisory group meetings to date. [https://health.ny.gov/health\\_care/medicaid/redesign/first\\_1000.htm](https://health.ny.gov/health_care/medicaid/redesign/first_1000.htm)

**Healthy Steps.** Evidence-based primary care program model that integrates child development professional (“specialist”) to primary care practice teams to enhance screening, family engagement and communication, and coordination of family support and follow up services.

- **National Healthy Steps** site includes an overview of the model and evidence base, materials for families, and resources for providers, including information on how to become a HealthySteps site. <https://www.healthysteps.org/>
- **New York Office of Mental Health Implementation of Healthy Steps** includes 2016 Request for Proposals to support implementation of Healthy Steps in primary care medical care practices across New York State. <https://omh.ny.gov/omhweb/rfp/2016/healthy-steps/>

**Help Me Grow.** A system model that works to promote cross-sector collaboration to build early childhood systems that mitigate the impact of adversity and support protective factors among families, so that all children can grow, develop, and thrive to their full potential. Help Me Grow is not a stand-alone program, but a system model that leverages and builds on programs and resources already in place to develop and enhance early childhood system building in any given community. Core

components of the model include Centralized Access Point, Family & Community Outreach, Child Health Care Provider Outreach, and Data Collection.

- **Help Me Grow National Center** site includes information on the model and the role of the national center to support local programs, links to its affiliate network of local programs, and other resources. <https://helpmegrownational.org/>
- **Help Me Grow New York** includes information on Western New York and Long Island Help Me Grow networks, partners, events, and other resources. <http://helpmegrownny.org/> See also **ECCS Impact Initiative** resource.

**Learn the Signs, Act Early.** This resource for parents from the Centers for Disease Control and Prevention provides information on milestones children should reach from birth to age 5 in how they play, learn, speak, act, and move. The website includes materials, training for early care and education providers, how to get involved, what to do about concerns with a child's development, autism case training, and multimedia and tools. It also provides a link to standardized, validated [developmental screening tools](https://www.cdc.gov/ncbddd/actearly/index.html) for parents and providers from AAP. <https://www.cdc.gov/ncbddd/actearly/index.html>

**Think Cultural Health.** U.S. Department of Health & Human Services, Office of Minority Health. Dedicated to advancing health equity, website features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Includes link to CLAS standards and resources for implementation. <https://www.thinkculturalhealth.hhs.gov/>

### **Focus Area 3: Child and Adolescent Health**

**Goal 3.2:** Increase supports for children and youth with special health care needs.

**Intervention 3.2.1: Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families.**

#### **Resources**

**Children and Youth with Special Health Care Needs (CYSCHN) Program.** The New York State CYSCHN Program seeks to improve the system of care for children with special health care needs from birth to 21 years of age and their families. The Program helps to shape public policy so families can get the best health care for their children. Programs in most counties in NYS help families of CSHCN by giving them information on health insurance and connecting them with health care providers. These programs will also work with families to help them meet the medical and non-medical needs of their children. State website includes link to contact information for local CYSCHN programs, materials, and other resources. [https://www.health.ny.gov/community/special\\_needs/](https://www.health.ny.gov/community/special_needs/)

**Early Intervention Program.** The New York State Early Intervention Program (EIP) is part of the national Early Intervention Program for infants and toddlers with disabilities and their families. First created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA), the EIP is administered by the New York State Department of Health through the Bureau of Early Intervention. To be eligible for services, children must be under 3 years of age and have a confirmed disability or established developmental delay in one or more areas of development. The EIP offers a variety of therapeutic and support services to eligible infants and toddlers with disabilities and their families, including family education and counseling, home visits, and parent support groups. The EIP Website includes wide array of resources for localities, providers, and families, multiple trainings for providers on working with families, [https://www.health.ny.gov/community/infants\\_children/early\\_intervention/index.htm](https://www.health.ny.gov/community/infants_children/early_intervention/index.htm)

**Early Intervention Family Outcomes Project.** New York's Early Intervention Program (EIP) has prioritized family and engagement and support as an area for improvement. Approximately 62% of families participating in the state's EIP met the state's standard for family impact scale in 2015-16. Improving performance in family outcomes is a core focus of the EIP State Systemic Improvement Plan (SSIP), which seeks to identify, implement, and evaluate evidence-based and promising practices to improve family centered services and family outcomes for children served in the state's Early Intervention Program.

- ***Child and Family Outcomes Survey*** – provides links to information about the Family & Child Outcomes surveys used in the EIP.  
[https://www.health.ny.gov/community/infants\\_children/early\\_intervention/outcomes\\_survey/](https://www.health.ny.gov/community/infants_children/early_intervention/outcomes_survey/)
- ***Early Intervention Family Outcomes & the State Systemic Improvement Plan*** - presentation on the SSIP Family Outcomes project to New York State Association of County Health Officials (NYSACHO) membership (May 2016).  
<http://www.nysacho.org/files/Family%20Outcomes%20and%20SSIP%20Presentation%20for%20NYSACHO%20May%206%202016.pdf>
- ***Improving Family Centeredness Together*** - presentation/ update on SSIP to York State Association of County Health Officials (NYSACHO) membership (April 2018).  
[http://www.nysacho.org/files/EICC%20Handouts/1\\_%20SSIP%20All%20County%20Meeting%20April%2025%202018%20.pdf](http://www.nysacho.org/files/EICC%20Handouts/1_%20SSIP%20All%20County%20Meeting%20April%2025%202018%20.pdf)

**Early Intervention Partners Training Project.** This training is for parents of infants and toddlers with disabilities currently receiving services through New York's Early Intervention Program. These training sessions provide information, resources, and skill-building activities designed to increase parent advocacy and leadership skills. Families interested in this training apply for admittance to the Family Initiative Coordination Services Project. Additional information on the PTP is available on the eiFamilies website: <https://www.eifamilies.com/ei-training-you-ei-partners-training-project>

**Families Together in New York State.** Families Together in New York State is a family-run, nonprofit organization that strives to establish a unified voice for children and youth with emotional, behavioral and social challenges. It provides training, education, support, referrals, and several workforce

development initiatives including a Parent Empowerment Program and Family Peer Advocate Credential. <https://www.ftnys.org/>

**Hands and Voices.** Parent-to-parent support for families of children with hearing loss, with a focus on providing unbiased information and interventions that best meet child and family needs.

- **National organization:** <http://www.handsandvoices.org>
- **New York State chapter:** <http://www.handsandvoicesny.org/>

**Parent to Parent of New York State.** Parent to Parent of New York State builds a supportive network of families to reduce isolation and empower those who care for people with developmental disabilities or special healthcare needs to navigate and influence service systems and make informed decisions. Parent to Parent also serves as New York's Family Voices state affiliate organization. Site includes information on parent-to-parent matching program, Family to Family (F2F) Health Information Center, parent trainings, and other resources. <http://parenttoparentnys.org/site/>

**National Center for Family/ Professional Partnerships (NCFPP).** Funded by the federal Maternal and Child Health Bureau, the NCFPP is a project of Family Voices, a national family-led organization of families and friends of CSHCN. NCFPP supports state and local Family-to-Family Information Centers (F2F), Family Voices state affiliate organizations, and other family organizations and initiatives. <http://familyvoices.org/ncfpp/>

### Focus Area 3: Child and Adolescent Health

**Goal 3.2:** Increase supports for children and youth with special health care needs

**Intervention 3.2.2.: 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).**

#### Resources

**Early Hearing Detection and Intervention Program (EHDI).** New York State Department of Health. Web page includes overview of newborn hearing screening and follow up requirements and a variety of resources for parents and providers including educational materials and links to state and national trainings.

[https://www.health.ny.gov/community/infants\\_children/early\\_intervention/newborn\\_hearing\\_screening/](https://www.health.ny.gov/community/infants_children/early_intervention/newborn_hearing_screening/)

**Hands and Voices.** Parent-to-parent support for families of children with hearing loss, with a focus on providing unbiased information and interventions that best meet child and family needs.

- **National organization:** <http://www.handsandvoices.org>
- **New York State chapter:** <http://www.handsandvoicesny.org/>

**Joint Committee on Infant Hearing.** Committee comprised of representatives from the American Academy of Pediatrics, the American Academy of Otolaryngology-Head and Neck Surgery, American Speech-Language-Hearing Association, Council of Education of the Deaf, and Directors of Speech and Hearing Programs in State Health and Welfare Agencies. The primary activity is the publication of position statements summarizing the state of the science and art in infant hearing and recommending the preferred practice in early identification and appropriate intervention of newborns and infants at risk for or with hearing loss. <http://www.icih.org/>

**National Center on Birth Defects and Developmental Disabilities (NCBDD).** (2018). Centers for Disease Control and Prevention. Provides research, basic information and statistics regarding hearing loss, screening, and diagnosis, as well as current articles and educational materials for clinicians and families. <https://www.cdc.gov/ncbddd/hearingloss/index.html>

**National Center for Hearing Assessment and Management (NCHAM).** Serves as the national resource center for the implementation and improvement of comprehensive and effective Early Hearing Detection and Intervention (EHDI) systems. Comprehensive website includes wide array of resources and links to other partner organizations. <http://www.infanthearing.org/index.html>

**Program to Enhance the Health & Development of Infants and Children (PEHDIC): Early Hearing Detection & Intervention** (2018). American Academy of Pediatrics (AAP). Comprehensive website outlines national AAP goals, innovative and promising practices, links to partner organizations, and a variety of resources and tools for primary care clinicians, including specific “lost to follow-up” resources. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Early-Hearing-Detection-and-Intervention.aspx>

### **Focus Area 3: Child and Adolescent Health**

**Goal 3.2:** Increase supports for children and youth with special health care needs

**Intervention 3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.**

#### **Resources**

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 12: Transition to Adulthood:

- **Evidence Analysis Report. NPM 12: Transition,** Johns Hopkins University. Under development. Link to be posted at: <https://www.mchevidence.org/tools/>
- **Evidence Brief. Transition to Adulthood.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-12->

[transition.php](#)

- **Title V Transformation Tools.** Recommendations to support NPM12 – Transition.  
<https://www.mchnavigator.org/transformation/npm-12.php>

**Care Coordination for CSHCN Challenge.** Sponsored by the federal Maternal and Child Health Bureau, this challenge will support the development and testing of low-cost, scalable, technology-based innovations to meet the needs of CSHCN and their families. Innovations should improve the quality of care, enhance family engagement, and positively impact health care outcomes with the potential of saving costs to families, society, and to the health care system. CSHCN and their families are the primary stakeholders for all solutions proposed and must be involved in the development. The design phase for this challenge will launch August 30, 2018, with subsequent development, small-scale testing, and scaling phases through Fall 2019. <https://mchbgrandchallenges.hrsa.gov/challenges/care-coordination-cshcn>

**Coordinating Care and Supporting Transition for Children, Adolescents and Young Adults with Sickle Cell Disease.** Funded and administered by the New York State Department of Health, this program contracts with three certified hemoglobinopathy centers to improve transition of care services for adolescents and young adults (AYA) with Sickle Cell disease. The program began in July 2018 and uses the “Got Transition” six core elements for successful transition to adult and self-care services. Linkage to Health Homes is a key aspect in this program, with relevant webinars delivered to the hemoglobinopathy centers and Health Home Case Managers, respectively.  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/webinars/docs/2017/2017-08-16\\_sickle\\_cell\\_and\\_transitional\\_care.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2017/2017-08-16_sickle_cell_and_transitional_care.pdf)

**Got Transition.** Got Transition/Center for Health Care Transition Improvement is a cooperative agreement between the Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health. Our aim is to improve transition from pediatric to adult health care through the use of new and innovative strategies for health professionals and youth and families. Partners are working to: expand the use of six core elements of health care transition; partner with professional training programs; develop youth and parent leadership; promote health system measurement, performance and policies; and, serve as a clearinghouse for transition tools and resources. Site includes resources, including sample tools, for health care providers, youth and families, researchers, and policymakers.  
<https://www.gottransition.org/>

**Medicaid Health Homes Serving Children.** New York State Department of Health. Medicaid Health Homes is a care management service to help eligible individuals get the care and services they need to stay healthy. To be eligible for Health Home services, the individual must: be enrolled in Medicaid; have an eligible condition (two or more chronic conditions, HIV/AIDS, or Serious Mental Illness, Serious Emotional Disturbance, or Complex Trauma); and satisfy the appropriateness criteria for need of intensive case management. The Health Home Serving Children’s (HHSC) program was launched in December 2016, with 16 Health Homes designated to serve children.

- **New York State Health Homes Serving Children Website** includes wide range of resources

including important information, guidance and presentation/webinars developed by the State (The New York State Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services) in consultation with Health Homes, Managed Care Plans, children’s advocates and other stakeholders to tailor the Health Home model to better serve children.

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/hh\\_children/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm)

- **Find a Health Home** page helps providers and families locate and contact Health Homes by county. [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/hh\\_map/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm)

**National Technical Assistance Center on Transition (NTACT).** NTACT is a Technical Assistance and Dissemination project, funded by the U.S. Department of Education’s Office of Special Education Programs (OSEP) and the Rehabilitation Services Administration (RSA). NTACT’s purpose is to assist State Education Agencies, Local Education Agencies, State VR agencies, and VR service providers in implementing evidence-based and promising practices ensuring students with disabilities, including those with significant disabilities, graduate prepared for success in postsecondary education and employment. Site includes evidence-based practices, capacity-building tools, lesson plan starters, publications, and other resources to help state agencies, educators, students, and families improve transition planning, services, and outcomes for youth with disabilities. <https://transitionta.org/>

**The Transition of Children from the New York State Department of Health Early Intervention Program to the State Education Department Preschool Special Education Program or Other Early Childhood Services.** This document provides guidance on the transition of children from the Early Intervention Program (EIP) to preschool special education programs and services, other state service delivery systems, or other early childhood services available to support children and their families. To ensure the transition process is successful for families, it is important that parents and professionals understand the requirements for transition and the services available in their communities for young children with, and without, disabilities. [https://www.health.ny.gov/community/infants\\_children/early\\_intervention/transition/purpose.htm](https://www.health.ny.gov/community/infants_children/early_intervention/transition/purpose.htm)

## **Focus Area 3: Child and Adolescent Health**

**Goal 3.3:** Reduce dental caries among children

**Intervention 3.3.1: Maintain and expand community water fluoridation.**

### **Resources**

**Best Practice Approach Reports - Use of Fluoride: Community Water Fluoridation.** Association for State and Territorial Dental Directors. May 2016. ASTDD Best Practice Reports capture key information

that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs.

<https://www.astdd.org/use-of-fluoride-community-water-fluoridation/>

**Community Water Fluoridation.** Centers for Disease Control and Prevention. February 2018. Available at: <https://www.cdc.gov/fluoridation/index.html>

**Community Water Fluoridation.** National Association of County and City Health Officials. 2018. Available at: <https://www.naccho.org/programs/community-health/community-water-fluoridation>

**Dental Caries (Cavities): Community Water Fluoridation.** Community Preventive Services Task Force. April 2013. Available at: <https://www.thecommunityguide.org/findings/dental-caries-cavities-community-water-fluoridation>

**Drinking Water Fluoridation Grant Program.** New York State Department of Health. August 2017. Applications are being accepted on the New York State Grants Gateway, <https://grantsgateway.ny.gov/>. (Drinking Water Fluoridation – Round 4 Component 1: Planning and Feasibility Projects (Grant Opportunity ID: DOH01-DWFR41-2017); Drinking Water Fluoridation – Round 4 Component 2: Implementation and Maintenance Projects (Grant Opportunity ID: DOH01-DWFR42-2017))

**Patient Engagement About Fluoride and Fluoridation.** Continuing education webinar produced by the New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation. August 2018. Available at [https://www.albany.edu/sph/cphce/fluoridation\\_webinars\\_aug2018.shtml](https://www.albany.edu/sph/cphce/fluoridation_webinars_aug2018.shtml).

## Focus Area 3: Child and Adolescent Health

**Goal 3.3:** Reduce dental caries among children

**Intervention 3.3.2:** Increase delivery of evidence-based preventive dental services across key settings, including school-based and community-based primary care clinics.

### Resources

Resources for evidence-based practice aligned with Title V (MCH Block Grant) National Performance Measure (NPM) 13: Oral Health:

- **Evidence Analysis Reports** (2017) Johns Hopkins University. Reports include detailed tables of interventions reviewed with citations for individual studies.
  - **NPM 13A – Oral Health in Pregnancy**

[https://www.mchevidence.org/documents/reviews/npm\\_13a\\_oral\\_health\\_in\\_pregnancy\\_evidence\\_review\\_june\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_13a_oral_health_in_pregnancy_evidence_review_june_2017.pdf)

- **NPM 13B – Oral Health in Childhood.**

- [https://www.mchevidence.org/documents/reviews/npm\\_13b\\_childrens\\_oral\\_health\\_evidence\\_review\\_august\\_2017.pdf](https://www.mchevidence.org/documents/reviews/npm_13b_childrens_oral_health_evidence_review_august_2017.pdf)

- **Evidence Brief. Oral Health.** National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University. <https://www.ncemch.org/evidence/NPM-13-oralhealth.php>

- **Title V Transformation Tools.** Recommendations to support NPM13 – Oral Health.

- <https://www.mchnavigator.org/transformation/npm-13.php>

**Best Practice Approach Reports.** Association for State and Territorial Dental Directors. Reports capture key information that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs.

- **School-Based Dental Sealant Programs** (2017). <https://www.astdd.org/school-based-dental-sealant-programs/>
- **Use of Fluorides in Schools.** (2018) <https://www.astdd.org/use-of-fluoride-in-schools/>
- **Prevention and Control of Early Childhood Tooth Decay** (2011). <https://www.astdd.org/docs/BPAEarlyChildhood.pdf>

**Dental Sealants.** Centers for Disease Control and Prevention. March 2018. Available at:

[https://www.cdc.gov/oralhealth/dental\\_sealant\\_program/index.htm](https://www.cdc.gov/oralhealth/dental_sealant_program/index.htm)

**Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs.** Community Preventive Services Task Force. April 2013. Available at: <https://www.thecommunityguide.org/findings/dental-caries-cavities-school-based-dental-sealant-delivery-programs>

**Medical-Dental Integration** Learning Session 1 continuing education webinar produced by New York State Department of Health and University at Albany School of Public Health. March 2018.

[https://www.albany.edu/sph/cphce/fluoridation\\_march2018.shtml](https://www.albany.edu/sph/cphce/fluoridation_march2018.shtml)

**Patient Engagement About Fluoride and Fluoridation.** Continuing education webinar produced by the New York State Department of Health, University at Albany School of Public Health, and New York State Dental Foundation. August 2018.

[https://www.albany.edu/sph/cphce/fluoridation\\_webinars\\_aug2018.shtml](https://www.albany.edu/sph/cphce/fluoridation_webinars_aug2018.shtml).

**Smiles for Life: A National Oral Health Curriculum, Third Edition.**

<https://www.smilesforlifeoralhealth.org/buildcontent.aspx?pagekey=101553&lastpagekey=101554&userkey=14079114&sessionkey=4355764&tut=555&customerkey=84&custsitegroupkey=0>

## Focus Area 3: Child and Adolescent Health

**Goal 3.3:** Reduce dental caries among children

**Intervention 3.3.3:** Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.

### Resources

**Best Practice Approach Reports.** Association for State and Territorial Dental Directors. Reports capture key information that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs.

- **Improving Children’s Oral Health through the Whole School, Whole Community, Whole Child (WSCC) Model.** (March 2017): [https://www.astdd.org/improving-childrens-oral-health-through-the-whole-school-whole-community-whole-child-\(wsc\)-model/](https://www.astdd.org/improving-childrens-oral-health-through-the-whole-school-whole-community-whole-child-(wsc)-model/)
- **Oral Health of Children, Adolescents and Adults with Special Health Care Needs.** (August 2007) <https://www.astdd.org/special-health-care-needs/>
- **Perinatal Oral Health.** (October 2012). Available at: <https://www.astdd.org/perinatal-oral-health/>

**Cavity Free Kids.** Cavity Free Kids is an oral health education initiative for young children ages from birth through five years and their families, developed by the Arcora Foundation, a non-profit foundation funded by Delta Dental. It is designed for use in Head Start and Early Head Start, child care, preschool, home visiting, and other programs. Cavity Free Kids includes a rich collection of lessons, activities, stories, songs and other resources that actively engage young children in fun-filled, play-based learning and help parents practice good oral health habits at home. Activities on the website are available for open use while the complete curricula, updates, and other training resources are available for download after attending a Cavity Free Kids training. <http://cavityfreekids.org/>

**Oral Health Educational Resources for Home Visitors and Families: Environmental Scan.** (2018 update). Association of State and Territorial Dental Directors, Early Childhood Committee. Update to previous 2014 report identifies oral health educational resources for home visitors and the families they serve and addresses gaps in existing oral health resources. <https://www.astdd.org/docs/home-visiting-environmental-scan-2018.pdf>

## Focus Area 4: Cross Cutting Health Women, Infants & Children (applicable to all HWIC focus areas & goals)

***Goal: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.***

**Intervention 4.1: 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.**

## **Resources**

**Essentials for Childhood Framework: Creating Safe, Stable, Nurturing Relationships and Environments for All Children.** Centers for Disease Control and Prevention (CDC). This framework outlines strategies communities can consider to promote relationships and environments that help children grow up to be healthy and productive citizens. The framework is intended for communities committed to the positive development of children and families, and specifically to the prevention of child abuse and neglect. It has four goal areas and suggests strategies based on best available evidence to achieve each goal. Site includes link to full framework and a number of related resources.  
<https://www.cdc.gov/violenceprevention/childabuseandneglect/essentials.html>.

**The EveryONE Project™.** American Academy of Family Physicians. Designed to help family physicians and their practice teams take action and confront health disparities. The EveryONE Project Toolkit provides clinicians with education, resources, and practical tools to address social determinants of health. <https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html>

**The Guide to Community Preventive Services: Health Equity Reviews.** A collection of evidence-based findings of the Community Preventive Services Task Force. Health Equity reviews focus on interventions to reduce health inequities among racial and ethnic minorities and low-income populations. Recommended interventions included in this set of reviews include: Center-Based Early Childhood Education, Full-Day Kindergarten Programs, School-Based Health Centers, High School Completion Programs, Out-of-School-Time Academic Programs, and Tenant-Based Rental Assistance Programs. Includes summaries and links to full reviews.  
<https://www.thecommunityguide.org/topic/health-equity>

**Health Impact in 5 Years (HI-5).** Centers for Disease Control and Prevention. The Health Impact in 5 Years (HI-5) initiative highlights 14 non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier. Examples of HI-5 interventions that address SDOH include public transportation system expansion, home improvement loans and grants, community water fluoridation, safe routes to school, and more. Site includes links to HI-5 implementation stories, slide sets, and detailed information and implementation resources for each of the 14 interventions.  
<https://www.cdc.gov/policy/hst/hi5/>

**Healthy People 2020: Social Determinants of Health Interventions & Resources.** Office of Disease Prevention and Health Promotion (last updated 2018). Summarizes information around five key domains: (1) Economic Stability, (2) Education, (3) Health and Health Care, (4) Neighborhood and Built

Environment, and (5) Social and Community Context. Site includes link to a variety of resources for communities to work collaboratively across sectors, organized by domain, including literature reviews; national, state, and local resources; and relevant HP2020 objectives and indicators.

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources>

**Maternal and Infant Community Health Collaboratives (MICHC) Initiative.** New York State Department of Health. The MICHC initiative supports improved outcomes for women, infants, and families through a combination of individual, family, community, and organizational strategies, including Community Health Workers (CHWs). Web page provides an overview of the MICHC initiative, link to on-line CHW training, and list of current projects across the state.

[https://www.health.ny.gov/community/adults/women/maternal\\_and\\_infant\\_comm\\_health\\_collaboratives.htm](https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm)

**National Center for Cultural Competence (NCCC).** Georgetown University Center for Child and Human Development. The NCCC is recognized as a national and international leader in the design, implementation, and evaluation of cultural and linguistic competence in a broad array of systems and organizations. The site provides a variety of publications, tools and other information and resources to promote health equity. <https://nccc.georgetown.edu/>

**New York State's Home Visiting Programs: Support for Pregnant and Parenting Families.** New York State Department of Health. State website includes information for providers and families, including a searchable list of home visiting programs in New York State by county.

[https://www.health.ny.gov/community/pregnancy/home\\_visiting\\_programs/](https://www.health.ny.gov/community/pregnancy/home_visiting_programs/)

**Paid Family Leave.** NY.gov (last updated 2018). Research studies have shown that new mothers who take paid leave have fewer postpartum depression symptoms, higher rates of breastfeeding, less stress, and stronger parent-child bonding. Website includes information on New York State's Paid Family Leave law and benefits to support bonding with a new child. <https://paidfamilyleave.ny.gov/>

**Parent to Parent of New York State.** Parent to Parent of New York State builds a supportive network of families to reduce isolation and empower those who care for people with developmental disabilities or special healthcare needs to navigate and influence service systems and make informed decisions. Parent to Parent also serves as New York's Family Voices state affiliate organization. Site includes information on parent-to-parent matching program, Family to Family (F2F) Health Information Center, parent trainings, and other resources. <http://parenttoparentnys.org/site/>

**Policy Resources to Support Social Determinants of Health.** Centers for Disease Control and Prevention (last updated 2017). CDC Web page includes resources on policies that support a multi-sector approach to improving health. Includes summaries and links to resources to help identify and describe policy opportunities and involve other sectors to improve health and well-being.

<https://www.cdc.gov/socialdeterminants/policy/index.htm>

**The Search Institute.** The Search Institute bridges research and practice to help young people be and become their best selves. The Institute supports a wide range of research-based resources including its Developmental Assets®, one of the foundational frameworks in positive youth development that has become among the most frequently cited and widely utilized frameworks in the world. Site includes a wide array of resources and tools for schools, youth and family serving programs, and community coalitions. [www.search-institute.org](http://www.search-institute.org)

**Sources for Data on Social Determinants of Health.** Centers for Disease Control and Prevention (last updated 2018). Data can be a catalyst for improving community health and well-being. Understanding data on social determinants of health, such as income, educational level, and employment, can help focus efforts to improve community health. Page lists and links to tools supported by CDC resources and to data sources outside of CDC. <https://www.cdc.gov/socialdeterminants/data/index.htm>

**Technical Packages for Violence Prevention.** Centers for Disease Control and Prevention. Technical packages help states and communities take advantage of the best available evidence to prevent violence using multi-level, multi-sector engagement. Each package is intended as a resource to guide and inform prevention decision-making in communities and states. The strategies and approaches in the technical package represent different levels of the social ecology with efforts intended to impact individual behaviors as well as the relationship, family, school, community, and societal factors that influence risk and protective factors for violence. Includes links to infographics that provide visual representations of technical package contents.

<https://www.cdc.gov/violenceprevention/pub/technical-packages.html>

**Think Cultural Health.** U.S. Department of Health & Human Services, Office of Minority Health. Dedicated to advancing health equity, website features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Includes link to CLAS standards and resources for implementation. <https://www.thinkculturalhealth.hhs.gov/>

**Tools for Putting Social Determinants of Health into Action.** Centers for Disease Control and Prevention (last reviewed February 2018). Collection of resources developed by CDC to help practitioners take action to address social determinants of health. Selected resources of particular relevance within this site include:

- ***At-a-Glance: 10 Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities.*** brief document to help public health agencies embed social determinants of health efforts as part of their portfolio in protecting the health of communities that they serve, with links to relevant examples of SDOH resources and tools. [https://www.cdc.gov/stltpublichealth/publichealthservices/pdf/ten\\_essential\\_services\\_and\\_sdo.pdf](https://www.cdc.gov/stltpublichealth/publichealthservices/pdf/ten_essential_services_and_sdo.pdf)
- ***Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health.*** Workbook with tools to develop, implement, and evaluate interventions that target social determinants of health. <https://www.cdc.gov/socialdeterminants/tools/index.htm>

**Use of Fluoride: Community Water Fluoridation – Best Practice Reports.** Association for State and Territorial Dental Directors. May 2016. ASTDD Best Practice Reports capture key information that describes specific public health strategies, assesses the strength of supporting evidence, and illustrates implementation with current practice examples. They are intended as resources to share ideas and promote best practices for state and community oral health programs. <https://www.ahaddd.org/use-of-fluoride-community-water-fluoridation/>

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# New York State Prevention Agenda

## Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan

Updated: June 30, 2023

### Define the Priority:

Mental and emotional well-being is essential to overall health. At any given time, almost **one** in five young people nationally are affected by mental, emotional and behavioral (MEB) disorders, including conduct disorders, depression and substance abuse. Adverse Childhood Experiences and many MEB disorders, such as substance abuse and depression, have lifelong effects that include high psychosocial and economic costs for people, their families, schools and communities. **The** financial costs nationally in terms of treatment services and lost productivity are estimated at \$467 billion in 2012, and \$442 billion for misuse of prescription drugs, illicit drugs and alcohol. Mental and physical health problems are interwoven. Improvements in mental health help improve individuals and populations' physical health. The best opportunities to improve the public's mental health are interventions delivered before a disorder manifests itself, to prevent its development. These interventions can be integrated with routine health care and wellness promotion in health care settings, as well as in schools and community settings.

**Additional** information about the burden of mental health and substance use disorders, underlying risk factors, associated disparities, and social determinants of health can be found at: [https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf#page=96](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf#page=96)

The Promote Well-Being and Prevent Mental and Substance Use Disorders has two focus areas with multiple goals:

### 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: Prevent Mental and Substance Use Disorders

- 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

## Focus Area 1: Promote Well-Being

**Goal 1.1:** Strengthen opportunities to build well-being and resilience across the lifespan.

Well-being is a relative and dynamic state where one maximizes his or her physical, mental, and social functioning in the context of supportive environments to live a full, satisfying, and productive life. Well-being is based on the relationship between social determinants of health and person's experiences with quality of life. A person's experience may be influenced by social capital, belief in one's capacity, inclusion, opportunities to engage in meaningful learning, and engagement in actions that influence our lives. Resilience is the capacity to cope with stress, overcome adversity, and thrive despite challenges in life. There is a wealth of evidence illustrating promoting well-being and resilience improves and sustains physical, mental, emotional and behavioral health, academic outcomes, and social capital.

**Objective 1.1.1** By December 31, 2024 increase New York State's Opportunity Index Score by 5% to 59.2 / 100.

Baseline: Opportunity Score 56.4 / 100 in 2017, NYS Opportunity Index ranked 17<sup>th</sup>  
Source: [Opportunity Index](#), Child Trends and Opportunity Nation

**Objective Geography level:** County

**Objective 1.1.2** By December 31, 2024, reduce the percentage of adult New Yorkers that report frequent mental distress during the past month by 10% to no more than 10.7%.  
Baseline: 11.9%.

**Objective 1.1.2.1** By December 31, 2024, reduce the percentage of adult New Yorkers ages 65 and over that report frequent mental distress during the past month to 13.0%. Baseline: 14.4%.

**Objective 1.1.2.2** By December 31, 2024, reduce the percentage of adult New Yorkers with incomes less than \$15,000 that report frequent mental distress during the past month to 9.9%. Baseline: 11%.

**Objective 1.1.2.3** By December 31, 2024, reduce the percentage of adult New Yorkers with incomes between \$15,000 and \$74,000 that report frequent mental distress during the past month to 21.8%. Baseline: 24.2% (average).

Source: 2017 BRFSS

**Objective Geography level:** County

**Objective 1.1.3** By December 31, 2024, reduce the percentage of youth grades 9-12 who felt sad or hopeless to 27.4% Baseline: 30.4%.

Source: 2017 YRBS

**Objective Geography level:** State

**Intervention:** 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.

**Evidence base:**

- [Robert Wood Johnson Foundation. Wealth Matters for Health Equity](#)
- [American Journal of Preventive Medicine. Should health studies measure wealth? A systematic review](#)
- [Asset Funders Network. The Health and Wealth Connection. Opportunities for Investments Across the Life Course](#)

**Resources:**

- [Democracy Collaborative. Anchor Institutions](#)
- [Center for Community Change. Understanding Work-Owned Cooperatives](#)
- [Illinois State University. Stevenson Center for Community and Economic Development? Worker Cooperatives as an Innovation Strategy to Address Income Equality?](#)
- [Tufts University. Development Without Displacement: The Case for Community Land Trusts](#)
- [Annie E. Casey Foundation. The Anchor Dashboard. Aligning Institutional Practice to Meet Low-Income Community Needs](#)

**Age range(s):** All Ages – adults, indirect benefits to children

**Social Determinant(s) of Health addressed:** Economic Stability, Housing, Health Care, Education, Transportation, Natural Environment, Food Security, Community Cohesion, Built Environment, Social Capital, ACES.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Employers, Business and Unions, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Aging/gerontological Agencies, Policy Makers and Elected Officials, Housing, Economic Development, Natural Environmental and Urban Planning Agencies.

**Sectors Playing Contributing Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers, Media, Transportation Agencies.

**Intermediate-level measures:**

- Documented community wealth-building assets (e.g., land trusts, public spaces for people to meaningful engage, worker cooperatives) in the community
- Dollars invested in creating community wealth (e.g., inclusive health spaces, community-owned businesses, community development financial institutions)
- Jobs and businesses created in the community and retained (1 year, 5 years)

**Intervention:** Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a “whole person” approach in medical care.

**Evidence base:**

- [Health Affairs. Housing and Health: An Overview of the Literature](#)
- [Robert Wood Johnson Foundation. Where We Live Matters for Our Health: The Links Between Housing and Health](#)

**Resources:**

- [Community-Wealth.org. Community Land Trusts](#)
- [Enterprise and Annie E. Casey Foundation. Food at Home: Affordable Housing as a Platform to Overcome Nutritional Challenges](#)
- [CMS may allow hospitals to pay for housing through Medicaid](#)

**Age range(s):** Adults and older adults, indirect benefits to children

**Social Determinant(s) of Health Addressed:** Economic Stability, Housing, Natural Environment, Food Security, Community Cohesion and Built Environment.

**Sectors Placing Lead Role:** Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Housing, and Urban Planning Agencies.

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers, Media, Colleges and Universities, Schools, Economic Development Agencies, Natural Environmental Agencies, and Transportation Agencies.

**Intermediate-level measures:**

- Level of community cohesion
- Affordability: cost and resale cost of Community Land Trust homes compared to median home prices in surrounding homes
- Stability of housing: delinquency and foreclosing rates

**Intervention:** Create and sustain inclusive, healthy public spaces.

Ensure space for physical activity, food access, sleep; civic and community engagement across the lifespan.

**Evidence base:**

- [Oxford Brookes University. William K and Green S. Literature Review of Public Space and Local Environments for the Cross-Cutting Review](#)

**Resources:**

- [Gehl Institute. Inclusive Healthy Places. A Guide to Inclusion and Health in Public Space: Learning Globally to Transform Locally](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health addressed:** Economic Stability, Housing, Health Care, Education, Transportation, Natural Environment, Food Security, Community Cohesion, Built Environment.

**Sectors Playing Leading Roles:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Media, Colleges and Universities, Schools, Community and Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials,

Housing, Economic Development, Natural Environmental, Urban Planning and Transportation Agencies.

**Sectors Playing Contributing Roles:** Insurers.

**Intermediate-level measures:**

- Level of participation (e.g., informative, advisory, transactional, decision-making)
- Rate of volunteerism
- Opportunities for impromptu conversations in commons

**Intervention:** Integrate social and emotional approaches across the lifespan and establish 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.

**Evidence base:**

- [Healthy People. Mental Health](#)
- [Mental Health Commission of New South Wales. Physical health and mental well-being. Evidence Guide](#)
- [Canadian Mental Health Association. The Relationship between Mental Health, Mental Illness and Chronic Physical Conditions](#)
- [Community Schools: An Evidence—Based Strategy for Equitable School Improvement](#)

**Resources:**

- [New York State Education Department. Social Emotional Learning: Essential for Learning, Essential for Life, Essential for New York](#)
- [New York State Education Department. Mental Health](#)
- [School Mental Health Resource Training Center](#)
- [Community Schools Playbook – A Practical Guide to Advancing Community Schools Strategies](#)
- [The Community Guide. Violence: Early Childhood Home Visitation to Prevent – Child Maltreatment](#)
- [Center for Addiction and Mental Health. Best practice guidelines for mental health promotion programs: Older adults 55+](#)
- [AARP. Framework of Isolation in Adults over 50](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health addressed:** Economic Stability, Housing, Health Care, Education, Transportation, Natural Environment, Food Security, Community Cohesion, Built Environment.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, Policy Makers and Elected Officials, Transportation, Housing, Economic Development, Natural Environmental and Urban Planning Agencies.

**Sectors Playing Contributing Role:** CBOs and Human Service Agencies.

**Intermediate-level measures:**

- Percentage of adults 55+ who report that they are satisfied with the relationships they have with professionals, family and friends
- Percentage of adults 55+ reporting good or excellent well-being

**Intervention:** Enable resilience for people living with chronic illness by increasing protective factors such as independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.

**Evidence base:**

- [Glasgow Center for Population Health. Resilience for public health: Supporting transformation in people and communities](#)
- [British Medical Journal. Road to resilience: a systematic review and meta-analysis of resilience training programmes and intervention](#)
- [Mental Health Commission of New South Wales. Building Community Resilience and Wellbeing Report](#)
- [Cogent Psychology. Resilience in chronic diseases: A systematic review](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health addressed:** Economic Stability, Housing, Health Care, Education, Transportation, Natural Environment, Food Security, Community Cohesion, Built Environment.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Housing, Economic Development, Natural Environmental and Urban Planning Agencies.

**Sectors Playing Contributing Role:** Media.

**Intermediate-level measures:**

- Self-sufficiency as linked with education, employment, or similar services

**Intervention:** 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.

**Evidence base:**

- [The Community Guide. Violence: Early Childhood Home Visitation to Prevent – Child Maltreatment](#)

**Age range(s):** Children, teens, adults and older adults

**Social Determinant(s) of Health Addressed:** Education, Community Cohesion.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Natural Environmental Agencies.

**Sectors Playing Contributing Role:** Media, Policy Makers and Elected Officials, Transportation Agencies, Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Knowledge of mental illnesses and their treatments
- Knowledge of appropriate mental health first aid strategies, i.e. steps to take to get support

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

Among the most important of human needs is the desire for respect and dignity across the lifespan. This is especially important to consider among vulnerable groups in our communities such children, people with mental, emotional and behavioral disorders, lower socioeconomic groups, people of color, immigrants, those incarcerated, LGBTQ, youth, older adults among others. Policies and program interventions that promote inclusion, integration and competence along with education are strategies that can help.

**Objective 1.2.1** By December 31, 2024 increase New York State's Economy Scores by 7% to 52.3%. Baseline Economy Score 48.9%

**Objective 1.2.2** By December 31, 2024 increase New York State's Community Scores by 7% to 61.3%. Baseline Community Score 57.3%

**Objective 1.2.3** By December 31, 2024 increase New York State's Education Scores by 7% to 59.9%. Baseline Education Score 56.0%

**Objective 1.2.4** By December 31, 2024 increase New York State's Health Scores by 7% to 68.1%. Baseline Health Score 63.6%

Source: [Opportunity Index](#), Child Trends and Opportunity Nation

**Objective Geography level:** County

**Intervention:** Implement Mental Health First Aid.

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 co-occur with substance abuse).

**Evidence base:**

- [Mental Health First Aid Efficacy: A Compilation of Research Efforts](#)

**Resources**

- [Mental Health First Aid](#)
- [Youth Mental Health First Aid](#)

**Age range(s):** Children, teens, adults and older adults

**Social Determinant(s) of Health Addressed:** Education, Community Cohesion.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Natural Environmental Agencies.

**Sectors Playing Contributing Role:** Media, Policy Makers and Elected Officials, Transportation, Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Knowledge of mental illnesses and their treatments
- Knowledge of appropriate mental health first aid strategies, i.e. steps to take to get support

**Intervention:** Implement policy and program interventions that promote inclusion, integration and competence.

**Evidence base:**

- [Pescosolido BA, Medina TR, Martin JK, Long SJ. The "Backbone" of stigma: Identifying the Global Core of Public Prejudice Associated with Mental Illness. Am J Public Health. 2013;103:853–860. doi:10.2105/AJPH.2012.301147](#)
- [Stuart H, Arboleda-Florez J, Sartorius N. 2012. Paradigms Lost: Fighting Stigma and the Lessons Learned. New York: Oxford University Press](#)
- [National Academy of Sciences. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Approaches to reducing stigma](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health Addressed:** Economic Stability, Housing, Community Cohesion.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental, Emotional, and Behavioral Health, Employers, Businesses, and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Natural Environmental Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Percent of people with lived experience engaged in development and decision-making roles in programs
- Percent of people with lived experience engaged in implementation roles in programs

**Intervention:** 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.

**Evidence base:**

- [Pescosolido BA, Medina TR, Martin JK, Long SJ. The ""Backbone"" of stigma: Identifying the Global Core of Public Prejudice Associated with Mental Illness. Am J Public Health. 2013;103:853–860. doi:10.2105/AJPH.2012.301147](#)
- [Stuart H, Arboleda-Florez J, Sartorius N. 2012. Paradigms Lost: Fighting Stigma and the Lessons Learned. New York: Oxford University Press](#)
- [National Academy of Sciences. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Approaches to reducing stigma](#)
- [Yang LH, Link BG. Measurement of Attitudes, Beliefs and Behaviors of Mental Health and Mental Illness, October 2015](#)

**Age range(s):** All ages

**Social Determinant(s) of Health Addressed:** Economic Stability, Housing, Health Care, Education, Transportation, Natural Environment, Food Security, Community Cohesion, Built Environment.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Natural Environmental, Housing, Economic Development and Urban Planning Agencies

**Intermediate-level measures:**

- Attitudes to mental illness by community members, health care providers, police officers
- Rejection Experiences based on validated questionnaire
- Stigma Scale based on validated questions

## Focus Area 2: Mental and Substance Use Disorders Prevention

**Goal 2.1:** Prevent underage drinking and excessive alcohol consumption by adults

According to the National Institute on Drug Abuse, nearly 90% of addictions begin before age 18. Alcohol is the most-often identified gateway drug by people who misuse other substances such as heroin and prescription drugs. Preventing adolescents from using alcohol and other substances and supporting conditions or attributes that mitigate the risk factors associated with substance use are key strategies that can be used to prevent alcohol misuse.

**Objective 2.1.1** By December 31, 2024 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%. Source: 2017 YRBS.

**Objective 2.1.2** By December 31, 2024, reduce the age-adjusted percentage of adults (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% from 18.2% to no more than 16.4%. Source: 2017 Expanded BRFSS.

**Objective 2.1.3** By December 31, 2024, 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%. Source: 2017 Expanded BRFSS.

**Geographic level:** State

**Intervention:** Implement environmental approaches, including implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access.

**Evidence base:**

- [The Community Guide. Excessive Alcohol Consumption](#)

**Age range(s):** Youth, adults, older adults

**Social Determinant(s) of Health Addressed:** Health Care, Community Cohesion, Built Environment.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Colleges and Universities, CBOs and Human Service Agencies, Policy Makers and Elected Officials.

**Sectors playing Contributing Role:** Media, Schools, Community or Neighborhood Residents, Transportation, Natural Environmental, Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Change in local laws and ordinances to reduce alcohol availability such as passage of Social Host liability laws, restrictions on hours and days of alcohol sales, happy hour

and drink promotions, outlet density and alcohol advertising restrictions, prohibitions or controls on alcohol use at community events or in public areas (parks, beaches)

- Impact of enforcement of law 6-months to a year after law is enacted; e.g., violations, underage drinking in the last 30 days

**Intervention:** Implement/Expand School-Based Prevention and 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.

**Evidence base:**

- [LifeSkills Training. Evaluation Studies](#)
- [New York State Office of Alcoholism and Substance Abuse Services](#)

**Age range(s):** Youth

**Social Determinant(s) of Health Addressed:** Education.

**Sectors Playing Leading Role:** Schools, CBOs and Human Service Agencies.

**Sectors playing Contributing Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Community or Neighborhood Residents, Policy Makers and Elected Officials, Transportation, Natural Environmental, Housing, Economic Development and Urban Planning Agencies

**Intermediate-level measures:**

- Participation and completion of sessions
- Follow up in 1 month and six months regarding alcohol use days, alcohol binge days, and use of other substances

**Intervention:** 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.

**Evidence base:**

- [JAMA. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults](#)

**Age range(s):** Adults 18 years and older

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Playing Leading Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers.

**Sectors playing Contributing Role:** Governmental Public Health Agencies, Employers Businesses and Unions, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Natural Environmental, Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Percentage of persons offered screening and counselling
- Percent followed up with treatment

**Intervention:** Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) using electronic screening and brief interventions (e-SBI) with electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI.

**Evidence base:**

- [SAMHSA-HRSA Center for Integrated Health Solutions. SBIRT](#)

**Age range(s):** All ages

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Playing Leading Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers.

**Sectors playing Contributing Role:** Governmental Public Health Agencies, Employers Businesses and Unions, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Natural Environmental, Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Percentage of persons offered SBIRT, completed prescreen and full screen
- Percent positive, and percent followed up with treatment

**Intervention:** Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and engaging in cross-system collaboration.

**Resources:**

- [Implementing a Trauma-Informed Approach for Youth across Service Sector](#)
- [Case Western Reserve University. Center for Evidence-based Practices. Motivational Interviewing](#)

**Age range(s):** All ages, with focus on children and youth

**Social Determinant(s) of Health Addressed:** Education, Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers, Colleges and Universities, Schools, Policy Makers and Elected Officials.

**Sectors playing Contributing Role:** Employers Businesses and Unions, Media, Community or Neighborhood Residents, CBOs and Human Service Agencies, Transportation, Natural Environmental. Housing, Economic Development, and Urban Planning Agencies.

**Intermediate-level measures:**

- Completion of training
- Change in policies and/or implementation of policies

**Goal 2.2:** Prevent opioid overdose deaths

New York, like many states, is experiencing an opioid epidemic. Prescription opioid use is a predictor of heroin use for many people. There is strong correlation between self-harm behaviors and traumatic experiences, particularly adverse childhood experiences, which in turn are linked to nearly all health and social conditions. A coordinated multi-pronged approach that includes policies and programs that support training, education, treatment, strengthening community supports, and data-sharing can prevent opioid and other substance misuse and deaths. The New York State Department of Health’s initiatives to address opioids [are multi-pronged and encompass prevention and treatment.](#)

**Objective 2.2.1** By December 31, 2024, reduce the age-adjusted rate of overdose deaths involving any opioids by 7% to 14.3 per 100,000 population. Baseline: 15.4 per 100,000 population.

Source: NYS Vital Records

**Geographic level:** County

**Objective 2.2.2** By December 31, 2024, 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. Baseline year: 2017.

Source: PMP Registry

**Geographic level:** County

**Objective 2.2.3** By December 31, 2024, reduce the opioid analgesics prescription for pain, age-adjusted rate, by 5% to 350.0 per 1,000 population Baseline: 368.3 per 1,000. Baseline year: 2017.

Source: PMP Registry

**Geographic level:** County

**Objective 2.2.4** By December 31, 2024, 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. Baseline: 56.1 per 100,000 population.

Source: SPARCS

**Geographic level:** County

**Intervention:** Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine.

**Evidence base:**

- [Laroche, M. R., et al. \(2018\). "Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study." Ann Intern Med, 169\(3\): 137-145.](#)
- [Sordo, L., et al. \(2017\). "Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-analysis of Cohort Studies." BMJ; 357: j1550.](#)
- [FDA Drug Safety Communication: FDA Urges Caution about Withholding Opioid Addiction Medications from Patients Taking Benzodiazepines or CNS Depressants: Careful Medication Management Can Reduce Risks](#)

**Resources:**

- [SAMHSA TIP 63: Medications for Opioid Use Disorder](#)
- [Facing Addiction in America: The Surgeon General's Spotlight on Opioids](#)
- [Increasing Access to Medication-Assisted Treatment of Opioid Abuse in Rural Primary Care Practices. Content last reviewed July 2018. Agency for Healthcare Research and Quality, Rockville, MD.](#)
- [New York State. You Don't Have to be Alone in Addiction](#)
- [NYSDOH. Buprenorphine](#)
- [OASAS. Addiction Medications](#)

**Age range(s):** Adults, older adults, youth

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Placing Lead Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers, Policy Makers and Elected Officials.

**Sectors Playing Contributing Role:** Governmental Public Health Agencies, Employers Business and Unions, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, Housing, Transportation, Economic Development, Natural Environmental and Urban Planning Agencies.

**Intermediate-level measures:**

- Percent initiation of pharmacotherapy upon new episode of opioid use disorder
- Percent staff trained in trauma informed approach
- Methadone Treatment measure; Naltrexone treatment measure, Buprenorphine treatment measure – to be determined

**Intervention:** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.

**Evidence base:**

- [Oregon Health and Science University. Best Practices in Naloxone Treatment Programs for Opioid Overdose](#)

**Resources:**

- [New York State’s Opioid Overdose Prevention Program](#)
- [NYSDOH. How to Become a Registered Opioid Overdose Program](#)
- [NYSDOH. Availability of Naloxone in Pharmacies](#)
- [Prescribe to Prevent](#)

**Age range(s):** Teens, adults, older adults

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, CBOs and Human Service Agencies.

**Sectors Playing Contributing Role:** Employers, Business and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, Policy Makers and Elected Officials, Housing, Transportation, Economic Development, Natural Environmental and Urban Planning Agencies.

**Intermediate-level measures:**

- Percent staff who completed naloxone administration training
- Percent staff trained in trauma informed approach

**Intervention:** Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations.

**Evidence base:**

- [Kattan, J. A., et al. \(2016\). "Public Health Detailing-A Successful Strategy to Promote Judicious Opioid Analgesic Prescribing." Am J Public Health 106\(8\); 1430-1438.](#)

**Resources**

- [CDC Guideline for Prescribing Opioids for Chronic Pain, MMWR Recommendations and Reports / March 18, 2016 / 65\(1\): 1-49; Erratum, March 25, 2016 / 65\(11\)](#)
- [NYSDOH. Opioids Regulation and Legislation](#)
- [NYSDOH. Opioids: Healthcare Provider Information](#)

**Age range(s):** Teens, adults, older adults

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health.

**Sectors Playing Contributing Role:** Employers Business and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies Policy Makers and Elected Officials, Housing, Transportation, Economic Development, Natural Environmental, and Urban Planning Agencies.

**Intermediate-level measures:**

- High dose prescribing rates
- Prescribing rate for opioid prescriptions with more than 7-day supply

**Intervention:** Build support systems to care for opioid users or those at risk of an overdose

**Evidence base:**

- [SAMHSA. Recovery and Recovery Support](#)

**Resources:**

- [OASAS. Building a Foundation of Recovery in New York State](#)
- [Drug User Health Hubs: A Model Public Health Response in New York](#)

**Age range(s):** Youth, adults, older adults

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, CBOs and Human Service Agencies, Policy Makers and Elected Officials.

**Sectors Playing Contributing Role:** Employers Business and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, Housing, Transportation, Economic Development, Natural Environmental, and Urban Planning Agencies.

**Intermediate-level measures:**

- Opioid patients referred; served; and admitted for treatment within a defined time-period
- Number of patients referred to Drug User Health Hubs within a defined time-period

**Intervention:** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days.

**Evidence base:**

- [FDA. Safe Disposal of Medicines](#)

**Resources:**

- [NYSDOH. Medication Drop Boxes by County](#)

**Age range(s):** Adults, older adults

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, CBOs and Human Service Agencies.

**Sectors Playing Contributing Role:** Employers Business and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, Policy Makers and Elected Officials, Housing, Transportation, Economic Development, Natural Environmental, and Urban Planning Agencies.

**Intermediate-level measures:**

- Proportion of controlled prescription drug units collected within a defined time-period
- Proportion of controlled prescription drug units dispensed within a defined time-period

**Intervention:** Integrate trauma informed approaches in training staff and implementing program and policy.

**Evidence base:**

- [Trauma Informed Practice & the Opioid Crisis. A Discussion Guide for Health Care and Social Service Providers.](#)

**Resources:**

- [Implementing a Trauma-Informed Approach for Youth across Service Sector](#)
- [Case Western Reserve University. Center for Evidence-based Practices. Motivational Interviewing](#)

**Age range(s):** All ages

**Social Determinant(s) of Health Addressed:** Community Cohesion, Health Care.

**Sectors Placing Lead Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers, Business and Unions.

**Sectors Playing Contributing Role:** Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Housing, Transportation, Economic Development, Natural Environmental and Urban Planning Agencies.

**Intermediate-level measures:**

- Completion of training
- Change in policies and/or implementation of policies

**Goal 2.3:** Prevent and address adverse childhood experiences (ACEs)

Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse and mental disorders. Preventing ACEs, engaging in early identification of people who have experienced them, and helping adults heal from ACEs could have a significant impact on a range of critical health problems.

**Objective 2.3.1** Reduce the percentage of adults experiencing two or more adverse childhood experiences (ACEs) by 5% to no more than 33.8%.

ACEs Data: 35.6% two or more ACEs

Source: 2016 Expanded BRFSS

**Geographic level:** County

**Objective 2.3.2** By December 31, 2024, reduce indicated reports of abuse/maltreatment rate per 1,000 children and youth ages 0-17 years by 9% to 15.6 per 1,000 children and youth 0-17 years. Baseline: 17.1 per 1,000 children and youth.

Source: 2017 NYS Office of Children and Family Services – National Child Abuse and Neglect Data System (NCANDS)

**Geographic level:** County

**Objective 2.3.3** By December 31, 2024, increase communities reached by opportunities to build resilience by at least 10 percent. Baseline to be established in 2019.

Source: DOH/OASAS/OMH

**Geographic level:** County

**Intervention:** Integrate principles of trauma-informed approaches 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.

**Evidence base:**

- [Community Resilience Cookbook](#)
- [SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach](#)

**Age range(s):** All Ages

**Social Determinant(s) of Health Addressed:** Economic Stability, Health Care, Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Natural Environmental, Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Mapping of resilience building assets/sites
- Change in policies and/or implementation of policies

**Intervention:** Address Adverse Childhood Experiences and other types of trauma in the primary care setting.

**Evidence base:**

- [American Academy of Pediatrics. Addressing Childhood Experiences and Other Types of Trauma in the Primary Care Setting](#)

**Age range(s):** All ages with focus on children

**Social Determinant(s) of Health Addressed:** Health Care, Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies.

**Sectors Playing Contributing Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Natural Environmental, Housing, Economic Development, and Urban Planning Agencies.

**Intermediate-level measures:**

- Percent of primary care settings that screen for ACEs
- Percent of referrals to services following through in six months of being screened for ACEs

**Intervention:** Grow resilient communities through education, engagement, activation/mobilization and celebration.

**Resources:**

- [International Journal of Mental Health Addiction. A Whole Community Approach toward Child and Youth Resilience Promotion: A Review of Resilience Literature](#)
- [ACEs Connection. Growing Resilient Communities 2.0](#)

**Age range(s):** All ages

**Social Determinant(s) of Health Addressed:** Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Natural Environmental, Housing, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Level of trust, motivation, self-efficacy, belief that change is possible
- Social cohesion

**Intervention:** 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.

**Evidence base:**

- [The Community Guide. Violence: Early Childhood Home Visitation To Prevent – Child Maltreatment](#)

**Age range(s):** Children, teens, adults and older adults

**Social Determinant(s) of Health Addressed:** Education, Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Colleges and Universities, Schools, Community or Neighborhood

Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Natural Environmental Agencies.

**Sectors Playing Supporting Role:** Media, Policy Makers and Elected Officials, Transportation, Housing, Economic Development, and Urban Planning Agencies.

**Intermediate-level measures:**

- Knowledge of mental illnesses and their treatments
- Knowledge of appropriate mental health first aid strategies, i.e. steps to take to get support

**Goal 2.4:** Reduce the prevalence of major depressive disorders

Major depression is a common and serious mood disorder. It is characterized by a persistent feeling of sadness or a lack of interest in outside stimuli. Meta-analyses suggest that 22-38% of major depressive episodes can be prevented<sup>47</sup> and the results of randomized controlled trials have shown that the incidence of major depressive episodes can be significantly reduced.

**Objective 2.4.1** By December 31, 2024, reduce the past-year prevalence of major depressive episodes among adults aged 18 or older to 6.2%.

Baseline: 6.5%

Source: 2016-2017 NSDUH

**Objective 2.4.2** By December 31, 2024, reduce the past-year prevalence of major depressive episodes among adolescents aged 12-17 years to 10.4%

Baseline: 11.5%

Source: 2016-2017 NSDUH

**Intervention:** Strengthen resources for families and caregivers

**Evidence base:**

- [Guide to Community Preventive Services. The Community Guide. Evidence-Based Strategies to Manage Depressive Disorders](#)

**Resources:**

- [CDC Promotes Public Health Approach To Address Depression Among Older Adults](#)

**Age range(s):** Adults

**Social Determinant(s) of Health Addressed:** Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Schools, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Housing, and Economic Development Agencies.

**Sectors Playing Supporting Role:** Media, Colleges and Universities, Community or Neighborhood Residents, Transportation, Natural Environmental, and Urban Planning Agencies.

**Intermediate-level measures:**

- Change in social connections
- Resilience scores as measured by validated surveys

**Intervention:** Implement an evidence-based cognitive behavioral approach such as Peter Lewinsohn’s Coping with Depression course, Gregory Clarke’s Cognitive-Behavioral Prevention Intervention.

**Evidence base:**

- [Effect of a Web-based Guided Self-help Intervention for Prevention of Major Depression in Adults with Subthreshold Depression: A Randomized Trial](#)
- [Major Depression Can Be Prevented](#)

**Age range(s):** Adults

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Playing Leading Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health.

**Sectors Playing Supporting Role:** Governmental Public Health Agencies, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Housing, Natural Environmental, Economic Development, and Urban Planning Agencies.

**Intermediate-level measures:**

- Participation rates in therapy
- Participants perceived level of improvement and therapist satisfaction level

**Intervention:** Implement the Combined Parent-Child Cognitive-Behavioral Therapy (CPC\_CBT).

This is a short-term (16-20 sessions), strength-based therapy program for children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies. These families can include those who have been substantiated for physical abuse, those who have had multiple unsubstantiated referrals, and those who fear they may lose control with their child.

**Evidence base:**

- [The California Evidence-Based Clearinghouse for Child Welfare. Combined Parent-Child Cognitive-Behavioral Therapy](#)

**Age range(s):** Children between 3-17 years old and their parents/caregivers.

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Playing Leading Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers, Community or Neighborhood Residents, CBOs and Human Service Agencies.

**Sectors Playing Supporting Role:** Governmental Public Health Agencies, Employers Businesses and Unions, Media, Colleges and Universities, Schools, Policy Makers and Elected Officials, Transportation, Housing, Natural Environmental, Economic Development, and Urban Planning Agencies.

**Intermediate-level measures:**

- Reduced children’s posttraumatic stress disorder symptoms (PTSD), depression, other internalizing symptoms and behavior problems
- Parent/caregiver use of effective non-coercive parenting strategies

**Goal 2.5:** Prevent suicides

Suicide can be prevented. A recent CDC study showed that range of factors contribute to suicide among those with and without known mental health conditions. These include relationship problems, life stressors and recent or impending crises. Communities can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

**Objective 2.5.1** By December 31, 2024, 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%. Baseline: 10.1%.

Source: 2017 YRBS

**Objective 2.5.2** By December 31, 2024, reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000. Baseline: 7.8 per 100,000.

Source: 2015 Bureau of Biometrics

**Intervention:** Strengthen economic supports: strengthen household financial security, and policies that stabilize housing.

**Evidence base:**

- [National Center for Injury Prevention and Control. Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health Addressed:** Housing.

**Sectors Playing Leading Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Housing, Economic Development, and Urban Planning Agencies.

**Sectors Playing Supporting Role:** Governmental Public Health Agencies, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Transportation, Natural Environmental Agencies.

**Intermediate-level measures:**

- Dollars in strengthening economic and housing supports
- Stability of housing: delinquency and foreclosure rates

**Intervention:** Strengthen access and delivery of suicide care – Zero Suicide (a commitment to comprehensive suicide safer care in health and behavioral health care systems).

**Evidence base:**

- [Zero Suicide](#)

**Age range(s):** Children, teens, adults and older adults

**Social Determinant(s) of Health Addressed:** Health Care, Built Environment.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Housing, Economic Development and Urban Planning Agencies.

**Sectors Playing Supporting Role:** Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Housing, Natural Environmental, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Percent of patients who were screened for suicide during reporting period [Could also consider % of behavioral health, primary care, crisis, and ER providers who received suicide prevention specific training]
- Percent of clients who screened and assessed positive for suicide risk and received and evidence-based intervention (same day as screening) during the reporting period (e.g., Stanley Brown Safety Plan Intervention)

**Intervention:** Create protective environments: reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches; reduce excessive alcohol use.

**Evidence base:**

- [Harvard T.H. Chan School of Public Health. Means Matter](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health Addressed:** Community Cohesion, Built Environment.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Community or Neighborhood Residents, CBOs and Human Service Agencies, Housing, and Urban Planning Agencies.

**Sectors Playing Supporting Role:** Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Policy Makers and Elected Officials, Transportation, Natural Environmental, and Economic Development Agencies.

**Intermediate-level measures:**

- Percent of providers who completed Counseling on Access to Lethal Means (CALM) training
- Percent of family and community members who complete lethal means counselling, and follow through on recommendations

**Intervention:** 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 suicide.

**Evidence base:**

- [Suicide Prevention Resource Center. Choosing a Suicide Prevention Gatekeeper Training Program – A Comparison Table](#)
- [RAND Suicide Prevention Program Evaluation Toolkit](#)
- [QPR Gatekeeper Training](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health Addressed:** Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials.

**Sectors Playing Supporting Role:** Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Transportation, Natural Environmental, Economic Development, Housing, and Urban Planning Agencies.

**Intermediate-level measures:**

- The number of individuals who received crisis intervention services (e.g., County Crisis Services, Lifeline Calls, Crisis Text Line messages)
- Percent of individuals with a suicide attempt during the reporting period who received an evidence-based intervention shown to reduce reattempts

**Intervention:** Promote connectedness, coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program

**Evidence base:**

- [National Center for Injury Prevention and Control. Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#)

**Age range(s):** All age groups

**Social Determinant(s) of Health Addressed:** Community Cohesion.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health, Employers Businesses and Unions, Insurers, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Housing, Natural Environmental, Economic Development, and Urban Planning Agencies.

**Sectors Playing Supporting Role:** Media, Transportation.

**Intermediate-level measures:**

- Extent to which individuals have engaged in help-seeking behaviors in the past three months (e.g., In the past three months, have they received treatment from a mental health professional)
- Proportion who had positive expectancies about living, engaged in civic life

**Goal 2.6:** Reduce the mortality gap between those living with serious mental illnesses and the general population

People with severe mental disorders on average tend to have a 10-24 year shorter life expectancy than the general populations. Most of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes, hypertension and suicide. Interventions exist to promote the mental and physical health of individuals with severe mental disorders. They include increasing access to quality care for patients with severe mental disorders, improve the diagnosis and treatment of coexisting physical conditions, and integration of mental and physical health care.

**Objective 2.6.1** By December 31, 2024, decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%

Baseline: 34.3%.

Source: 2015-2016 NSDUH.

**Intervention:** Implement a multilevel intervention model that focuses at the individual, health systems, community and policy-levels. This model describes a comprehensive framework that may be useful for designing, implementing and evaluating interventions and programs to reduce excess mortality in persons with SMD.

**Evidence base:**

- [World Psychiatry. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas](#)

**Age range(s):** Adults and older adults

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Playing Leading Role:** Governmental Public Health Agencies, Healthcare Delivery System, Mental Emotional and Behavioral Health.

**Sectors Playing Supporting Role:** Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Housing, Natural Environmental, Economic Development, and Urban Planning Agencies.

**Intermediate-level measures:**

- Evidence of a written plan that has components of individual, health systems, community and policy level interventions
- Evidence of implementation and evaluation of the plan

**Intervention:** Implement integrated treatment including concurrent therapy for mental illness and nicotine addiction.

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 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.

**Evidence base:**

- [National Institute on Drug Abuse. Do people with mental illness and substance use disorders use tobacco more often?](#)

**Age range(s):** Adults and older adults

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Playing Leading Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health.

**Sectors Playing Supporting Role:** Governmental Public Health Agencies, Employers Businesses and Unions, Insurers, Media, Colleges and Universities, Schools, Community or Neighborhood Residents, CBOs and Human Service Agencies, Policy Makers and Elected Officials, Transportation, Housing, Natural Environmental, Economic Development and Urban Planning Agencies.

**Intermediate-level measures:**

- Proportion of patients follow treatment regime recommended by mental health providers
- Extent to which an individual is adhering to prescribed psychotropic medications

**Intervention:** Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers.

**Evidence base**

- [Promoting Health Systems Improvement for a Tobacco-Free New York. Supporting Evidence-based Tobacco Dependence, Screening and Treatment. Behavioral Health Settings Training Toolkit](#)

**Age range(s):** All ages

**Social Determinant(s) of Health Addressed:** Health Care.

**Sectors Playing Leading Role:** Healthcare Delivery System, Mental Emotional and Behavioral Health, Insurers, Colleges and Universities.

**Sectors Playing Supporting Role:** Governmental Public Health Agencies, Employers Businesses and Unions, Media, CBOs and Human Service Agencies, Policy Makers and Elected Officials.

**Intermediate-level measure:** Proportion of mental health providers licensed to screen and treat for tobacco dependence

## References

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<sup>47</sup> Muñoz RF, Beardslee WR, Leykin Y. Major depression can be prevented. *American Psychology*. 2012: May-Jun;67(4):285-95. doi: 10.1037/a0027666.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4533896/>

# New York State Prevention Agenda

## Prevent Communicable Diseases Priority Action Plan

Updated: June 30, 2023

### Define the Priority:

A communicable disease is an illness or infection that can be spread from person to person, animal to person, animal to animal or person to animal. Communicable diseases contribute to sickness and death in New York State and are preventable. Additional information about the burden of communicable diseases, underlying risk factors and associated disparities can be found at:

[https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/docs/sha/contributing\\_causes\\_of\\_health\\_challenges.pdf#page=153](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/sha/contributing_causes_of_health_challenges.pdf#page=153)

The Prevent Communicable Disease Action plan contains five focus areas, each with at least one goal:

#### **Focus Area 1:** Vaccine Preventable Diseases

**Goal 1.1:** Improve vaccination rates

**Goal 1.2:** Reduce Vaccination coverage disparities

#### **Focus Area 2:** Human Immunodeficiency Virus (HIV)

**Goal 2.1:** Decrease HIV morbidity (new HIV diagnoses)

**Goal 2.2:** Increase viral suppression

#### **Focus Area 3:** Sexually Transmitted Infections

**Goal 3.1:** Reduce the annual rate of growth for STIs

#### **Focus Area 4:** Hepatitis C Virus (HCV)

**Goal 4.1:** Increase the number of persons treated for Hepatitis C Virus

**Goal 4.2:** Reduce the number of new HCV cases among people who inject drugs

#### **Focus Area 5:** Antimicrobial Resistance and Healthcare-Associated Infections

**Goal 5.1:** Improve infection control in healthcare facilities

**Goal 5.2:** Reduce infections caused by multidrug resistant organisms

**Goal 5.3:** Reduce inappropriate antibiotic use

## Focus Area 1: Vaccine Preventable Diseases

The reduction of vaccine-preventable diseases is an extremely important public health goal achieved through immunization. Although vaccine-preventable disease (VPD) rates are low in New York State (NYS) and in the United States (US), the prevalence of certain diseases is beginning to increase due to pockets of under-immunization and global travel. In addition, lagging human papillomavirus (HPV) and influenza vaccine coverage in NYS puts New Yorkers at risk of these serious vaccine-preventable diseases.

### **Goal 1.1:** Improve Vaccination Rates

#### **Objectives:**

1.1.1 By December 31, 2024, increase the rates of immunization among NYS 24-35-month-olds with the 4:3:1:3:3:1:4 series (4 DTaP, 3 polio, 1 MMR, 3 Hep B, 3 Hib, 1 varicella, 4 PCV13) by 10% from 64.1% in 2018 to 70.5%.

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

1.1.2 By December 31, 2024, increase the percentage of NYS 13-year-old adolescents with a complete HPV vaccine series by 10% from 34.0% in 2018 to 37.4%.

*Data Source: NYSIIS and CIR*

1.1.3 By December 31, 2024, increase influenza immunization rates of New Yorkers aged 6 months and older by 10% from 49.80% in 2016-17 to 54.8%.

*Data Source: FluVaxView*

1.1.4 By December 31, 2024, increase the age-adjusted pneumococcal vaccination rate of New Yorkers aged 65 years and older by 10% from 69.3% in 2016 to 76.2%.

*Data Source: Behavioral Risk Factor Surveillance System*

### **Goal 1.2:** Reduce vaccination coverage disparities

#### **Objectives:**

1.2.1 By December 31, 2024, reduce the disparity measured by the difference in the 4:3:1:3:3:1:4 vaccine series coverage between NYS 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 50% to 4.90%.

- Baseline: 9.70%; Year: 2016

*Data Source: National Immunization Survey*

1.2.2 By December 31, 2024, reduce the difference in HPV vaccine series completion between NYS adolescent boys and girls by 50% to 5.50%.

- Baseline: 11%; Year: 2016

*Data Source: National Immunization Survey – Teen*

**Intervention #1:** Ensure and enforce strong immunization requirements for child care, school and post-secondary institution entry and attendance.

**Evidence base:**

- [Community Preventive Services Task Force Finding and Rationale Statement: Vaccination Requirements for Child Care, School, and College Attendance](#)

**Age range(s):** May impact all ages, but primarily impacts:

- Children up to age 12
- Adolescents (13-21)

**Social Determinant of Health addressed:** Education

**Sector(s) playing lead role:** Governmental Public Health Agencies; Colleges and Universities; Schools (K-12); Policy makers and elected officials

**Sector(s) playing contributing role:** Healthcare Delivery System, Insurers, Media, Community or neighborhood residents, CBOs and Human service agencies

**Intermediate-level measures:**

- Increased annual school immunization coverage rates.
- Decreased annual school medical and religious exemption rates.

**Intervention #2:** Maximize use of the New York State Immunization Information System (NYSIIS) and the Citywide Immunization Registry (CIR) for vaccine documentation, assessment, decision support, reminders and recall. Increased use of the registries can better inform assessments of vaccine coverage, missed vaccination opportunities and help address disparities in vaccine coverage including those for specific age groups.

**Evidence base:**

- [Community Preventive Services Task Force Finding and Rationale Statement: Immunization Information Systems](#)

**Age range(s):** All Ages, including older adults.

**Social Determinant of Health addressed:** Health Care

**Sector(s) playing lead role:** Governmental Public Health Agencies; Healthcare Delivery System; Policy makers and elected officials

**Sector(s) playing contributing role:** Insurers; Media; Colleges and Universities; Schools (K-12); CBOs and Human service agencies

**Intermediate-level measures:**

- Increased proportion of immunizations reported to NYSIIS within 14 days of administration

- Increased number of reminder/recall reports run in NYSIIS each year

**Intervention #3:** Implement and promote use of standing orders for vaccine administration.

**Evidence base:**

- [Community Preventive Services Task Force Finding and Rationale Statement: Standing Orders](#)

**Age range(s):** All ages, including older adults.

**Social Determinant of Health addressed:** Health Care

**Sector(s) playing lead role:** Healthcare Delivery System;

**Sector(s) playing contributing role:** Governmental Public Health Agencies; Insurers; Colleges and Universities; CBOs and Human service agencies; Policy makers and elected officials

**Intermediate-level measures:**

- Increased number of clinics utilizing standing orders for vaccine administration
- Increased proportion of vaccines administered by the clinic for which standing orders have been implemented

**Intervention #4:** Minimize client out-of-pocket costs for vaccinations.

**Evidence base:**

- [Community Preventive Services Task Force Finding and Rationale Statement: Reducing Client Out-of-Pocket Costs for Vaccinations](#)

**Age range(s):** All ages

**Social Determinant of Health addressed:** Economic Stability; Health Care

**Sector(s) playing lead role:** Governmental Public Health Agencies; Healthcare Delivery System; Policy makers and elected officials

**Sector(s) playing contributing role:** Media; CBOs and Human service agencies

**Intermediate-level measures:**

- Increased number of no-cost or reduced-cost vaccine doses administered
- Increased number of patients referred to health insurance navigators

**Intervention #5:** 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.

**Evidence base:**

Stinchfield PK. Practice-proven interventions to increase vaccination rates and broaden the immunization season. The American Journal of Medicine. 2008;121(7): S11–S21.

**Age range(s):** All ages including older adults

**Social Determinant of Health addressed:** Economic Stability; Education; Transportation; Health Care

**Sector(s) playing lead role:** Healthcare Delivery System; Employers and businesses and unions

**Sector(s) playing contributing role:** Governmental Public Health Agencies; Insurers; Media; Colleges and Universities; Schools (K-12); CBOs and Human service agencies; Policy makers and elected officials

**Intermediate-level measures:**

- Improved patient/parent satisfaction with clinic locations and hours
- Increased number of patients seen per clinic date and location

## Focus Area 2: Human Immunodeficiency Virus (HIV)

New York State is engaged in a three-point plan to move closer to the end of the AIDS epidemic. The goal is to reduce the number of new HIV infections to just 750 (from an estimated 3,000 in 2013) by 2020 and achieve the first ever decrease in HIV prevalence in New York State.

The three-point plan identifies persons with HIV who remain undiagnosed and link them to health care; links and retains persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission; and facilitates access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

[Ending the Epidemic \(ETE\)](#) is maximizing the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. It will move New York from a history of having the worst HIV epidemic in the country to a future where new infections are rare and those living with the disease have normal lifespans with few complications. This focus area plan was developed in conjunction with and supports *Ending the Epidemic*.

**Goal 2.1:** Decrease HIV Morbidity (new HIV Diagnoses)

**Goal 2.2:** Increase Viral Suppression

### Objectives

2.1.1 By December 31, 2024, reduce the number of new HIV diagnoses by 70% to 1,020 diagnoses or 5.2 per 100,000 population. (Baseline: 3,391 diagnoses or 17.3 per 100,000 population; Year: 2013; Data Source: HIV Surveillance)

2.1.2 By December 31, 2024, reduce the newly diagnosed HIV case rate among African Americans by 70% to no more than 13 new diagnoses per 100,000 population. (Baseline: 43 per 100,000 population; Year: 2013; Data Source: HIV Surveillance)

2.1.3 By December 31, 2024, reduce the newly diagnosed HIV case rate among Hispanics by 70% to no more than 10 new diagnoses per 100,000 population. (Baseline: 32 per 100,000 population; Year: 2013; Data Source: HIV Surveillance)

2.2.1 By December 31, 2024, increase the percentage of all persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 17% to 95%. (Baseline: 81%; Year: 2013; Data Source: HIV Surveillance)

2.2.2 By December 31, 2024, increase the percentage of African American persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 23% to 95%. (Baseline: 77%; Year: 2013; Data Source: HIV Surveillance)

2.2.3 By December 31, 2024, increase the percentage of Hispanic American persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 17% to 95%. (Baseline: 81%; Year: 2013; Data Source: HIV Surveillance)

**Intervention #1:** 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

**Evidence Base:** PrEP is a targeted biomedical intervention to facilitate “health care as prevention,” a six-pronged intervention for people who are HIV-negative and at high risk for infection. The intervention includes a once daily pill; periodic HIV testing; periodic STD screening; counseling about the use of condoms to prevent STDs; education about harm reduction options; and, counseling to promote adherence to the once-a-day PrEP medication. PrEP has been studied in multiple randomized controlled and open-label trials in several populations, including MSM,<sup>48 49</sup> heterosexual serodiscordant couples,<sup>50</sup> heterosexual men and women,<sup>51, 52, 53</sup> transgender women,<sup>54</sup> and PWID.<sup>55</sup> A recent meta-analysis suggests >70% protection across all studies in which >70% adherence was reported.<sup>56</sup>

**Implementation Resources:** NYS Medicaid, along with most insurance plans, covers the only currently FDA-approved PrEP medication, Truvada®. Uninsured individuals may receive Truvada® through the Gilead patient assistance program: (<https://start.truvada.com/>). The NYS PrEP Assistance Program can also help to cover the costs of clinical visits and lab testing for uninsured and underinsured individuals who qualify:

[https://www.health.ny.gov/diseases/aids/general/prep/docs/prep\\_payment\\_options.pdf](https://www.health.ny.gov/diseases/aids/general/prep/docs/prep_payment_options.pdf). The NYS DOH website on PrEP has useful information on PrEP and nPEP programming, as well as links to additional resources:

<https://www.health.ny.gov/diseases/aids/general/prep/consumers.htm>

**Target Population by Age:** New Yorkers of all ages at highest risk for acquiring HIV

**Social Determinants of Health:** Health care

**Sectors Playing Lead Role:** State and local health departments, STI service providers, healthcare delivery system.

**Sectors Playing Contributing Role:** Insurers, Colleges and universities, community or neighborhood residents, CBOS Human Service agencies

**Intermediate Measures:** Number of New Yorkers prescribed PrEP, by patient demographic factors to ensure equal access.

**Intervention #2: 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.

**Evidence Base:** Clinical trials and cohort studies have long supported the fact that adherence to Antiretroviral Therapy (ART) reduces the risk of transmitting HIV. Today, treatment as prevention (TasP) has become a widely-accepted strategy for addressing the HIV epidemic and reducing new infections. Most recently, results from the HIV Prevention Trials Network 052<sup>57</sup> and PARTNER<sup>58</sup> studies demonstrate that, not only does effective antiretroviral treatment improve the health of each person living with HIV, it also prevents transmission of HIV to sexual partners. Thus, individuals with a sustained undetectable viral load will not sexually transmit HIV, or “Undetectable equals Untransmittable” (U=U). Please visit <https://health.ny.gov/endingtheepidemic> to view a recent webinar on the topic of U=U and to receive updates as they become available.

Data to Care (D2C) is a public health strategy that uses HIV surveillance and other data to support the HIV Care Continuum, by identifying persons living with HIV who are in need of HIV medical care or other services and facilitating linkage to those services. Some examples of D2C activities include using HIV surveillance data to identify persons who are not in care (NIC) and then link or re-engage them in care; and identifying persons who are in care but are not virally suppressed and work with clients and their providers to support attaining viral suppression.

D2C has been shown to:

- Improve linkage to or re-engagement in care for persons living with HIV;
- Improve viral suppression;
- Improve surveillance data quality; and
- Promote better collaboration between surveillance, prevention and care and treatment staff.

More information on DTC is available at: <https://effectiveinterventions.cdc.gov/en/2018-design/data-to-care/group-1/data-to-care/data-to-care-essential-elements>

**Implementation Resources:** Strategies and Resources for Retention in Care resource has been posted to the NYSDOH website. It can be found at:  
[http://www.health.ny.gov/diseases/aids/general/standards/docs/strategies\\_resources\\_retention\\_in\\_care.pdf](http://www.health.ny.gov/diseases/aids/general/standards/docs/strategies_resources_retention_in_care.pdf).

**Target Population by Age:** New Yorkers living with diagnosed HIV infection who are not virally suppressed (or who are risk of becoming unsuppressed)

**Social Determinants of Health:** Health Care

**Sectors Playing Lead Role:** State and local health departments, including partner services programs, healthcare delivery system, MCOs.

**Sectors Playing Contributing Role:** Colleges and universities, community or neighborhood residents, CBOS Human Service agencies

**Intermediate Measures:** Viral suppression, by patient demographic factors to ensure equity across all groups

## Focus Area 3: Sexually Transmitted Infections (STIs)

One important aspect of achieving optimal sexual health is the identification, treatment, and prevention of sexually transmitted infections (STIs). STIs can be spread from person to person through condomless genital, anal, and oral sex. Untreated STIs can lead to abdominal pain, infertility, pelvic inflammatory disease, and more serious complications. Pregnant women with syphilis may pass their infection on to their infants (or in the uterus) which can cause major health problems, including stillbirth or death shortly after birth.

STIs are the most commonly reported communicable disease. To interrupt the steady increase in rates, public health and health care professionals engage in education and counseling, testing, and treatment, along with provider and community engagement to support prevention.

### **Goal 3.1:** Reduce the annual rate of growth for STIs

#### **Objectives**

3.1.1 By December 31, 2024, reduce the annual rate of growth for early syphilis by 50% to 10%. (Baseline: 20%; Year: 2012-2016 average 5-year percent change; Data Source: STI Surveillance)

3.1.2 By December 31, 2024, reduce the annual rate of growth for gonorrhea by 50% to 4%. (Baseline: 8%; Year: 2012-2016 average 5-year percent change; Data Source: STI Surveillance)

3.1.3 By December 31, 2024, reduce annual rate of growth for chlamydia by 50% to 1%. (Baseline: 2%; Year: 2012-2016 average 5-year percent change; Data Source: STI Surveillance)

3.1.4 By December 31, 2024, keep the age-adjusted diagnosis rate of gonorrhea to no more than 242.6 per 100,000 population (Baseline: 149.8 per 100,000; Year: 2016; Data Source: STI Surveillance).

3.1.5 By December 31, 2024, keep the age-adjusted diagnosis rate of chlamydia to no more than 676.9 per 100,000 population (baseline: 567.0 per 100,000; Year: 2016; Data Source: STI Surveillance).

3.1.6 By December 31, 2024, keep the age-adjusted diagnosis rate of early syphilis to no more than 79.6 per 100,000 population (Baseline: 31.2 per 100,000; Year: 2016; Data Source: STI Surveillance).

**Intervention #1: Increase partner services**

**Evidence Base:** Partner Services is the front-line public health intervention for interrupting HIV and STI transmission in the community. Trained DOH workers work with persons newly diagnosed with HIV or STIs to ensure they and their partners are linked to care, treatment, and prevention. Any provider who diagnoses STIs should work with their local DOH partner services program to ensure their patients have access to this free, confidential service.

**Implementation Resources:**

[https://www.health.ny.gov/diseases/communicable/std/partner\\_services/index.htm](https://www.health.ny.gov/diseases/communicable/std/partner_services/index.htm)

<https://www.cdc.gov/std/program/partners.htm>

<https://nysptc.org/>

[https://www.health.ny.gov/diseases/aids/ending\\_the\\_epidemic/docs/std\\_workgroup\\_strategies.pdf](https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/std_workgroup_strategies.pdf)

**Target Population by Age:** New Yorkers of all ages

**Social Determinants of Health:** Health care

**Sectors Playing Lead Role:** Governmental public health agencies, healthcare delivery system

**Sectors Playing Contributing Role:** Insurers, colleges and universities, community or neighborhood residents, CBOs and human service agencies

**Intermediate Measures:** Number of patients offered and accepting Partner Services, number of patients naming at least one partner, number of partners linked to testing and treatment

**Intervention #2 Increase STI testing and treatment**

**Evidence Base:** 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. While STIs are increasing, testing and treatment are effective methods for reducing transmission and promoting sexual health at the individual level. STI testing should be offered in venues and at times that are convenient for population groups most affected by STIs. Providers should ask their patients about which body parts they and their partners use during sex and offer STI testing of the throat and rectum (in addition to genitals) as appropriate.

**Implementation Resources:** <https://www.cdc.gov/std/tg2015/screening-recommendations.htm>

**Target Population by Age:** New Yorkers of all ages

**Social Determinants of Health:** Health care

**Sectors Playing Lead Role:** Healthcare delivery system

**Sectors Playing Contributing Role:** Governmental public health agencies, insurers, colleges and universities, schools, CBOs and human service agencies

**Intermediate Measures:** *Number of patients testing for STIs; number of patients positive for STIs; number of patients diagnosed with an STI who receive treatment*

**Intervention #3:** Promote distribution of condoms

**Evidence Base:** 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. New approaches for increasing condom utilization, and making condoms a regular part of sexual health, will be important for reducing STI impact in NYS. Providers of sexual health services can partner with the NYSCondom program to make condoms more available within their local community.

**Implementation Resources:** <https://www.cdc.gov/condomeffectiveness/index.html>  
<https://www.health.ny.gov/diseases/aids/consumers/condoms/nyscondom.htm>  
[https://www.health.ny.gov/diseases/aids/ending\\_the\\_epidemic/](https://www.health.ny.gov/diseases/aids/ending_the_epidemic/)  
[https://www.health.ny.gov/diseases/aids/ending\\_the\\_epidemic/docs/std\\_workgroup\\_strategies.pdf](https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/std_workgroup_strategies.pdf)

**Target Population by Age:** New Yorkers of all ages

**Social Determinants of Health:** Health care

**Sectors Playing Lead Role:** Healthcare delivery system

**Sectors Playing Contributing Role:** Governmental public health agencies, insurers, media, colleges and universities, schools, community or neighborhood residents, CBOs and human services agencies, housing agencies

**Intermediate Measure:** **Number of condoms distributed; percentage of sexually active people who report using condoms**

**Intervention #4:** Promote Expedited Partner Therapy

**Evidence Base:** 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. Broad implementation of EPT across multiple provider types will be an important population-level intervention for chlamydia control, given this STI's prevalence in the state (with over 110,000 diagnoses annually it is the most commonly reported communicable disease). Providers of sexual health services should take steps to ensure EPT is offered to patients who they diagnose with chlamydia.

**Implementation Resources:**

<https://www.health.ny.gov/diseases/communicable/std/ept/>  
[https://www.health.ny.gov/diseases/aids/ending\\_the\\_epidemic/docs/std\\_workgroup\\_strategies.pdf](https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/std_workgroup_strategies.pdf)

**Target Population by Age:** New Yorkers of all ages

**Social Determinants of Health:** Health care

**Sectors Playing Lead Role:** Healthcare delivery system

**Sectors Playing Contributing Role:** Governmental public health agencies, insurers, media, colleges and universities, CBOs and human services agencies, policy makers and elected officials

**Intermediate Measure:** Number of providers who offer EPT, number of patients who receive an EPT prescription, number of EPT prescriptions filled

## Focus Area 4: Hepatitis C Virus (HCV)

Hepatitis C virus (HCV) causes liver disease and it is found in the blood of persons who are infected. HCV is spread by contact with the blood of an infected person.

HCV is a major public health problem causing substantial morbidity and mortality, including cirrhosis and liver cancer. Most people with HCV are unaware they are infected. Individuals with chronic infection are at risk for developing chronic liver diseases such as cirrhosis and cancer of the liver.

The approval of direct acting antiviral therapies makes it possible to cure most people who are treated, making HCV elimination possible. The majority of HCV infections occurs among PWID. Data released from Centers for Disease Control and Prevention (CDC), in 2017, shows that, in over just five years, the number of new HCV infections reported to CDC has nearly tripled, reaching a 15-year high. 850 new cases were reported in 2010, and 2,436 new cases reported in 2015.<sup>59</sup>

An estimated 114,000 New Yorkers are living with HCV. New York State has established a Hepatitis C Elimination Task Force to advise the state as it implements a plan to eliminate HCV. This Focus area was developed in conjunction with those efforts.

### **Goal 4.1:** Increase the number of persons treated for HCV

Objective 4.1.1: By December 31, 2024, increase the cumulative number of Medicaid enrollees treated for HCV by 497% - 724%, from 6,560 in 2017 to 32,611 – 47,466.  
(Baseline: 6,560; Year: 2017; Data Source: NYS Medicaid)

**Intervention #1:** Conduct educational campaign promoting testing and treatment for HCV.

**Evidence Base:** [CDC Know More Hepatitis Campaign](#)

**Implementation Resources:** [CDC Know More Hepatitis Campaign](#); [NYSDOH Hepatitis](#) web site; [NY Cures Hepatitis C](#) web site

**Target Population by Age:** New Yorkers of all ages

**Social Determinants of Health:** Community Cohesion, Health Care

**Sectors Playing Lead Role:** Public Health agencies, Healthcare Delivery

**Sectors Playing Contributing Role:** Employers businesses and unions, insurers, media, Colleges and universities, schools, community or neighborhood residents, human service agencies, policy makers and elected officials, transportation agencies housing agencies

**Intermediate Measures:** Availability of HCV educational materials, client awareness of Hepatitis C

**Intervention #2:** Increase capacity for HCV treatment across NYS by increasing provider knowledge and skills for prescribing HCV medications.

**Evidence Base:**

- [New York State Department of Health, Treatment of Hepatitis C Virus with Direct-Acting Antivirals](#)
- [AASLD/IDSA HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C](#)

**Implementation Resources:** The [New York State Department of Health AIDS Institute Clinical Education Initiative \(CEI\)](#) enhances the capacity of New York's diverse health care workforce to deliver clinical services to improve health outcomes related to HIV, sexually transmitted diseases (STDs) and hepatitis C (HCV).

**Target Population by Age:** All ages

**Social Determinants of Health:** Community Cohesion, Health Care

**Sectors Playing Lead Role:** Public Health agencies, Healthcare Delivery

**Sectors Playing Contributing Role:** Employers businesses and unions, insurers, media, Colleges and universities, schools, community or neighborhood residents, human service agencies, policy makers and elected officials, transportation agencies housing agencies

**Intermediate Measures:** MOUs with HCV providers for timely linkage to care; provider knowledge of HCV treatment

**Goal 4.2:** Reduce the number of new HCV cases among people who inject drugs

Objective 4.2.1: By December 31, 2024, increase the number of individuals with a syringe transaction at an AIDS Institute registered syringe exchange program by 3% annually to 33,781 clients in 2024. (Data Source: AIDS Institute Reporting System)

**Intervention #1:** Expand capacity for harm reduction services.

**Evidence Base:** Based on existing evidence, the U.S. Surgeon General has [determined](#) that Syringe Service Programs, when part of a comprehensive prevention strategy, can play a critical role in preventing HIV among persons who inject drugs (PWID); can facilitate entry into drug treatment and medical services; and do not increase the unsafe illegal injection of drugs. These programs have also been associated with reduced risk for infection with hepatitis C virus (HCV).

**Implementation Resources:** [NYSDOH AIDS Institute Policies and Procedures for Syringe Exchange Program.](#)

[CDC Syringe Services Program Guidance and Resources](#)  
[Syringe Services Program \(SSP\) Development and Implementation Guidelines for State and Local Health Departments, NASTAD.](#)

**Target Population by Age:** All New Yorkers with special focus on those < 30 years of age

**Social Determinants of Health:** Community Cohesion, Health Care

**Sectors Playing Lead Role:** Public Health Agencies

**Sectors Playing Contributing Role:** Healthcare Delivery, Employers businesses and unions, insurers, media, Colleges and universities, schools, community or neighborhood residents, human service agencies, policy makers and elected officials, transportation agencies housing agencies

**Intermediate Measures:** Increases in syringe distribution, provision of HCV screening and linkage to care

**Intervention #2:** Increase access to HCV screening among injection drug users < 30 years of age by providing onsite HCV rapid testing.

**Evidence Base:**

- [Recommendations for Prevention and Control of Hepatitis C Virus \(HCV\) Infection and HCV-Related Chronic Disease](#)
- [New York State Department of Health, Treatment of Hepatitis C Virus with Direct-Acting Antivirals](#)
- [AASLD/IDSA HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C](#)
- [CDC Recommendations for Hepatitis C Screening Among Adults in the United States](#)

**Implementation Resources:** [NYSDOH Hepatitis C Rapid Testing Implementation Guide](#)

**Target Population by Age:** All New Yorker with special focus on those < 30 years of age

**Social Determinants of Health:** Health Care, Education

**Sectors Playing Lead Role:** Health Care Delivery Systems, Public Health Agencies, CBOs and Human Service Providers

**Sectors Playing Contributing Role:** Healthcare Delivery, Employers businesses and unions, insurers, media, Colleges and universities, schools, community or neighborhood residents, human service agencies, policy makers and elected officials, transportation agencies housing agencies

**Intermediate Measures:** Establish MOU with agencies that conduct HCV screening.

## Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections

Antibiotic resistance occurs when antibiotics no longer work against bacteria that cause infections. Antibiotics can be lifesaving, but bacteria are becoming more resistant to treatment. Antibiotic resistance is part of a broader threat called antimicrobial resistance (AR), which is resistance to medicines used to treat all types of infections, including those caused by bacteria, parasites, and fungi. AR has been found in all regions of the world, and newly discovered strains continue to emerge and spread.

Factors such as increased globalization, poor infection control in hospitals and clinics, overprescribing of antibiotics, and unnecessary antibiotic use in agriculture are increasing the global threat of AR. The spread of AR is evident in the discovery of the *mcr-1* gene, which confers resistance to colistin, an antibiotic of last resort. The gene was initially identified in China in 2015, but has since been identified in more than 20 countries, including the United States (US). It has been found in humans, food, animals, and environmental samples. Infections acquired in the healthcare setting, both those with or without resistance, can lead to significant illness and death. Since 2007, New York State Public Health Law § 2819 has required acute care hospitals to report selected hospital-acquired infections to the NYSDOH. Reporting these infections allows NYSDOH to determine which hospitals need help implementing practices to decrease infection rates, and it enables hospitals themselves to identify areas for potential improvement. Additionally, people can use publicly reported infection rates to help them make decisions about where to seek medical care.

Approximately 3,600 carbapenem-resistant Enterobacteriaceae (CRE) (a highly resistant group of bacteria) cases were reported by NYS hospitals in 2015. Eleven percent of the cases were bloodstream infections, resulting in an estimated 130 deaths. The overall prevalence rate was highest in the New York City area. Additionally, *C. difficile* infections (CDI) are a common adverse effect of antibiotic use. Over 20,000 cases of CDI were identified by NYS hospitals in 2015 with 40% of cases associated with medical care during that hospital stay, while others were identified in an emergency department or soon after a hospital admission. These infections may have caused an estimated 1,120 deaths.

Studies indicate that 30-50% of antibiotics prescribed nationally are unnecessary or inappropriate. The New York State Department of Health (NYSDOH) Be Antibiotics Aware Program performed an analysis of 2010-2016 NYS Medicaid prescribing data which revealed significant avoidable prescribing and wide variation in use of potentially avoidable outpatient antibiotics for acute upper respiratory conditions. Therefore, one of the most important preventive approaches to combat AR is to decrease inappropriate antibiotic use.

The prevention and control of AR requires a multifaceted, aggressive, and coordinated statewide approach involving improved infection control and prevention, improved surveillance for multidrug-resistant organisms (MDROs), and a reduction in inappropriate antibiotic use.

### **Goal 5.1:** Improve infection control in healthcare facilities

- **Objective 5.1.1:** By December 31, 2024, 100% of hospitals and 85% of long-term care facilities implement an interfacility communication system regarding patient multidrug-resistant organism (MDRO) infection or colonization history.  
Metric: Number of healthcare facilities that implement a system.  
(Baseline: not yet known; Year: 2019; Data Source: NYS Health Commerce System (HCS) survey)
- **Objective 5.1.2:** By December 31, 2024, reduce central line-associated blood stream infections (CLABSIs) in hospital intensive care units and wards by 25% to 0.70 infections per 1,000 central line days.  
(Baseline: 0.92 CLABSI per 1,000 central line days in ICUs and medical/surgical wards and step-down units; Year: 2017; Data Source: National Healthcare Safety Network (NHSN))

#### **Interventions:**

1. 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 about infection prevention and control, healthcare-associated infections, and antibiotic resistance and to report healthcare-associated outbreaks.
2. Ensure staff who lead infection prevention and control at long-term care facilities have appropriate infection prevention and control training.
3. Ensure all staff are educated on infection prevention and control measures.
4. Ensure hospital evaluation of CLABSI rates and submission of an improvement plan, as appropriate.

#### **Evidence Base and Resources:**

- New York State (NYS) HCS User Account Request:  
[https://apps.health.ny.gov/pub/ctrldocs/paperless\\_edoc2.pdf](https://apps.health.ny.gov/pub/ctrldocs/paperless_edoc2.pdf)
- NYS HCS: [https://commerce.health.state.ny.us/public/hcs\\_login.html](https://commerce.health.state.ny.us/public/hcs_login.html)
- The Centers for Disease Control and Prevention (CDC) Infection Control:  
<https://www.cdc.gov/infectioncontrol/index.html>
- The CDC Inter-Facility Infection Control Transfer Form:  
<https://www.cdc.gov/hai/pdfs/toolkits/InfectionControlTransferFormExample1.pdf>
- The NYS Department of Health (NYSDOH) Hospital-Acquired Infection Rates in NYS Hospitals:  
[https://www.health.ny.gov/statistics/facilities/hospital/hospital\\_acquired\\_infections/](https://www.health.ny.gov/statistics/facilities/hospital/hospital_acquired_infections/)

- NYSDOH Infection Control:  
<https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/>

**Age range(s):** All ages; however, given the focus on improved infection prevention and control and patient safety in hospitals and long-term care facilities, these interventions will support older adults.

**Social Determinant of Health addressed:** Healthcare

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies and insurers

**Intermediate-level measures:**

- Long-term care facilities with an Infection Preventionist in the HCS role.
- An Infection Preventionist with completed specialized training in infection prevention and control.
- Number of infection prevention and control training and education materials provided to all staff in healthcare facility.
- Number of hospitals flagged with CLABSI rates significantly higher than the state average submitting improvement plans to the NYSDOH Hospital Associated Infection Reporting Program reporting program in time recommended.

**Goal 5.2:** Reduce infections caused by multidrug resistant organisms and *Clostridium difficile*

- **Objective 5.2.1:** By December 31, 2024, expand surveillance of healthcare associated multidrug-resistant organisms (MDROs). (Baseline: Not available; Data Source: NHSN)
- **Objective:** Decrease carbapenem-resistant Enterobacteriaceae (CRE) and *Clostridium difficile* Infection (CDI) identified by hospitals.
  - 5.2.2 By December 31, 2024, reduce hospital onset CRE bloodstream infections (BSIs) by 25% to 0.14 infections per 10,000 patient days. (Baseline: 0.18 cases per 10,000 patient days; Year: 2017; Data Source: NHSN)
  - 5.2.3 By December 31, 2024, reduce admission prevalent CRE BSIs by 25% to 0.30 infections per 10,000 hospital admissions. (Baseline: 0.40 cases per 10,000 patient days; Year: 2017; Data Source: NHSN)
  - 5.2.4 By December 31, 2024, reduce hospital-onset CDIs by 25% to 3.91 cases per 10,000 patient days. (Baseline: 5.21 cases per 10,000 patient days; Year: 2017; Data Source: NHSN)
  - 5.2.5 By December 31, 2024, reduce admission prevalent CDIs by 25% to 2.90 cases per 1,000 admissions. (Baseline: 3.87 cases per 1,000 admissions; Year: 2017; Data Source: NHSN)

- **Objective 5.2.6:** By December 31, 2024, reduce the total number of CRE infections/colonizations identified statewide by 10%. (Baseline: unknown; Year: 2020; Data Source: NYS Electronic Clinical Laboratory Reporting System (ELCRS) and NHSN)
- **Objective 5.2.7:** By December 31, 2024, improve identification of *Candida auris* (*C. auris*) infection and colonization. (Baseline: unknown; Year: unknown; Data Source: unknown)

**Interventions:**

1. Institute healthcare facility surveillance system for MDROs, such as by use of the NHSN MDRO module beyond CRE and CDI.
2. Ensure hospital evaluation of hospital onset CDI rates and submission of an improvement plan, as appropriate.
3. Expand laboratory testing capability for *C. auris*.

**Evidence Base and Resources:**

1. The CDC NHSN: <https://www.cdc.gov/nhsn/index.html>
2. The NYSDOH Hospital-Acquired Infection Rates in NYS Hospitals: [https://www.health.ny.gov/statistics/facilities/hospital/hospital\\_acquired\\_infections/](https://www.health.ny.gov/statistics/facilities/hospital/hospital_acquired_infections/)

**Age range(s):** All ages; however, given a higher prevalence of antimicrobial resistant infections found in individuals with comorbid conditions and exposure to healthcare, these interventions will support older adults.

**Social Determinant of Health addressed:** Healthcare

**Sector(s) playing lead role:** Healthcare delivery system,

**Sector(s) playing contributing role:** Governmental public health agencies and insurers

**Intermediate-level measures:**

- Number of healthcare facilities using the NHSN MDRO module for expanded MDRO surveillance beyond CRE and CDI.
- Number of hospitals identified with hospital onset CDI rates significantly higher than the state average submitting improvement plans to the NYSDOH HAI reporting program in time recommended.
- Number of clinical laboratories with a rapid test for *C. auris*.

**Goal 5.3:** Reduce inappropriate antibiotic use

**Objective 5.3.1:** By December 31, 2024, reduce potentially avoidable antibiotic prescribing rates for adult outpatient acute upper respiratory infections by 25% to 30%. (Baseline: 40% among adults 18 to 64 in Medicaid; Year: 2016; Data source: NYS Medicaid <https://health.data.ny.gov/Health/Potentially-Avoidable-Antibiotic-Prescribing-Rates/vg7a-h5ss>).

**Interventions:**

1. Use healthcare provider-level feedback data to inform antibiotic prescribing.
2. Conduct an educational campaign for the public on antimicrobial resistance and appropriate antibiotic use.
3. Offer healthcare provider education and public health detailing to prescribers.

**Evidence Base and Resources:**

1. The CDC Antibiotic Prescribing <https://www.cdc.gov/antibiotic-use/community/improving-prescribing/evidence/systematic-reviews.html>
2. The CDC Core Elements of Outpatient Antibiotic Stewardship: <https://www.cdc.gov/antibiotic-use/community/improving-prescribing/core-elements/core-outpatient-stewardship.html>
3. The CDC 6/18 Initiative <https://www.cdc.gov/sixeighteen/>

**Age range(s):** All ages; however, however, given higher rates of antimicrobial prescribing and use in older age groups, these interventions will support older adults.

**Social Determinant of Health addressed:** Healthcare

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies and insurers

**Intermediate-level measures:**

- Provision of antimicrobial prescribing data to all primary and acute care providers with comparison of their antibiotic prescribing patterns to benchmark.
- Number of healthcare providers reached with education and tools on antimicrobial resistance.

**Objectives:**

5.3.2 By December 31, 2024, 100% of hospitals and long-term care facilities will have an antimicrobial stewardship program (ASP) that meets the seven CDC core elements of antimicrobial stewardship. (Baseline: 88%; Year: 2017; Data Source: Health Commerce System Survey)

Compared to a baseline for hospitals from 2017, 88% of the 177 hospitals that participate in the NYS Hospital Associated Infection Reporting Program indicated on survey response in 2017 that they have an ASP that meets the seven core elements of hospital ASPs set forth by the CDC. Long-term care facilities-no baseline. In the future, this information can be collected from an annual survey on the Health Commerce System.

**Interventions:**

Evaluate the impact of the healthcare facility ASP (or an element of the program) to determine areas for improvement.

**Evidence Base and Resources:**

1. The CDC 6/18 Initiative <https://www.cdc.gov/sixeighteen/>
2. The CDC Core Elements of Hospital Antibiotic Stewardship Programs: <https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements.html>
3. The CDC Core Elements of Antibiotic Stewardship for Nursing Homes: <https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html>
4. The CDC NHSN: <https://www.cdc.gov/nhsn/index.html>

**Age range(s):** All ages; however, however, given higher rates of antimicrobial prescribing and use in older age groups, these interventions will measure support older adults.

**Social Determinant of Health addressed:** Healthcare

**Sector(s) playing lead role:** Healthcare delivery system

**Sector(s) playing contributing role:** Governmental public health agencies, insurers

**Intermediate-level measures:**

- Number of hospitals reporting antibiotic use data through NHSN Antibiotic Use and Resistance (AUR) Module.

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