New York State
Department of Health
Health Equity Plan

Year 1 (August 2024 – August 2025)

Building a Health Equity Foundation

NEW YORK STATE | Department of Health

Prepared by the Office of Health Equity and Human Rights

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LETTER FROM THE COMMISSIONER

I am excited to share the New York State Department of Health's Health Equity Plan.

In May 2024, I announced updated mission, vision, and values statements for the New York State Department of Health as well as a formal commitment to health equity. To be intentional about operating with a foundation of health equity, we need a plan. The Health Equity Plan is the first time we as the New York State Department of Health are laying out clearly what everyone's responsibility is to advance health equity in their job role.

Health equity means everyone has a fair and just opportunity to be healthy, where no one is limited in achieving optimal health because of who they are or where they live. This means that to work towards health equity, everyone must be able to access and experience the conditions in life that contribute to optimal health: safe and secure housing, steady and livable income, quality education, social support networks, quality health care, nutritious food, safe transportation, green spaces, clean air and water, and freedom from discrimination based on race, gender, sexual orientation, disability status, or any other part of one's identity.

At the heart of public health is health equity. Recognizing not all of us start at the same place, nor have the same advantages, health equity is about helping everyone, regardless of who they are or where they live, have a fair and just opportunity to achieve optimal health.

As public servants, we all play a significant role in putting an end to the health inequities, injustices, and systemic discrimination that marginalized communities face every day. As such, the New York State Department of Health is committed to making New York healthier for all, regardless of their race, ethnicity, age, disability, sexual orientation, gender identity, immigration, or socio-economic status.

I am proud of the work that many teams across the Department have already done to fight for health equity in New York State, and the Department has a lot to look forward to with new initiatives launching in the year ahead. The Health Equity Plan marks the beginning of a unified, Department-wide effort to work towards health equity.

The Health Equity Plan is a step towards building a culture in the New York State Department of Health where all employees share a common understanding of health equity as a core value of our work, and all employees understand that it is the responsibility of every one of us to fight for health equity in our roles at the Department. Whether your job function is data analysis, research, contracting and procurement, human resources, communications, or program administration; the Health Equity Plan contains important information about the expectations for your job role.

The Health Equity Plan is a living document. It will be updated regularly, and new tools and resources for staff will be added on an ongoing basis. This document will serve to guide efforts and ensure accountability as we work toward eliminating health disparities and improving the health of all New Yorkers.

Health inequities are unacceptable, and as a Department, we are committed to addressing them. I look forward to the work ahead knowing that we are unified as the New York State Department of Health in our fight for health equity.

James V. McDonald M.D., M.P.H.
Commissioner of Health

ACKNOWLEDGMENTS

The Executive Team of the Office of Health Equity and Human Rights would like to thank the following teams for their input and guidance on the development of the Health Equity Plan:

- Members of the New York State Department of Health's Health Equity and Diversity, Equity, and Inclusion Advisory Committee
- Staff from the Health Equity Unit as well as the Education and Training Program within the AIDS Institute (Louise Square, Richard Cotroneo, Atticus Ranck, Haseya Kee, and Dan Millard), who created the content for the three referenced training modules: "Health Equity", "Promoting Health Equity by Addressing Medical Mistrust" and "Applying a Health Equity Lens – An Organizational Approach". The content of these training modules helped to lay the groundwork for this Health Equity Plan.
- The Office of Minority Health and Health Disparities Prevention for beginning the original process of developing a Health Equity Plan for the Department.

The Office of Health Equity and Human Rights would also like to thank the following individuals for their input and guidance on the development of the Health Equity Plan (in alphabetical order by last name):

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We would also like to acknowledge all Department employees who have already gone above and beyond to advance health equity in their daily work. You can learn more about some of these initiatives in the Department case studies section.

Thank you to the current leadership at the New York State Department of Health: Commissioner Dr. James McDonald, for his steadfast commitment to and prioritization of health equity, and to Executive Deputy Commissioner Johanne Morne, who was instrumental in building the Office of Health Equity and Human Rights in her former role as Deputy Commissioner. Finally, we'd like to acknowledge former Commissioner Dr. Mary Bassett, for her unwavering leadership in establishing the Office of Health Equity and Human Rights within the New York State Department of Health in 2022.

WHAT IS THE PURPOSE OF THE HEALTH EQUITY PLAN?

This Health Equity Plan is designed to be a guide and action plan for **all staff in the New York State Department of Health** (the Department). The information in the Health Equity Plan is intended for **all levels of staff**, including front line staff, supervisors, middle managers, and executive staff. Whether your job function is data analysis, research, contracting and procurement, human resources, communications, or program administration; this document contains important information for you.

The goal of the Health Equity Plan is to ensure that health equity is the foundation for every decision made in the Department. The following pages provide Department staff with information about what health equity is, and how to apply the principles of health equity in their job role. All Department staff are encouraged to read through the Health Equity Plan and pay close attention to the resources that are available to learn more about how to work towards health equity for all.

WHAT IS IN THE HEALTH EQUITY PLAN?

This is the first issuance of the Department-wide Health Equity Plan (August 2024 – August 2025). The theme for the first year's Health Equity Plan is ***Building a Health Equity Foundation***. As a result, much of the content of this Health Equity Plan is intended to be educational, to support Department staff with building an understanding of what health equity is, why health equity is important, and how staff can work towards health equity through their daily job responsibilities.

The Health Equity Plan also includes a list of **Year 1 Strategies to Advance Health Equity**. This list describes strategies that the Department will focus on for the first year of the Health Equity Plan (August 2024 – August 2025). The goal is to build our skillset as a Department to advance health equity in our daily work. These strategies reflect some of the work required to build a health equity foundation for Department work. At the end of Year 1, the Department will assess the success of these strategies and determine what new strategies will be identified for Year 2.

> **In future iterations of the New York State Department of Health's Health Equity Plan, a larger portion of the document will be dedicated to action planning for Department-wide health equity initiatives. Because this is the first issuance of the Department's Health Equity Plan, more of this inaugural document is dedicated to sharing essential background knowledge for understanding health equity.**

HOW SHOULD I USE THE HEALTH EQUITY PLAN?

We encourage you to read the Health Equity Plan once through from start to finish, but the following guide offers suggestions for key sections to pay close attention to:

A suggested guide for reading the Health Equity Plan:

1. Review the “Glossary of Key Terms ”in Appendix A (readers are encouraged to refer to the Glossary of Key Terms as many times as needed while reading through the Health Equity Plan).
2. Read through the “What is Health Equity”? section to learn more about health equity, social determinants of health, and why health equity is important.
3. Review the "New York State Department of Health’s Health Equity Values".
4. Read the “What is a Health Equity Foundation?” section to learn how to prioritize working towards health equity in your job role.
   a. Be sure to review the “Applying a Health Equity Foundation: Sample Checklist”.
5. Review "Department Case Studies” to learn how different teams across the Department have used a health equity foundation in their work.

Once you have reviewed the Health Equity Plan from start to finish, some suggestions for becoming more familiar with using a health equity foundation include (but are not limited to):

1. Print out the following to keep at your desk/workstation as reminders:
   a. Applying a Health Equity Foundation: Sample Checklist
   b. New York State Department of Health’s Health Equity Values
   c. New York State Department of Health’s Mission, Vision, Values
   d. New York State Department of Health Commitment to Health Equity
2. Discuss the Health Equity Plan (section by section) at your next team meeting. How does this align with work you’re already doing? What might be some opportunities in your work to utilize a health equity foundation, for example?
3. Consider ways to encourage the professional development of your staff to build skills and knowledge related to health equity.
   a. If you are not a supervisor, consider ways to build your own skills and knowledge related to health equity (see the “Health Equity Resource Hub” for suggestions)
4. Check out the "Health Equity Resource Hub” SharePoint site, where you can find other teams across the Department working on health equity, review existing resources within the Department, and find external resources to continue learning about health equity.
5. Join the Health Equity and Diversity, Equity and Inclusion (DEI) Advisory Committee (convened by the New York State Department of Health’s Office of Health Equity and Human Rights) if you want to get more involved in intra-departmental health equity efforts.
6. Contact the Office of Health Equity and Human Rights at ohehr@health.ny.gov with your questions about the Health Equity Plan.

EXECUTIVE SUMMARY

Health equity means everyone has a fair and just opportunity to be healthy, where no one is limited in achieving optimal health because of who they are or where they live. This means that to work towards health equity, everyone must be able to access and experience the conditions in life that contribute to optimal health: safe and secure housing, steady and livable income, quality education, social support networks, quality health care, nutritious food, safe transportation, green spaces, clean air and water, and freedom from discrimination based on race, gender, sexual orientation, disability status, or any other part of one's identity. In a world where health equity is the norm, everyone has fair and just access to these conditions, and therefore, has a fair and just opportunity to achieve optimal health.

The Department is working towards establishing a Department-wide culture where all employees share a common understanding of health equity as a core value in theory and in practice, and where all departmental work is informed by health equity principles. Health equity is foundational to everything we do to help all people in New York State achieve optimal physical, mental and social well-being. This means that all program areas across the Department will use a health equity foundation as the basis for decision-making in their programs, planning, policies, and operations, so that working towards health equity becomes integrated into everyone's job function.

The Department's overarching goal is to achieve health equity and eliminate health disparities. Your work at the Department contributes to that goal. To achieve this goal, all Department staff must use a health equity foundation when performing their job duties. With a focus on health equity, the Department will be better prepared to identify, assess, and eliminate preventable health disparities and health related injustices in New York State.

A health equity foundation refers to an approach to thinking and decision-making grounded in health equity. When someone is using a health equity foundation to make decisions in their job role, key considerations include (but are not limited to):

- How racism, sexism, ableism, homophobia, transphobia, and other forms of discrimination unfairly disadvantage people by influencing access to social determinants of health, and lead to social and health inequities;
- How policies, programs, practices, services, and environments that support health can reduce or perpetuate health inequities;
- How structural factors and access to social determinants of health weigh more heavily on health outcomes than individual behaviors;
- How to facilitate a fair and just opportunity for health and a reduction in disparities (which will involve giving everyone what they need, rather than giving everyone the same thing), and;
- The importance of providing information that is understandable, and culturally and linguistically appropriate for all people.

Above all, when Department staff are thinking from a health equity foundation, they are always considering and asking themselves and each other the question: **Who may be facing barriers to accessing services, programs, or opportunities and how can we reduce or eliminate those barriers?**

> **It is the expectation and the responsibility of all Department staff, regardless of office, bureau, division, grade or job title, to understand what health equity is, share the commitment to health equity and seek opportunities to work towards health equity in their job role.**

The New York State Department of Health believes...

1. Health is a human right and should not be determined by discriminatory structural factors.
2. Achieving optimal health means a complete state of physical, social, and mental well-being. Optimal health includes:
   - **a.** Access to safe and secure housing
   - **b.** Living wages, secure employment, and safe working conditions
   - **c.** Access to quality education
   - **d.** Access to quality health care services
   - **e.** Access to affordable and nutritious food
   - **f.** Freedom from racism, homophobia, transphobia, sexism, ableism, and other forms of discrimination
   - **g.** Access to social support networks
   - **h.** Access to transportation
   - **i.** Access to safe green spaces
   - **j.** Access to clean air and water; community is free from environmental hazards
3. There are systemic factors that impact individual behaviors and one's ability to secure basic life necessities. This means that not everyone has a fair opportunity to achieve optimal health.
4. When advancing health equity in its work, the New York State Department of Health commits to centering race explicitly, not exclusively.
   - **a.** Racism is a national crisis that has profound impacts on public health. It is a foundational evil of our nation, and to this day, dictates access to and experience of social determinants of health. The New York State Department of Health names race explicitly, not exclusively, because racial inequities are deep and pervasive. When examining health disparities across various markers of identity, racial disparities often persist.
   - **b.** Racial inequities in health care are also historically normalized, accepted and willfully ignored. Fundamental to advancing health equity is asking "why" when we see health disparities present, especially when examining health disparities between different racial and ethnic groups. **Racism, not race, leads to health disparities present among racial groups.**
5. Racism, sexism, ableism, homophobia, transphobia, and other forms of discrimination are still deeply embedded in our society overall, and all public health and health care institutions. This includes the New York State Department of Health. The New York State Department of Health is committed to naming, discussing, and pursuing ways to mitigate all forms of discrimination within the Department.

The Health Equity Plan identifies specific strategies that the Department will initiate or continue in the first year of the Health Equity Plan (August 2024 – August 2025), which will hereafter be referred to as "Year 1". These strategies reflect conversations with staff across the Department to discuss the best "starting place" as an agency as we work towards a unified approach to achieve health equity. The goal of these strategies is to build our skillset as a Department to advance health equity in our daily work. The following table summarizes Year 1 Strategies. A more detailed explanation of the Year 1 Strategies can be found on page 29.

Summary of Year 1 Strategies to Advance Health Equity

STRATEGY	ACTION ITEM
Strategy 1: Establish New York State Department of Health's public commitment to health equity.	Update the New York State Department of Health's mission, vision, and values statements to reflect commitment to health equity.
Strategy 2: Assess Department staff skills, knowledge and needs as they relate to advancing health equity.	Develop report to summarize the skills, knowledge and needs of Department staff related to advancing health equity.
Strategy 3: Increase understanding of health equity foundational concepts and application among Department staff and contractors.	Require all Department staff and current and future contractors to participate in three health equity training modules, available through the HIV Education Center (offered through the AIDS Institute within the New York State Department of Health). • *Health Equity* • *Applying the Health Equity Lens – An Organizational Approach* • *Promoting Health Equity by Addressing Medical Mistrust*
Strategy 4: Ensure that health equity is a core component of all data analyses conducted by the Department and that health disparities are evaluated and considered.	Continue the development of Department-wide guidelines for equity-centered data analysis and presentation.
Strategy 5: Explore strategies for evaluating health equity as a criterion in New York State Department of Health procurement and contracting processes.	Convene an internal taskforce that includes Department staff from appropriate program areas (such as Bureau of Contracts within the Office of Administration) to devise strategies for centering health equity as a core component of program area's review and rating of organizations for Requests for Information/Requests for Applications.
Strategy 6: Enhance existing strategies to prioritize health equity competencies during the recruitment, hiring and performance evaluation processes within the Department.	The Office of Health Equity and Human Rights, in partnership with the Human Resources Management Group and the Division of Legal Affairs, will lead and oversee the planning, development, and implementation of updating practices to prioritize health equity competencies during the recruitment, hiring, and performance evaluation processes.

This Health Equity Plan is designed to be a guide and action plan for **all staff in the Department**. The information in the Health Equity Plan is intended for **all levels of staff**, including front line staff, supervisors, middle managers, and executive staff. Whether your job function is data analysis, research, contracting and procurement, human resources, communications, or program administration; this Health Equity Plan contains important information for you.

NEW YORK STATE DEPARTMENT OF HEALTH: UPDATED MISSION VISION AND VALUES

May 2024

Mission, Vision and Values

Mission	Vision	Values
To protect and promote health and well-being for all, building on a foundation of health equity.	New York is a healthy community of thriving individuals and families.	Public Good Integrity Innovation Collaboration Excellence Respect Inclusion

Definition of Health

Health is a state of optimal physical, mental and social well-being.

Statement on Health Equity

Health equity is foundational to everything we do to help all people achieve optimal physical, mental and social well-being. Everyone at the Department of Health shares responsibility for achieving health equity and eliminating health disparities.

NEW YORK STATE | Department of Health

05/24

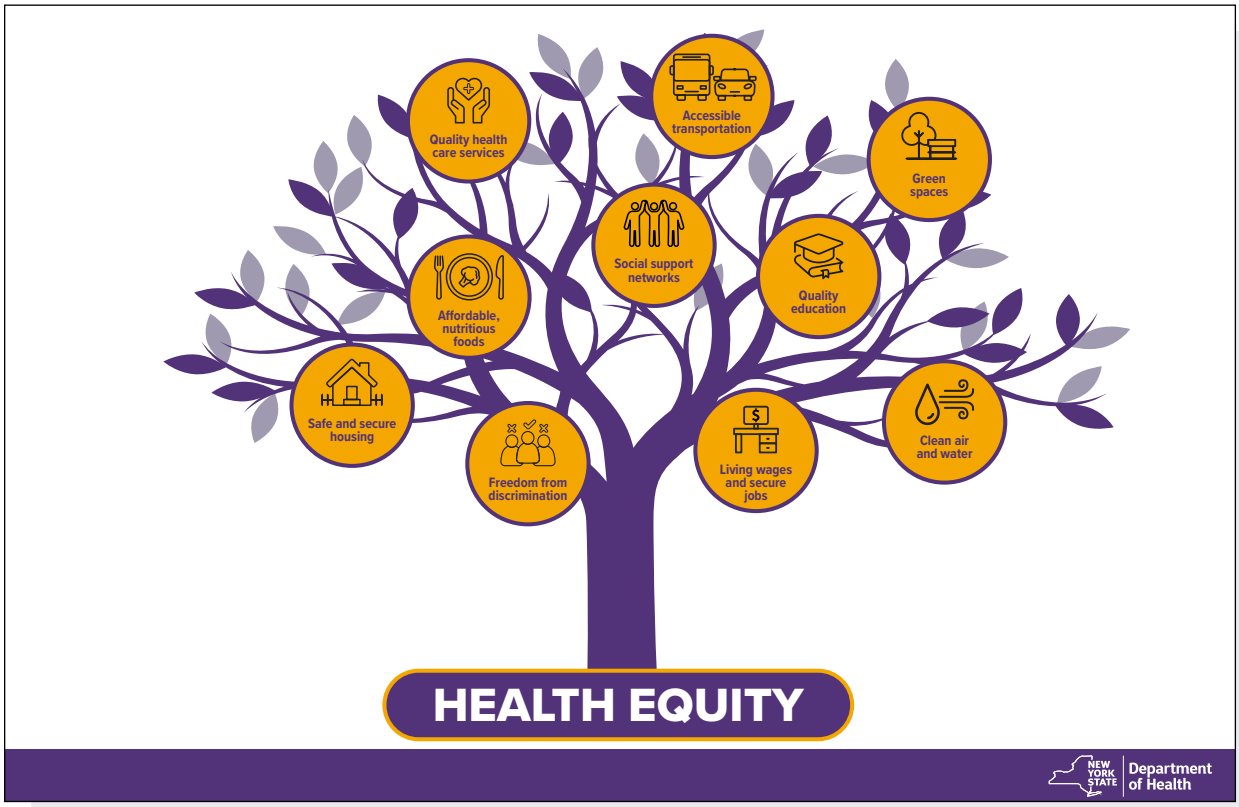
WHAT IS HEALTH EQUITY?

In 2022, Governor Kathy Hochul signed into law a bill that formalized New York State's acknowledgment of health inequities, health disparities, and structural racism. The enacted state legislation, now state law, formalized definitions in New York Public Health Law for health equity, health disparities, and social determinants of health. The law reads,

> "Health equity' shall mean achieving the highest level of health for all people and shall entail focused efforts to address avoidable inequalities by equalizing those conditions for health for those that have experienced injustices, socioeconomic disadvantages, and systemic disadvantages."

With the release of the first Health Equity Plan, the Department is expanding on this definition of health equity to further clarify what the legislation means.

Health equity means everyone has a fair and just opportunity to be healthy, where no one is limited in achieving optimal health because of who they are or where they live. This means that to work towards health equity, everyone must be able to access and experience the conditions in life that contribute to optimal health: safe and secure housing, steady and livable income, quality education, social support networks, quality health care, nutritious food, safe transportation, green spaces, clean air and water, and freedom from discrimination based on race, gender, sexual orientation, disability status, or any other part of one's identity. In a world where health equity is the norm, everyone has fair and just access to these conditions, and therefore, has a fair and just opportunity to achieve optimal health.



To give everyone the opportunity to achieve optimal health, services and programs must be tailored to meet the different and unique needs of individuals and communities, rather than providing everyone with the same services and programs and expecting to achieve the same results. Working towards health equity requires an understanding of the role that systemic discrimination has played in causing health inequities. Simply providing the same services to everyone, which is defined as health equality, is not sufficient to meet the needs of those who have been historically prevented from accessing the conditions in life that contribute to optimal health (such as stable housing, nutritious food, livable wages, freedom from discrimination, etc.). **The goal of health equity is to eliminate health inequities that are avoidable and unjust through proactive and inclusive processes**.

Why Does Health Equity Matter?

When health inequities persist, they lead to worse health outcomes, shorter life expectancy, and chronic stress that otherwise could have been avoided. Those who suffer the brunt of health inequities, and these worse health outcomes, are communities who have already suffered marginalization and systemic discrimination.

Across the country, and in New York State specifically, there are countless examples of health disparities that are avoidable, and therefore, are health inequities. These examples of health inequities are not just found in the long history of oppression communities have faced, but persist in the present day.

Nationally, the maternal mortality rate for Black, non-Hispanic women is 2.6 times the rate for non-Hispanic White women.[1] Even with comparatively low infant and maternal mortality rates to other states across the nation, even wider racial disparities exist in New York State. Black, non-Hispanic women are five times more likely to die of pregnancy-related causes than White, non-Hispanic women.[2] In New York City, this disparity is even starker: Black women are nine times more likely to die from pregnancy or childbirth than White women.[3] "Even when income, education, and access to health care are matched, racial disparities in health cut lives short. College-educated Black mothers, for example, are more likely to die, almost die, or lose their babies than White mothers who haven't finished high school."[4]

A recent study exposed another inequity related to racism in finding that there are stark disparities in how children of color are treated in the emergency room as compared to their White peers. "The review found children of color are less likely to get diagnostic imaging and more likely to experience complications during and after some surgical procedures. They face longer wait times for care at the emergency room, and they are less likely to get diagnosed and treated for a developmental disability. The strongest disparity evidence was found in pain management. Kids of color are less likely than their White peers to get painkillers for a broken arm or leg, for appendicitis or for migraines."[5]

In a 2018 study of transgender people who had visited a health care provider within the last year, researchers found that out of the nearly 2,000 respondents[6]:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity.
- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition.
- 23 percent said a doctor or other health care provider intentionally misgendered them or used the wrong name.

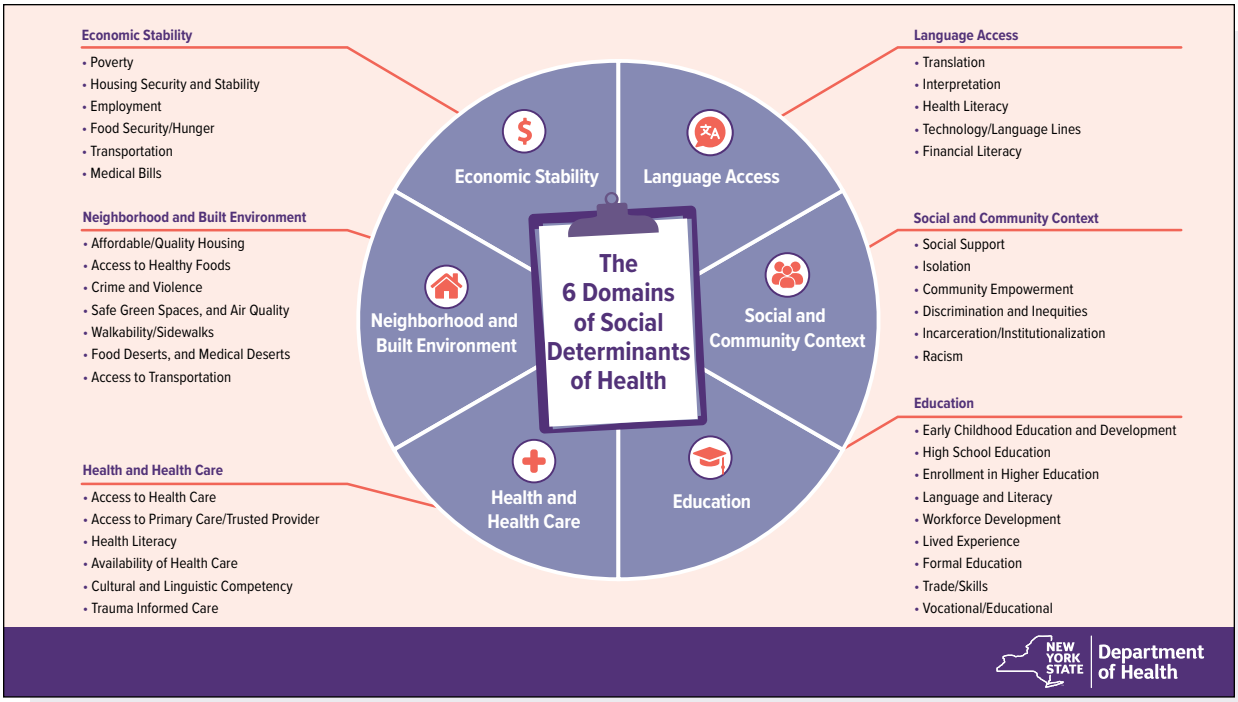
1. Hoyert DL. Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. 2023. DOI: https://dx.doi.org/10.15620/cdc:124678.CDC.
2. The New York State Report of Pregnancy-Associated Deaths in 2018.
3. Villarosa, Linda. "Why New York Has Faltered in Making Childbirth Safer for Black Mothers" The New York Times, January 7, 2024.
4. Villarosa, Linda. *Under the Skin: The Hidden Toll of Racism on American Lives and on the Health of our Nation*. New York, NY, Doubleday, 2022 (p. 2).
5. Godoy, Maria. "Kids of Color Get Worse Health Care Across the Board in the U.S., Research Finds." National Public Radio, January 18, 2024.
6. Mirza, Shabab Ahmed et al. "Discrimination Prevents LGBTQ People From Accessing Health Care." Center for American Progress, January 18, 2018.

It is important to note that those who suffer the worst impacts of health disparities are often blamed for their health outcomes. In a systemic denial of the role of discrimination and bias in health care, many people justify these health disparities as resulting from individual choices or behaviors, rather than a result of the stress of systemic discrimination along with discrimination and bias experienced when receiving health care services. Using a health equity foundation requires us to analyze stark health disparities by examining the broader social conditions underlying these disparities more closely than individual behaviors.

There are, unfortunately, countless more examples of health inequities that are a direct result of unequal access to social determinants of health, and in particular, the result of persistent and systemic racism and other forms of discrimination.

Being explicit about the health inequities that are present in New York State today is a crucial part of operating from a health equity foundation. What isn't acknowledged and named cannot be addressed. As the New York State Department of Health, we are a regulator, a provider of services, and the agency responsible for ensuring the health and well-being of all New Yorkers. It is therefore our individual and collective responsibility to work to dismantle the health inequities that impact the lives of all New Yorkers.

WHAT ARE SOCIAL DETERMINANTS OF HEALTH? WHAT DO THEY HAVE TO DO WITH HEALTH EQUITY?



"Social determinants of health" is a term used to describe the different conditions in a person's life that can influence their ability to be as healthy as they can be. Some of the conditions in a person's life that influence their ability to achieve optimal health are:

- **a.** Access to safe and secure housing
- **b.** Living wages, secure employment, and safe working conditions
- **c.** Access to quality education
- **d.** Access to quality health care services
- **e.** Access to affordable and nutritious food
- **f.** Freedom from racism, homophobia, transphobia, sexism, ableism, and other forms of discrimination
- **g.** Access to social support networks
- **h.** Access to transportation
- **i.** Access to safe green spaces
- **j.** Access to clean air and water; community is free from environmental hazards

While many people assume that health is a product of genes and individual behaviors, research has shown that may be only 20% of what impacts individual health. What's listed above (the social determinants of health) may be more important.[7]

However, not everyone has equal access to the social determinants of health listed above. They are 'social' in the sense that social policies have impacted people's ability to access them. In particular, racism and other forms of discrimination have driven social policies that have excluded some communities from these social determinants of health, or conditions they need for optimal health. This means that not everyone has an equal opportunity to achieve optimal health.

7. Greer ML, Garza MY, Sample S, Bhattacharyya S. "Social Determinants of Health Data Quality at Different Levels of Geographic Detail." Studies in Health Technology and Informatics, *PubMed*, May 18, 2023.

Keep in mind, **difficulty accessing any of these social determinants of health often makes it difficult to access others**. For example, without steady employment and livable wages, it is difficult to have enough resources to pay for nutritious food or pay for safe and secure housing. Without access to reliable transportation options, ability to access health care services, employment opportunities, or nutritious food, may also be limited.

It is not an accident that not all people have equal access to the social determinants of health (or conditions in life that are necessary for achieving optimal health). The disparities in access to social determinants of health are the result of decades of structural and interpersonal discrimination, the legacy of which persist to the present day. Health inequities are rooted in different levels of access to the social determinants of health and social injustices that make some population groups more vulnerable to poor health than other groups. Below[8] are some examples of the histories behind unequal access to social determinants of health.

Neighborhood and Built Environment

The practice of "redlining" between the 1930s and late 1960s drew boundaries around neighborhoods based on residents' race and deprived them of resources and opportunities, such as loans to purchase homes. This effectively racialized poverty in cities across the United States. Owning a home is a powerful way to achieve financial stability. These policies concentrated people of color in neighborhoods deprived of investment and prevented them from accessing loans and buying property – while White residents were provided more resources and opportunities. "Neighborhoods that were redlined in the 1930s have higher rates of poverty even today – nearly 100 years after the maps were created."[9]

Health Care

In the 1950s, over 1,000 women in Puerto Rico signed up to participate in the trials of the first birth control pill, but they were not given enough information to provide informed consent for their participation in the study. "They were told only that the drug prevented pregnancy, not that the drug was experimental or that they might experience potentially dangerous side effects. The pills used in the trial had hormone levels 20 times higher than birth control pills on the market today."[10]

Since the early 1900s, "conversion therapy" has been used as a form of "treatment" intended to change a person's sexual orientation or gender identity. These programs have been widely condemned and included many harmful practices such as electroshock therapy. "20 U.S. states have banned the practice (for minors only, in some instances). But it is important to note that despite condemnation and refutation from all major medical, psychiatric, and psychological organizations, these harmful and abusive practices continue, and remain legal in other states." Some practitioners of conversion therapy are licensed mental health professionals who exploit their credentials to take advantage of vulnerable families and youth."[11]

These historical examples illustrate possible root causes of medical mistrust. Medical mistrust is often more prevalent in communities who have experienced the most harm from the policies and practices of medical personnel and/or medical institutions, and have therefore learned not to trust the health care system. Medical mistrust has very real consequences, causing patients to skip appointments, refuse medications, and avoid seeking help until they are in a crisis – leading to worse health outcomes.

8. Adapted from "Health Equity" training module, HIV Education and Training Center (New York State Department of Health, AIDS Institute).
9. "A Brief History of Redlining." Data Stories: Environment and Health Data Portal, New York City Department of Health and Mental Hygiene, January 6, 2021.
10. "Our History." Planned Parenthood Federation of America.
11. "GLAAD Media Reference Guide – In Focus: 'Conversion therapy'". GLAAD [formerly Gay Lesbian Alliance Against Defamation], February 2022.

Key to advancing health equity is earning the trust of communities that have experienced racism, homophobia, transphobia, or other forms of discrimination from medical institutions. Asking, "who may face barriers when trying to participate in this service, and what can we do about it?" helps the Department fulfill its functions with a spirit of understanding the systemic factors behind individual behaviors and supports the development of healthy communities and individuals by addressing larger social conditions.[12]

Social and Community Context

The Willowbrook State School in Staten Island, NY was an institution for children with intellectual and developmental disabilities. During the 1900s, families were often encouraged by medical professionals to send their children to institutions like Willowbrook as there were limited community options for providing services and supports for young people with disabilities.[13] For years, there was "public outcry over the deplorable conditions and the treatment of the people who resided there."[14] "Willowbrook State School was a public health crisis, fostering abuse and dehumanization of its residents, while actively deceiving the public. Investigative reporter Geraldo Rivera exposed the abuse, neglect and unsafe conditions at Willowbrook in 1972. Rivera reported that a staggering 100% of residents at Willowbrook contracted hepatitis within six months, and it was so rampant that researchers took advantage of the situation; using residents in medical trials and intentionally exposing them to the deadly virus without their consent.[15] The school ultimately was shut down in 1987, but the lingering impacts of institutionalization and abuse continue to this day. "Disability is often equated with poor health status, and the health needs of people with disabilities are often considered only in relation to their disability. The management of the primary disabling condition becomes the overriding concern, with less attention paid to the generally recommended standards of health screening and disease prevention."[16]

In the early 1800s, the United States began to establish and support Indian Boarding Schools across the country, and continued this practice into the late 20th century. These schools were designed to culturally assimilate American Indian, Alaska Native (AIAN), and Native Hawaiian children by forcibly removing them from their families and communities as part of efforts to dispossess them from their native lands. The children suffered severe abuse and neglect. Many children died at these institutions and were buried in unmarked and marked graves on the school grounds. In 2022, an investigation by the Bureau of Indian Affairs identified ongoing impacts of the school system, including loss of life, territories and wealth, negative impacts on physical and mental health and Tribal and family relations, and erosion of the use of Tribal languages as well as religious and cultural practices.[17]

12. Adapted from "Applying a Health Equity Lens – An Organizational Approach" training module, HIV Education and Training Center (New York State Department of Health, AIDS Institute)
13. "Willowbrook 51 Years Later: A Look at History and Modern Advocacy", Disability Rights Tennessee, January 6, 2023.
14. "Commemorating the Willowbrook Mile." New York State Office for People with Developmental Disabilities.
15. "Willowbrook 51 Years Later: A Look at History and Modern Advocacy", Disability Rights Tennessee, January 6, 2023.
16. "Disability in New York State", Disability and Health Program, New York State Department of Health, Disability and Health Program, October 2011.
17. "How History Has Shaped Racial and Ethnic Health Disparities: A Timeline of Policies and Events", *Kaiser Family Foundation*.

WHAT IS THE DIFFERENCE BETWEEN EQUITY AND EQUALITY?

Health inequities arise from systemic and structural factors that create barriers to accessing health care services, resources and the social determinants of health. As illustrated on the left, not everyone is starting from the same place when trying to achieve optimal health and well-being. Not all people have equal access to the things they need to be healthy.

This is where health equity comes in. As illustrated on the right, equity is the idea that everyone – regardless of their race, ethnicity, where they live, or any other factor – should have a fair opportunity to achieve their best health outcomes. It's not necessarily about giving equally. It is the idea of making sure individuals get what they need in order to achieve optimal health and well-being, considering their circumstances.

Equality means treating everyone the same. Equality can only work when everyone starts from the same place, and needs the same help. "It is rare that everyone needs the same help to achieve the same outcome".[18] Providing everyone with the exact same resources and services won't help everyone achieve optimal health.

Equity means giving everyone what they uniquely need to be successful.

An example of giving people what they need to be successful is the program model of the Nurse Family Partnership Program. The Nurse Family Partnership Program originated in New York State and now operates in 40 states and the U.S. Virgin Islands. The Nurse Family Partnership Program offers a range of supportive services for first-time parents who are eligible for Medicaid and the Supplemental Nutrition Program for Women, Infants and Children (also known as WIC). Participants in the program are paired with a nurse to support them with learning how to take care of their health during pregnancy, caring for their baby's health, to connect them to other supportive services (such as mental health care, housing, child care, etc.), and to assist new parents with planning out their own educational or career goals.[19] The nurse provides the number of services and amount of time needed for each family, based on their assessment of that family's particular needs.

18. Adapted from "Health Equity" training module, HIV Education and Training Center (New York State Department of Health, AIDS Institute).
19. "Nurse Family Partnership – New York State Profile", *Nurse Family Partnership*, 2023.

How does the Nurse Family Partnership program exemplify an approach rooted in equity?

AN EQUALITY APPROACH Providing the same resources for all	AN EQUITY APPROACH Providing people the resources they need to be successful
• All first-time parents receive insurance benefits for prenatal and postpartum doctor visits, regardless of their access to any other social determinant of health. • This assumes that providing insurance coverage for prenatal and postpartum doctor's visits will be enough to ensure the health and wellbeing of first-time parents and their babies, since that may be sufficient for those with access to other social determinants of health.	• Takes into consideration additional factors (like social determinants of health) that may impact the family's ability to achieve optimal health for themselves and their baby. • Works to increase access to available resources that help in achieving optimal health such as: adequate nutrition, quality education, safe and secure housing, social support networks, etc.

Thinking about our work in the Department, consider the example below. This example illustrates an additional opportunity to operate from **an equity foundation** (providing people the resources they need to be successful), instead of an **equality foundation** (providing the same resources for all). Consider the example of a Request for Applications (RFAs).[20]

AN EQUALITY FOUNDATION Providing the same resources for all	AN EQUITY FOUNDATION Providing people the resources they need to be successful
Advertises Requests for Applications and shares information about the opportunity **solely** according to requirements set forth in the procurement.	Makes a concerted effort to reach community-based organizations with fewer resources; engage those who haven't typically partnered with the state.
Assumes that publishing a Request for Applications on Department website will mean it's accessible to all.	Understands that organizations with fewer resources or less experience with state funding may not be aware of opportunities or have much experience with submitting proposals. Makes efforts to remove as many barriers as possible for applicants.
Holds all applicants to the same standard of work completed, without acknowledging differences in operating budgets, communities served, or credibility in their community. Values universal interventions to improve health outcomes.	Evaluates applicants based on their experience and credibility in their community, rather than their experience with managing funding. Considers what applicants are doing to prioritize tailored interventions for marginalized communities and remove barriers to access.

20. To distribute federal and state funds to organizations across the state, the New York State Department of Health often utilizes a competitive process called a Request for Applications or Request for Procurements, depending on the program and funding mechanism. As part of the process, the Department outlines the required components and considerations for the funding opportunity, and then organizations submit proposals. Applicants are then identified and "awarded" contracts to disburse funds. The development of the outlined requirements, application writing and submission, then internal review are all considered parts of the RFA/RFP process.

What is the difference between "Diversity, Equity and Inclusion" and "Health Equity"?
The work to advance health equity and the work to advance diversity, equity, and inclusion are connected, but distinct from one another. The table below highlights some of the differences and similarities between the concepts of diversity, equity and inclusion and health equity.

DIVERSITY, EQUITY AND INCLUSION	HEALTH EQUITY
Diversity, equity, and inclusion efforts (DEI) are primarily focused on promoting fair treatment of all people by way of interpersonal and individual actions within an organization. These efforts are primarily focused on internal agency staff and policy (e.g. personnel). These efforts include initiatives such as: • Increasing diversity of different identity groups in the Department's workforce • Bolstering inclusion of different identity groups and ensuring they are meaningfully included at all levels of the organization • Responding to and preventing discrimination based on race, ethnicity, sexual orientation, gender identity, ability, age, religion, national origin, etc. • Ensuring that employees have equitable access to opportunities for advancement and career growth **Diversity, Equity, and Inclusion initiatives can be a part of any organization, institution, or program area, and do not necessarily need to be tied to health equity, public health, or health care. Every executive agency of the State of New York is required to have a Diversity, Equity, and Inclusion Officer.**	Efforts to advance health equity are primarily focused on the people that are served by the Department. Health equity efforts are centered on an understanding of the broader context and social forces that impact a person's ability to achieve optimal health, and influence health behaviors. A health equity approach is focused on ensuring the Department provides every individual served in New York with the supports they need to achieve optimal health, rather than provide everyone with the same intervention. Health equity efforts may include diversity, equity, and inclusion efforts; but not all diversity, equity, and inclusion efforts are necessarily focused on health equity.

For more information on Diversity, Equity and Inclusion efforts within the Department, please contact the Office of Diversity, Equity, and Inclusion within the Office of Health Equity and Human Rights at ODEI@health.ny.gov.

NEW YORK STATE DEPARTMENT OF HEALTH'S HEALTH EQUITY VISION

The Department is working towards establishing a Department-wide culture where all employees share a common understanding of health equity as a core value in theory and in practice, and where all departmental work is informed by health equity principles. Health equity is foundational to everything we do to help all people in New York State achieve optimal physical, mental and social health and well-being.

The Department's overarching goal is to achieve health equity and eliminate health disparities. To fulfill this responsibility, all Department staff must use a health equity foundation when performing their job duties. With a focus on health equity, the Department will be better prepared to identify, assess, and eliminate preventable health disparities and health related injustices in New York State.

NEW YORK STATE DEPARTMENT OF HEALTH'S HEALTH EQUITY VALUES

The list below outlines the health equity values of the Department. In their professional capacities carrying out work for the Department, all staff are expected to understand and embody these values in their work to serve all New Yorkers.

> **It is the expectation and the responsibility of all Department staff, regardless of office, bureau, division, grade, seniority or job title, to understand what health equity is, share the commitment to health equity, and to seek opportunities to apply a health equity foundation in their job role.**

The Department believes...

1. Health is a human right and should not be determined by discriminatory structural factors.
2. Achieving optimal health means a complete state of physical, social, and mental well-being. Optimal health includes:
   - **a.** Access to safe and secure housing
   - **b.** Living wages, secure employment, and safe working conditions
   - **c.** Access to quality education
   - **d.** Access to quality health care services
   - **e.** Access to affordable and nutritious food
   - **f.** Freedom from racism, homophobia, transphobia, sexism, ableism, and other forms of discrimination
   - **g.** Access to social support networks
   - **h.** Access to transportation
   - **i.** Access to safe green spaces
   - **j.** Access to clean air and water; community is free from environmental hazards

   While many people assume that health is a product of genes and individual behaviors, research has shown that may be only 20% of what impacts individual health. What's listed above, (the social determinants of health), may be more important.[21]
3. There are systemic factors that impact individual behaviors and one's ability to secure basic life necessities. This means that not everyone has a fair opportunity to achieve optimal health.
4. When advancing health equity in its work, the Department commits to centering race explicitly, not exclusively.
   - **a.** Racism is a national crisis that has profound impacts on public health. It is a foundational evil of our nation, and to this day, dictates access to and experience of social determinants of health. The Department names race explicitly, not exclusively, because racial inequities are deep and pervasive. When examining health disparities across various markers of identity, racial disparities often persist.
   - **b.** Racial inequities in health care are also historically normalized, accepted and willfully ignored. Fundamental to advancing health equity is asking "why" when we see health disparities present, especially when examining health disparities between different racial and ethnic groups. **Racism, not race, leads to health disparities present among racial groups.**
5. Racism, sexism, ableism, homophobia, transphobia, and other forms of discrimination are still deeply embedded in our society overall, and all public health and health care institutions. This includes the New York State Department of Health. The Department is committed to naming, discussing, and pursuing ways to mitigate all forms of discrimination within the Department.

21. Greer ML, Garza MY, Sample S, Bhattacharyya S. "Social Determinants of Health Data Quality at Different Levels of Geographic Detail." *Studies in Health Technology and Informatics*, PubMed, May 18, 2023.

WHAT IS A HEALTH EQUITY FOUNDATION?

The Department's overarching goal is to achieve health equity and eliminate health disparities. To fulfill this responsibility, Department staff must use a health equity foundation when performing their job duties. With a focus on health equity, the Department will be better prepared to identify, assess, and eliminate preventable health disparities and health related injustices in New York State.

A health equity foundation refers to an approach to thinking and decision-making grounded in health equity. Using a health equity foundation requires intention: to pause, reflect, and consider the potential impact of a decision, and whether that can help New Yorkers achieve optimal health, or create further barriers to achieving optimal health. When someone is using a health equity foundation to make decisions in their job role, key considerations include (but are not limited to):

- How racism, sexism, ableism, homophobia, transphobia, and other forms of discrimination unfairly disadvantage people by influencing access to social determinants of health, and lead to social and health inequities;
- How policies, programs, practices, services, and environments that support health can reduce or perpetuate health inequities;
- How structural factors and access to social determinants of health weigh more heavily on health outcomes than individual behaviors;
- How to facilitate a fair and just opportunity for health and a reduction in disparities (which will involve giving everyone what they need, rather than giving everyone the same thing); and,
- The importance of providing information that is understandable, and culturally and linguistically appropriate for all people.

For health care and public health work, applying a health equity foundation involves assessing who may be facing barriers to access services, programs, or opportunities and taking steps to reduce or eliminate any barriers that exist.

Above all, when Department staff are thinking from a health equity foundation, they are always considering and asking themselves and each other the question: **Who may be facing barriers to accessing services, programs, or opportunities and how can we reduce or eliminate those barriers?**

To apply a health equity foundation when making decisions in their programs, staff should consider the following questions:

> **The questions listed below in the Health Equity Foundation sample checklist may be most applicable to those working in program or policy development.**

APPLYING A HEALTH EQUITY FOUNDATION

Sample Checklist[22]

☐ What is the intended goal of the proposed policy, program, or action?

Keep in mind: A proposed policy, program, or action could entail any decision (with its resulting impact internal and/or external) made in your professional role. Some examples of proposed policies, programs or actions might be:

- a funding opportunity to be released to the public
- a new or existing program initiative
- a new or existing workplace policy for your team, division, or bureau
- a grant opportunity you're applying for
- a proposed law change or state budget funding request
- a collaboration between state agencies

Example: Creating assistance programs to provide additional financial support for basic necessities like food, housing and transportation for low-income families. To ensure equitable access, the program will not use eligibility criteria that might exclude certain communities such as:

- Conduct or morals-based eligibility guidelines.
- Exclusion based on prior criminal history.
- Work or educational program engagement requirements.

☐ Which communities or groups of individuals is this policy, program, or action intended to impact?

Keep in mind: Communities may refer to geographic location, age, race, ethnicity, gender, sexual orientation, ability, national origin, etc.

Example: All low-income families, as defined by the policy, across New York State.

22. Adapted from 3 resources: "Health Equity Toolkit", *Washington State Health Care Authority*, November 2023; Balajee, Sonali et al. "Equity and Empowerment Lens", *Portland, OR: Multnomah County*, 2012, "Organizational Health Equity Checklist", *Association of State and Territorial Health Officials (ASTHO)*.

APPLYING A HEALTH EQUITY FOUNDATION
Sample Checklist (cont'd)

☐ Could the proposed policy, program, or action impact an individual or a group of individuals differently than another based on…

- Age;
- Ability (or disability status);
- Gender or gender identity;
- Sexual orientation;
- Pregnancy status;
- Employment status;
- Access to safe and affordable housing;
- Income;
- Education or work level;
- English proficiency, or preferred language;
- National origin or immigration status;
- Race, ethnicity, or color;
- Religion or creed, and/or;
- Geographic location (i.e. urban vs. rural setting)?

— If we don't know the answer to the question above, who can we speak to in the communities we serve to learn about potential impacts of this policy, program or action?

Example: Looking at data that focuses on who is living with poverty in New York, we can already identify existing disparities in the State that will need to be addressed when developing program/regulatory parameters. For example:

- Nearly 1 in 5 children live in poverty.[23]
- Families with female heads of household experience poverty at more than two times the rate of all families and four times the rate of married couples.[24]
- One in five New Yorkers in poverty has a disability.
- Black, Native Hawaiian and Pacific Islander and Native American/Indigenous New Yorkers experience poverty at two times the rate of White New Yorkers.
- Poverty rates for Hispanic New Yorkers are more than double compared to White, Non-Hispanic New Yorkers.

23. New York Children in Need: The Urgency of Lifting Children Out of Poverty, NYS Comptroller Report, May 2024.
24. New Yorkers in Need: A Look at Poverty Trends in New York State for the Last Decade, NYC Comptroller Report, December 2022.

APPLYING A HEALTH EQUITY FOUNDATION
Sample Checklist (cont'd)

☐ Consider the full list of social determinants of health…

(Safe housing, living wages, safe and secure employment, quality education, quality healthcare services, nutritious food, social support networks, transportation, green spaces, clean air and water, and freedom from discrimination based on race, gender, sexual orientation, ability, or another part of identity)

- Based on this list of social determinants of health, look for and identify potential barriers to achieving optimal health.
  - — For example, if someone does not have access to any of these conditions, will that impact their ability to access the proposed service or program? If so, what can we do to fix that?
- Identify measures to reduce or mitigate these barriers to achieving optimal health.
- Have the root causes of these barriers been taken into consideration when developing this program, policy, or action? (Consider historical and current disadvantages, and whether these disadvantages are being addressed or perpetuated)

Example: Based on existing data and historical narrative, we understand that certain populations will have greater need than others. Policies will be developed to mitigate this fact as well as ensure for program changes on an annual basis on current need and program evaluation. As such, program parameters will be established via statute and regulation. However, program eligibility will be made through administrative determination where possible. This ensures flexibility in program operation based on actual need.

Additionally, the data will inform program operation such as:

- Ensuring outreach is targeted at specific communities with identified need.
- Late night and weekend hours of operation for assistance in completing applications.
- Online application processes to facilitate access.
- Short day care services where in-person attendance is required.
- Accessibility guidelines are adhered to and enhanced for individuals with disabilities including in-home assistance in partnership with existing service providers.

☐ Will any groups or communities disproportionately benefit from the policy, program or action?

Example: Based on the data identified, certain populations might have greater need and the potential for bias in program administration and operation is present. As such, program evaluation and monitoring will be put in place to monitor ongoing operations and provide immediate solutions. Administrative relief (appeals, hearings, etc) processes that have already been developed will be modified to support ease of operation.

☐ How easy or hard would it be to reverse or modify the policy, program, or action if there are impacts which further inequities and/or cause harm?

Example: Program development will be well planned to ensure opportunity for adjustment as needed. Therefore, minimal operational policy will be expressed in statute or regulation to facilitate program operation and changes. Administrative functions such as standards, guidelines, FAQs, etc. and contract requirements will be utilized for program oversight.

APPLYING A HEALTH EQUITY FOUNDATION
Sample Checklist (cont'd)

☐ How were different communities involved in the development of this policy, program or action? Which communities were not involved?

Examples:

- A series of virtual and in-person forums were held across the state.
- Attendance at existing councils and community groups operated, facilitated or supported by other state agencies.
- Collaboration and partnership with trusted community partners such as places of worship, community services, childcare locations and schools, etc.

☐ Who is accountable for this policy, program, or action? What biases might the people that are accountable hold? (Additionally, what reflection and conversations are required to understand what biases might be held?)

Example: Program oversight, monitoring and evaluation will occur under one central office with routine reporting on public platforms for accountability.

☐ How will the policy, program, or action be monitored for outcomes once it has been implemented? Who is responsible for monitoring and addressing both positive and negative outcomes?

Example: Rigorous program evaluation will be developed with real-time feedback built in to ensure timely program adjustment and response to any issues. Themes will be examined quarterly.

☐ Have we ensured that the information about this policy, program, or action is available in the languages spoken by the communities we are hoping to reach? Have we ensured it is culturally appropriate for the communities we are trying to reach?

Example: The Outreach and Messaging Plan developed uses culturally competent and linguistically appropriate messaging, tested with focus groups.

For roles such as scientists and regulatory programs assessors within the Department, the checklist of questions below may be more relevant.

USING A HEALTH EQUITY FOUNDATION AT THE NEW YORK STATE DEPARTMENT OF HEALTH

Additional Considerations for Scientists and Regulatory Programs Assessors[25]

- ☐ What is the goal of the study or test and what could be the potential impact of the findings?
- ☐ Who are the populations of focus for this study or test?
- ☐ If looking at a representative sample of a larger population, does your study group have the same proportions as the entire population studied? If a minority group is present at a small scale in a population such that their n<1 for your representative sample, how do you adjust?
- ☐ Could this study be used to identify inequities in certain areas or populations? If so, is the design such that those areas/populations won't be stigmatized? Is there a plan to provide resources should any inequities be identified?
- ☐ Are we assessing something the population of focus is concerned about?
- ☐ Does the goal address the unique needs and circumstances of different populations?
- ☐ What social factors could I incorporate in my analysis or test?
  - Race/Ethnicity
  - Housing
  - Income
  - Built environment (urban to rural)
  - Food Sources/Availability
  - Unique cultural considerations (language, cuisine, transportation, clothing, etc.)
- ☐ How might unconscious bias impact the results of this study? Could those impact any quality controls conducted in this setting? What might we do to mitigate that?
- ☐ How are we educating the population of focus about what we are assessing or testing for?
- ☐ As a public health laboratory, how do we reduce health inequities?
- ☐ What community organizations serve our population of focus, and have their trust? How might we engage those organizations?
- ☐ Have we invited, considered, and incorporated input from the population of focus and community partners where appropriate?

25. Adapted from two resources from the Centers for Disease Control and Prevention (CDC): "Smartie Goals" and "Writing Effective Objectives" [for National Breast and Cervical Cancer Early Detection Program].

USING A HEALTH EQUITY FOUNDATION AT THE NEW YORK STATE DEPARTMENT OF HEALTH

Additional Considerations for Scientists and Regulatory Programs Assessors (cont'd)

- ☐ How will we ensure the population of focus understands the findings of our research study and the test results being provided?
- ☐ How will we share our findings with colleagues and public health practitioners?
- ☐ How might our research work help people to achieve optimal health? How might it provide more information about health disparities in New York State?
- ☐ How might our regulatory oversight help people to achieve optimal health? How might it provide more information about health disparities in New York State?
- ☐ Do our regulatory programs need to consider the populations being served by the facilities we regulate?
- ☐ Will a citation or finding on a particular facility affect one portion of the population over others?
- ☐ When developing a new assay, how do you ensure the test will behave the same way in all populations? Are there genetic/diet/etc cofounders?

Approaching our work from a health equity foundation requires **intention**. It requires us to pause, reflect, and consider the potential impact of our decisions, and whether that can help New Yorkers achieve optimal health, or create further barriers to achieving optimal health. Understanding the concept of health equity is not enough. Using a health equity foundation requires us to go beyond carrying out our job responsibilities with the spirit of "business as usual." It requires us to change the way we do things, by pausing, thinking, and reflecting before acting.

ACTION PLAN: YEAR 1 STRATEGIES TO BUILD A HEALTH EQUITY FOUNDATION AT THE NEW YORK STATE DEPARTMENT OF HEALTH

The following list includes strategies that the Department will focus on for the first year of the Health Equity Plan (August 2024 – August 2025). These strategies reflect conversations with staff across the Department about the best "starting place" as an agency as we work towards a unified approach to achieve health equity. The goal of these strategies is to build our skillset as a Department to advance health equity in our daily work. At the end of Year 1, we will assess the success of these strategies and determine what new strategies will be identified for Year 2.

Strategy 1: Establish New York State Department of Health's public commitment to health equity.

Action Item: Update the Department's mission, vision, and values statements to reflect commitment to health equity.

Working towards health equity is a top priority for the Department, but working towards health equity was historically not reflected in the Department's Mission, Vision, and Values. Explicitly naming health equity as a Department-wide value is an essential step for helping staff understand the agency's overall commitment to work towards health equity and to help individual staff adopt it themselves.

Strategy 2: Assess Department staff skills, knowledge and needs as they relate to advancing health equity.

Action item: Develop report to summarize the skills, knowledge and needs of Department staff related to advancing health equity.

The Department is contracted with a consultant for two years, which is responsible for conducting focus groups, surveys, and providing training for all Department staff (participation is on a voluntary basis). Following these interventions, the contracted consultant will make recommendations about strategic steps the Department can take to advance health equity and meet staff needs. This report will serve as a guide for the Office of the Commissioner and the Office of Health Equity and Human Rights to craft strategy for future years to build Department capacity to advance health equity. This report should also be used to inform the development of priorities in future iterations of the Health Equity Plan.

Strategy 3: Increase understanding of health equity foundational concepts and application among New York State Department of Health staff and contractors.

Action Item: Require all Department staff and current and future contractors to participate in three health equity training modules, available through the HIV Education Center (offered through the AIDS Institute within the Department).

- *Health Equity*
- *Applying the Health Equity Lens – An Organizational Approach*
- *Promoting Health Equity by Addressing Medical Mistrust*

To strengthen the Department's ability to advance health equity, it is essential for all Department staff to have a common understanding of the key components of healthy equity work, both in theory and in practice. This Health Equity Plan includes many resources for staff to increase their knowledge of health equity, but the completion of these three trainings will assist with building a common knowledge base of all Department staff about the key concepts of health equity – which will in turn help staff use a health equity foundation as the basis for the decisions made in their job role.

While these training sessions were designed for stakeholders served by the AIDS Institute, and therefore have a focus on supporting people living with HIV, the core principles apply to all audiences. The Department may update these training sessions to be more generalizable to all Department programming. Once this is done, the Department can begin the process of requiring the training for current and future contractors (some examples may include: grant recipients, contract recipients, and collaborating agencies, such as local health departments). Working for and on behalf of the Department, contractors should also understand and reflect the Department's commitment to health equity.

Strategy 4: Ensure that health equity is a core component of all data analyses conducted by the Department and that health disparities are evaluated and considered.

Action Item: Continue the development of Department-wide guidelines for equity-centered data analysis and presentation.

Work towards developing guidelines for equity-centered data analysis and presentation is already underway in different offices across the Department. To enhance this effort and ensure health equity is a core component of all data analyses across the entire agency, the Department will convene an internal taskforce to:

- Identify current data collected by the Department (for example, health outcomes, demographics, program participation, etc.)
- Determine whether existing data are adequate to identify health disparities
- Determine whether existing data are adequate to identify which populations are being served by Department programming
- Determine whether gaps are present in existing demographic data and identify whether measures can be taken to reduce data gaps
- Recommend mechanisms for capturing the context and story behind health disparities identified in Department data

After gathering this information, the end goal will be the development of guidelines to be used across the Department, to ensure that health equity is a core component of all data analyses and that health disparities are evaluated and considered.

Strategy 5: Explore strategies for evaluating health equity as a criterion in Department procurement and contracting processes.

Action Item: Convene an internal taskforce that includes Department staff from appropriate program areas (such as Bureau of Contracts within the Office of Administration) to devise strategies for centering health equity as a core component of program area's review and rating of organizations for Requests for Information/Requests for Applications.

Program areas across the Department (such as the Bureau of Health Equity and Community Engagement, the Office of Minority Health and Health Disparities Prevention, etc.) have already had success implementing innovative strategies that draw on a foundation of health equity during the procurement and contracting processes, and successfully engage non-traditional community-based partners. The taskforce for Strategy 5 will explore the application and feasibility of scaling up these strategies to be used Department-wide, to enhance the use of a health equity foundation across the Department. Some examples of such strategies may include:

- Simplifying the application process to remove barriers for non-traditional community partners seeking State funding.
- Engaging trusted community members to support with sharing information about funding opportunities with their communities, and expanding outreach efforts to reach community partners with less or no experience receiving state funding.

- Standardizing systems to provide advance payments and rapid payment systems to ensure inclusion of smaller agencies with less cash on hand to wait for payments.

  For example, utilizing deliverable-based contracting (meaning awardees are paid after each deliverable is completed) so that small, grassroots organizations are not excluded from participating in state funding opportunities and a standard consultant rate for all awardees.
- Investing in capacity building and technical assistance for awardees of state funding, and paying community partners for the time spent participating in capacity building activities (so that community partners with less resources have the opportunity to participate).
- Prioritizing a positive experience working with the Department as a critical measure of success, rather than measuring success only through the completion of deliverables.

  For example, provide organizations the opportunity to give feedback on their experience working with the Department, and how the Department could do a better job supporting communities. This feedback would then be incorporated into subsequent procurement processes to improve communities' experience working with the Department.
- Ensure evaluation criteria of Requests for Applications/Requests for Information are utilizing a health equity foundation to make decisions.
  — Ensuring staff evaluating RFA's and RFI's are adequately trained to use a health equity foundation when evaluating applications

Strategy 6: Enhance existing strategies to prioritize health equity competencies during the recruitment, hiring and performance evaluation processes within the Department.

Action Item: The Office of Health Equity and Human Rights, in partnership with the Human Resources Management Group and the Division of Legal Affairs, will lead and oversee the planning, development, and implementation of updating practices to prioritize health equity competencies during the recruitment, hiring, and performance evaluation processes.

In 2023, the Department undertook efforts to prioritize awareness of health equity throughout the recruitment/hiring process. The Department started this work by first including standard language in State job postings that articulates the Department's commitment to health equity. In addition, the Department revised State interview evaluation forms to ensure interviews with potential candidates include express, consistent articulation of the Department's commitment to health equity and include specific equity-focused questions.

Beginning in July 2023, the Department's Human Resources Management Group (HRMG) Interview Evaluation templates now include a required Department statement on health equity as well as the addition of health equity questions.

As part of Year 1 of the Health Equity Plan, the Office of Health Equity and Human Rights will take steps to outline the project plan which will expand on the existing efforts described above, including but not limited to the following strategies:

- Update the existing statement on health equity listed on the HRMG Interview Evaluation Form by mentioning the Department's recently announced commitment to health equity statement, include the definition of health equity, a more comprehensive overview of the Department's commitment, and the rationale behind it. The end goal is for recruitment-related documents from hiring contractors such as Health Research Inc., PCG, and others, to mirror what has been done on New York State Human Resources Management Group's recruitment-related documents.

The Office of Health Equity and Human Rights will develop and deliver trainings and technical assistance to supervisors and hiring managers across the Department to achieve the following:

- Address regular inquiries/comments from supervisors and hiring managers on “why” health equity questions should be included
- Provide guidance for interviewers to assess candidates’ responses to health equity related interview questions
- Provide guidance on how to prioritize health equity competencies for existing Department employees (i.e. update position descriptions, include review of health equity competencies in performance evaluations)

The Office of Health Equity and Human Rights, in partnership with the Human Resources Management Group and the Division of Legal Affairs, will lead and oversee the planning, development, and implementation of Strategy 6.

NEXT STEPS: ENSURING SUSTAINABILITY OF THE HEALTH EQUITY PLAN

The first issue of the Health Equity Plan is a start to formalizing and documenting the Department's approach to working towards health equity in New York State. The inaugural Health Equity Plan provides the Department the opportunity to move forward with a coordinated plan of action in Year 1 (August 2024 – August 2025). The Health Equity Plan is intended to be a guide for staff and is a step towards launching a Department-wide effort towards centering health equity as the foundation for everything we do in the Department. The Health Equity Plan has a short timeframe (one year), but it is the intention that future issues will address a longer timeframe (i.e., 5 years). This will allow for more ambitious goals, proposed activities, and performance metrics.

While the strategies that are presented in the previous section will be the focus of the Health Equity Plan during Year 1, the Department will also seek to gain feedback from internal and external stakeholders on the Health Equity Plan. This feedback will be incorporated into subsequent plans so that the Health Equity Plan remains an iterative "living" document that is responsive to the evolving needs of Department staff and promotes activities that support health equity across the Department's offices and activities.

The Role of the Office of Health Equity and Human Rights

The Office of Health Equity and Human Rights will oversee the implementation of the Health Equity Plan and future updates of this document. Oversight of the Health Equity Plan will include:

- Serving as a project manager for implementation of each of the "Year 1 Strategies" listed above. This may include…
  - — Convening appropriate intradepartmental taskforces and identifying necessary Department staff to participate
  - — Developing success metrics for each of the strategies and monitoring progress towards those metrics
- Conducting an annual review, update and re-release of the Health Equity Plan (including keeping records of feedback on the Plan)

  To determine priorities for future iterations of the Health Equity Plan, the Office of Health Equity and Human Rights may:
  - — Conduct staff focus groups (internally, at the Department) to gather staff recommendations for new priority action items for the Health Equity Plan
  - — Solicit input from existing advisory bodies (such as the Interagency Task Force on Health Equity, the Community Stakeholder Council on Health Equity and Human Rights, the Health Equity Council, and the Racial Equity Working Group) to provide input on suggested priorities for the Plan.
  - — Conduct community listening sessions to gather community input on priority action items for the Health Equity plan. Communities engaged should include grantees, applicants who have not been awarded state funding, representatives from community-based organizations, etc.

FINAL NOTE: WHERE DO I GO FROM HERE?

The release of the Health Equity Plan marks the very beginning of a Department-wide effort to achieve health equity. For many of you who have already begun health equity work on your respective teams, much of the information shared in the Health Equity Plan is not new or surprising. For others, it may be the first time you are learning about health inequities, social determinants of health, and what it means to work towards health equity. Wherever you are, everyone has a role to play to work towards making health equity a reality in New York state.

The Health Equity Plan includes lots of content beyond these pages, including the Department Case Studies, Glossary and Resource pages. We encourage you to revisit the Health Equity Plan often to consider how each of the sections apply to you and your job role.

Suggested next steps:

1. Read the glossary to review key terms related to health equity.
2. Review "Department Case Studies" to learn how different teams across the Department have used a health equity foundation in their work.
3. Check out the "Health Equity Resource Hub" SharePoint site, where you can find other teams across the Department working on health equity, review existing resources within the Department, and find external resources to continue learning about health equity.
4. Print out the following to keep at your desk/workstation as reminders:
   - **a.** Applying a Health Equity Foundation: Sample Checklist
   - **b.** New York State Department of Health's Health Equity Values
   - **c.** New York State Department of Health's Mission, Vision, Values
   - **d.** New York State Department of Health Commitment to Health Equity
5. Discuss the Health Equity Plan (section by section) at your next team meeting. How does this align with work you're already doing? What might be some opportunities in your work to utilize a health equity foundation, for example?
6. Consider ways to encourage the professional development of your staff to build skills and knowledge related to health equity.
   - **a.** If you are not a supervisor, consider ways to build your own skills and knowledge related to health equity (see the "Health Equity Resource Hub" for suggestions)
7. Join the Health Equity and Diversity, Equity and Inclusion (DEI) Advisory Committee (convened by the Office of Health Equity and Human Rights) if you want to get more involved in intra-departmental health equity efforts.
8. Contact the Office of Health Equity and Human Rights at ohehr@health.ny.gov with your questions about the Health Equity Plan.

APPENDICES

Appendix A: Glossary of Key Terms

Key terms used throughout the Health Equity Plan.

Terms in this section:

- Ableism
- Accessibility
- Cisgender
- Cultural humility
- Diversity, equity, and inclusion
- Discrimination
- Ethnicity
- Gender identity
- Health
- Health disparities
- Health equity
- Health equity foundation
- Health inequity
- Homophobia
- LGBTQ+
- Medical mistrust
- People of color
- Race
- Racism (Interpersonal, Institutional and Systemic)
- Sexism
- Sexual orientation
- Social determinants of health
- Transgender
- Transphobia
- Xenophobia

Ableism: Discrimination and prejudice against people living with mental, physical, cognitive, or intellectual disabilities. Ableism can include negative actions, beliefs, and judgments against a person with a disability in social and professional settings, which can result in discrimination, prejudice, or violence. One of these examples of violence is the United States' long history of forcibly sterilizing people with developmental disabilities.[26] Ableism can also include creating structures and institutions that favor able-bodied people.[27] For example, a restaurant may not have a bathroom that is accessible to people who use wheelchairs or the entrance may have stairs and there is no ramp.

Accessibility: The ability to access facilities, programs, services, and effectively communicate. Accessibility is a term often used when referring to people with disabilities. It is about making environments, programs, systems, and information usable by as many people as possible regardless of ability.[28]

Cisgender: A term used to describe a person whose gender identity aligns with the sex assigned to them at birth. The prefix *cis-* means "on this side of" or "not across."[29]

26. Roy, A. et al. "The Human Rights of Women with Intellectual Disability." *Journal of the Royal Society of Medicine*, Vol. 105, Issue 9, National Library of Medicine, September 2012.
27. "Glossary", *Planned Parenthood Federation of America*.
28. "Disability Etiquette" training module, (New York State Department of Health, Disability and Health Program) Slide 9.
29. "*Gender Identity in the Workplace: A Toolkit for New York State Employees*", Governor's Office of Employee Relations.

Cultural humility: An active process of self-reflection, in which individuals seek to:

- Examine their personal history/background and social position related to gender, ethnicity, socio-economic status, profession, education, assumptions, values, beliefs, biases, and culture, and how these factors impact interpersonal interactions.
- Reflect on how interpersonal interactions and relationships are impacted by the history, biases, norms, perception, and relative position of power of one's professional organization.
- Gain deeper realization, understanding, and respect of cultural differences through active inquiry, reflection, reflexivity, openness to establishing power-balanced relationships, and appreciation of another person's/community's/population's expertise on the social and cultural context of their own lives (lived experience) and contributions to public health and wellbeing.
- Recognize areas in which they do not have all the relevant experience and expertise and demonstrate a nonjudgmental willingness to learn from a person/community/population about their experiences and practices.[30]

Diversity, Equity, and Inclusion (sometimes referred to as "DEI" or "D&I") *to review the differences between "Diversity Equity and Inclusion" and "Health Equity", see page 19*.

- **Diversity:** Representation of different identities (identity categories might include: race, ethnicity, gender, ability, religion, nationality, sexual orientation, etc.). Diversity looks at representation in terms of quantity. In other words, how many people are represented from different identity-based groups?
- **Inclusion:** Inclusion is a mindset and happens when people of all ability levels are appreciated and welcomed as valued members of a community and can participate fully and meaningfully. All systems, structures, and policies are designed to work for all people. It's not about making people fit into the existing environment. This can look like meaningful participation of a diverse range of identity groups (across ability, religion, race, ethnicity, gender identity, etc.) in multiple levels of the agency, and especially on leadership teams that have influence over decision-making. Inclusion is about the quality of the diversity represented in the organization.[31] In other words, to what extent are members of different identity-based groups included meaningfully in the leadership, decision-making, and staff culture of the organization?
- **Equity:** Policies and practices that lead to equitable outcomes, meaning everyone gets what they need to be successful. Equity ensures that identity is not predictive of opportunities or outcomes. In the case of health equity, this means everyone having a fair opportunity to achieve optimal health. Another way of thinking about achieving "optimal health" is that everyone has equitable access to the conditions in life to achieve optimal health (see social determinants of health above).[32]

Discrimination: Prejudicial treatment based on a wide range of characteristics, including race, ethnicity, gender, disability, sexual orientation, income level, religion, age, and other characteristics that have been associated with social exclusion or marginalization.[33]

Ethnicity: A grouping of people based on having a shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry (usually from the same geographic area) and shared history.[34]

30. "Embracing Cultural Humility and Community Engagement", U.S. Centers for Disease Control and Prevention (CDC), May 15, 2024.
31. "Disability Etiquette" training module (New York State Department of Health, Disability and Health Program), Slide 10.
32. "What is Racial Equity?" *Race Forward*, 2023.
33. Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. "What Is Health Equity? And What Difference Does a Definition Make?" Princeton, NJ: *Robert Wood Johnson Foundation*, 2017.
34. "Race and Ethnicity", *American Psychological Association*, 2024.

Gender identity: An individual's concept of self as male, female, a blend of both, or neither. One's gender identity can be the same as or different from their sex assigned at birth. An individual's gender identity may be consistent for their whole life or may change over time.[35]

Health: A state of optimal physical, mental and social well-being.

Health disparities: Health disparities refer to measurable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health between population groups.[36] Health disparities may lead to differences in health outcomes that are avoidable, unfair, and unjust.

Health equity: Health equity means everyone has a fair and just opportunity to be healthy, where no one is limited in achieving optimal health because of who they are or where they live. This means that to work towards health equity, everyone must be able to access and experience the conditions in life that contribute to optimal health: safe and secure housing, steady and livable income, quality education, social support networks, quality health care, nutritious food, safe transportation, green spaces, clean air and water, and freedom from discrimination based on race, gender, sexual orientation, disability status, or any other part of one's identity. In a world where health equity is the norm, everyone has fair and just access to these conditions, and therefore, has a fair and just opportunity to achieve optimal health.

Health equity foundation: A health equity foundation refers to an approach to thinking and decision-making grounded in health equity. Using a health equity foundation requires intention: to pause, reflect, and consider the potential impact of a plan or decision, and whether the potential impact can help New Yorkers achieve optimal health, or create further barriers to achieving optimal health. When someone is using a health equity foundation for decision-making, key considerations include (but are not limited to):

- How racism, sexism, ableism, homophobia, transphobia, and other forms of discrimination unfairly disadvantage people by influencing access to social determinants of health, and lead to social and health inequities;
- How policies, programs, practices, services, and environments that support health can reduce or perpetuate health inequities;
- How structural factors and access to social determinants of health weigh more heavily on health outcomes than individual behaviors;
- How to facilitate a fair and just opportunity for health and a reduction in disparities (which will involve giving everyone what they *need*, rather than giving everyone the same thing);
- The importance of providing information that is understandable, and culturally and linguistically appropriate for all people.

For health care and public health work, applying a health equity foundation involves assessing who may be facing barriers to access services, programs, or opportunities and taking steps to reduce or eliminate any barriers that exist.

Health inequity: Health inequities are differences in health that are unnecessary, unfair, unjust, and avoidable. Health inequities are rooted in different levels of access to the social determinants of health, and social injustices.[37] Health inequities make some groups more vulnerable to poor health than other groups. For example, in New York State, Black women are 5 times more likely to die from a pregnancy-related cause compared to White women.[38] This is a health inequity because it is unfair, unjust, and avoidable.

Homophobia: Attitudes, beliefs, behaviors, and policies that marginalize or discriminate against people who are gay, lesbian, or bisexual, and can result in discrimination, prejudice, and/or violence.[39]

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35. "*Gender Identity in the Workplace: A Toolkit for New York State Employees*", Governor's Office of Employee Relations.
36. "Health Disparities", *Center for Disease Control and Prevention*, May 26 2023.
37. Adapted from "Health Equity" training module, HIV Education and Training Center (New York State Department of Health, AIDS Institute).
38. The New York State Report of Pregnancy-Associated Deaths in 2018, (p. 3): *Black, non-Hispanic women had a pregnancy-related mortality ratio five times higher than White, non-Hispanic women*.
39. "Glossary", *Planned Parenthood Federation of America*.

LGBTQ+: An acronym commonly used to represent the lesbian, gay, bisexual, transgender, and queer communities. Other variations exist, including LGBT and LGBTQIA (referring to intersex and asexual). They all refer to the communities of people who do not identify as heterosexual, do not identify as cisgender, or do not identify as either.[40] The 'plus' is used to signify all of the gender identities and sexual orientations that letters and words cannot yet fully describe.

Medical mistrust: Medical mistrust is formally defined as "an absence of trust that healthcare providers and organizations genuinely care for patients' interests, are honest, practice confidentiality, and have the competence to produce the best possible results". Medical mistrust has very real consequences, causing patients to skip appointments, refuse medications, and avoid seeking help until they are in a crisis.[41] Medical mistrust is often more prevalent in communities who have experienced the most harm from the policies and practices of medical personnel and/or medical institutions, and have therefore learned not to trust the health care system. There are countless examples of harm perpetrated by medical institutions that have caused communities not to trust them, such as forced sterilization of people with disabilities and women of color, experimentation and medical research conducted on people of color without informed consent, and conversion therapy against people who are lesbian, gay, or bisexual.

People of color: Generally used to describe any person who is not White, to emphasize a common experience of systemic racism.

Race: Today, the term "race" is usually used to refer to a group of people descended from common ancestors (often from the same geographic area). However, it's important to note that racial categories and labels have been created by people, and are considered social constructs that are not based in biology. The labels of race have historically been used to create advantages and disadvantages between these categories of people.[42]

40. "*Gender Identity in the Workplace: A Toolkit for New York State Employees*", Governor's Office of Employee Relations.
41. Adapted from "Promoting Health Equity by Addressing Medical Mistrust" training module, HIV Education and Training Center (New York State Department of Health, AIDS Institute).
42. "Glossary", *Planned Parenthood Federation of America*.

Racism: Refers to prejudice or discrimination towards a person because of their membership in a particular racial or ethnic group, usually one that is marginalized. Racism dis-empowers racial groups relative to another and reduces access to resources and opportunities such as employment, housing, education, and health care. There are several different forms of racism, described below. Some are more visible or obvious than others.

- **Interpersonal Racism:** Refers to bias, bigotry, or discrimination that is based on race and shows up in interactions with others. It can be conscious or subconscious and is often the most overt form of racism. It can range from prejudiced comments to overt verbal or physical attacks.[43]
- **Institutional Racism:** Refers to bias, bigotry, or discrimination that occurs within institutions or is explicitly or inadvertently perpetuated by institutions. It involves unjust policies, practices, procedures, and outcomes that work better for White people than people of color, whether intentional or not. Example: A school district that concentrates students of color in the most overcrowded, under-funded schools with the least experienced teachers.[44]
- **Systemic or Structural Racism:** Racial discrimination that is built into policies, social structures, history, and culture. Examples of this might include racial discrimination that is built into education, health care, criminal justice, and other institutions. Structural racism occurs when racist policies and practices create advantages for White people and oppression and disadvantages for people of color. These advantages and disadvantages are interconnected and reinforce each other, which worsens racial inequities across the social determinants of health. Policies and practices don't have to directly mention race in order for them to treat people differently based on race.[45] For example, even 100 years after slavery ended, Jim Crow laws, lack of equitable investment in education, redlining, and exclusion from public insurance programs are just some of the policies and practices that worked to prevent people of color from building wealth and health. The consequences of the barriers to wealth and health created by structural racism persist to this day.

Example, from *Race Forward*

For more information on Systemic or Structural Racism, watch *Race Forward's* video series on this topic.

Imagine two neighborhoods.

In one neighborhood is a family of four, the Smiths. The Smiths' neighborhood is stagnating, with abandoned homes, poor schools, and over-policing. Most of their neighbors, including themselves, are people of color.

In the adjoining neighborhood is another family of four, the Jones. The Jones' neighborhood has plenty of fresh food markets, a robust bus system, parks, health centers and good schools. Families flock there because all these services translate to economic opportunity and good health. Most of the families who live in this neighborhood, including the Jones, are White.

The racial composition of their neighborhoods did not just happen on their own. Who lives in which neighborhood and whether that neighborhood has decent housing, good schools, and well-paying jobs is determined by multiple, institutional policies and practices. Whether intentionally or not, these policies and practices have often discriminated by race, which is why we see so much difference in life outcomes based on race.

For example, in King County, Washington, there is a 10-year life expectancy difference between ZIP codes where residents are predominantly White and zip codes where residents are predominantly people of color.

We call this reality "structural racial inequity."

43. "What is Racial Equity?" *Race Forward*, 2023.
44. "What is Racial Equity?" *Race Forward*, 2023.
45. Adapted from "What is Racial Equity?" *Race Forward*, 2023; "Glossary", *Planned Parenthood Federation of America*; and "Health Equity" training module, HIV Education and Training Center (New York State Department of Health, AIDS Institute).

Sexism: Systemic and individual discrimination against women.[46]

Sexual orientation: Sexual orientation refers to an individual's attraction to another person romantically, emotionally, and sexually. Common sexual orientations include heterosexual (straight), gay, lesbian, bisexual, and asexual.

- Sexual orientation is different than gender identity. Sexual orientation is about who you are attracted to. Gender identity is about who you are. This means that being transgender is not the same thing as being gay, lesbian, or bisexual, although some transgender individuals also identify as gay, lesbian, bisexual, queer, or asexual. Every individual has both a sexual orientation and a gender identity.

Social determinants of health: Social determinants of health is a term used to describe the different conditions in a person's life that can influence their ability to be as healthy as they can be. Some of the conditions in a person's life that influence their ability to achieve optimal health are:

a. Access to safe and secure housing

b. Living wages, secure employment, and safe working conditions

c. Access to quality education

d. Access to quality health care services

e. Access to affordable and nutritious food

f. Freedom from racism, homophobia, transphobia, sexism, ableism, and other forms of discrimination

g. Access to social support networks

h. Access to transportation

i. Access to safe green spaces

j. Access to clean air and water; community is free from environmental hazards

Transgender: A term for people whose gender identity and/or expression is different from the sex assigned to them at birth. Transgender is often abbreviated to trans. Being transgender does not imply any specific sexual orientation. Transgender people may identify as straight, gay, lesbian, bisexual, et cetera.[47]

Transphobia: Attitudes, beliefs, behaviors, and policies that marginalize or discriminate against transgender people and others who are perceived to be transgender, and can result in discrimination, prejudice, and/or violence.[48]

Xenophobia: Fear or hatred of people who have a different cultural background or national origin than one's own.

46. "Glossary", *Planned Parenthood Federation of America*.
47. "*Gender Identity in the Workplace: A Toolkit for New York State Employees*", Governor's Office of Employee Relations.
48. "Glossary", *Planned Parenthood Federation of America*.

APPENDIX B

New York State Department of Health's Commitment to Health Equity: A Foundation to Build On

The Department's commitment to health equity builds on existing work towards health equity globally, nationally, and within the Department itself.

Aligning with National and International Efforts

- In the U.S., the first *Healthy People* report was released in 1980. This evolved into 10-year plans that include ambitious objectives for measuring the health of Americans. One of the three broad goals included in *Healthy People 2000* was to reduce health disparities. Similar goals have been included in all the subsequent reports. One of the five goals in *Healthy People 2030* is to "...create social, physical, and economic environments that promote attaining the full potential for health and well-being for all."
- In 2005, the World Health Organization established the Commission on Social Determinants of Health. The Commission sought to draw the attention of governments and society to the social determinants of health, with the goal of creating better social conditions for health, particularly among the most vulnerable people.
- In 2023, the U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services, released several resources to help support federal agencies and states, local, and tribal governments to better coordinate health care, public health, and social services. The U.S. Playbook to Address Social Determinants of Health highlights ongoing and new actions by federal agencies to support health by improving the individuals' social circumstances. This includes initiatives by HHS, U.S. Department of Agriculture, U.S. Department of Housing and Urban Development, U.S. Department of Veterans Affairs, and the U.S. Environmental Protection Agency. To accompany the Playbook to Address Social Determinants of Health, HHS released a Call to Action to Address Health-Related Social Needs. It encourages cross-sector partnerships among those working in health care, social services, public and environmental health, government, and health information technology to achieve a more integrated health and social care system.

Legislative Action Related to Health Equity in New York State

The New York State Legislature has passed important laws related to health equity, some of which have given specific charges to the Department.

Note: The enacted laws listed below are selected examples of legislative action related to health equity in recent years. As earlier explained in the Health Equity Plan, there is a wide range of initiatives that are relevant to health equity, since efforts to achieve health equity include all initiatives that focus on securing the conditions in life that impact a person's ability to achieve optimal health (food, healthcare access, safe and secure housing, etc.). Therefore, the list below does not include all enacted laws related to health equity, but instead, a selection that mention health equity explicitly.

2023	
Chapter 702 of the Laws of 2023; signed on 12/8/23. **Bill Number:** S.3609B (Webb)/A.3113A (Clark) **Effective Date:** June 22, 2023	This bill enhances the scope of Health Equity Impact Assessments to require the consideration of reproductive health services and maternal health care.
Chapter 697 of the Laws of 2023; signed on 12/8/23. **Bill Number:** S.1451 (Sanders)/A.782 (Peoples-Stokes) **Effective Date:** Immediate	This bill expands upon a collaborative program to include programs that will address disparities in health care access and treatment, or address conditions with a higher prevalence in defined populations across New York State. Some of these conditions include cardiovascular disease, hypertension, diabetes, chronic kidney disease, obesity, asthma, sickle cell disease, sepsis, lupus, various types of cancer and substance abuse.
Chapter 684 of the Laws of 2023; signed on 12/8/23. **Bill Number:** S.1839A (Sanders)/A.2609A (Hyndman) **Effective Date:** Immediate	This bill requires the Health Equity Council to advise the Commissioner of Health on sickle cell disease and create recommendations to promote sickle cell screening and detection.

2022	
Chapter 523 of the Laws of 2022; signed into law on 8/17/22. **Bill Number:** S9185 (Rivera)/A9764 (De Los Santos) **Effective Date:** Immediate	This bill renames the Office of Minority Health to the Office of Health Equity. The law also defines health equity, health disparities, social determinants of health, and broadens the responsibilities of the Health Equity Council.
Chapter 232 of the Laws of 2022; signed into law on 6/26/22. **Approval Memo #9** **Bill Number:** A9418-A (Cruz)/ S8884A (Hoylman-Sigal) **Effective Date:** Immediate	This bill enacts the Lorena Borjas transgender and gender non-binary (TGNB) wellness and equity fund.

2021	
Chapter 775 of the Laws of 2021; signed into law on 12/22/21. **Bill Number:** S.2987A (Parker)/A.5679A (Darling) **Effective Date:** 30 days after becoming law	This bill declares racism a public health crisis and establishes a Racial Equity Working Group.
Chapter 766 of the Laws of 2021; signed into law on 12/22/21. **Approval Memo #127** **Bill Number:** S.1451A (Rivera)/A.191A (Gottfried) **Effective Date:** 180 days after becoming law	This bill requires a Health Equity Impact Assessment to be filed with an application for any project that will affect certain health care facilities' health care services.

Health Equity Efforts to Date

In alignment with the national and international public health community, and in response to legislation and input from stakeholders, the Department has initiated activities designed to address social determinants of health and the broader issue of health equity. These efforts pre-date the Health Equity Plan by decades. They include:

- Major initiatives;
- Specific offices charged with leading Department efforts focused on reducing health disparities and increasing health equity;
- Advisory bodies; and
- Efforts to collect and disseminate data to track health disparities and document efforts to increase health equity.

Major Initiatives

Prevention Agenda

In 2008, the Department released its first Prevention Agenda. Now in its third cycle, 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 are hardest hit by 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. The vision of the most recent version of the Prevention Agenda is that New York State is the healthiest state, across all age groups. Steady progress is being made. Since 2008, New York State has moved from the 28th to 10th healthiest state on America's Health Rankings. To learn more about health disparity data collected as part of the Prevention Agenda, visit the Prevention Agenda Dashboard (more information is also available on the following page).

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. The County Health Rankings model is used as the framework for understanding the modifiable determinants of health (without discounting the role of genetics). The 2019-2024 Prevention Agenda cycle built 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.

Health Across All Policies

In January 2017, New York State launched Health Across All Policies, a collaborative approach that integrates health considerations across all sectors. The Health Across All Policies approach was incorporated in the Prevention Agenda 2019-2014 cycle. It calls on all New York State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. The goal is to improve community health and wellness, recognizing that a community's greatest health challenges are complex and often linked with other societal issues that extend beyond healthcare and traditional public health activities. To successfully improve the health of all communities, health improvement strategies must target social determinants of health and other complex factors that are often the responsibility of non-health partners such as housing, transportation, education, environment, parks, and economic development. By implementing a Health Across All Policies approach, the state is considering social and community factors of health and wellbeing. This approach can be a successful tool in working towards health equity for all New Yorkers.

New York State Department of Health Offices

Office of Health Equity and Human Rights

In 2022, the Department underwent an extensive strategic reorganization. Under the agency's strategic reorganization to add emphasis to select priorities including health equity, the Office of Health Equity and Human Rights (OHEHR) was established in August of 2022. The mission of the Office of Health Equity and Human Rights in the Department is to address inequities and disparities experienced by communities. The Office of Health Equity and Human Rights is committed to confronting systemic racism and determinants of health to improve the health and human rights of communities and the Department workforce. The units within the Office of Health Equity and Human Rights include: AIDS Institute; Office of Diversity, Equity, and Inclusion; Office of Gun Violence Prevention; Health Equity Impact Assessment Unit; and the Office of Minority Health and Health Disparities Prevention.

Office of Minority Health and Health Disparities Prevention

More than two decades ago, the Department took a major step to address health disparities by establishing the Office of Minority Health and Health Disparities Prevention (OMH-HDP), which focuses on ensuring high-quality, affordable, and accessible health care for all New Yorkers. The Office of Minority Health and Health Disparities Prevention was originally established by Public Health Law § 241 in 1992 and became operational in 1994. Over the years, it has aligned its work with other significant state and national initiatives, including the Department's Prevention Agenda, Healthy People 2030, and the National Partnership for Action. The Director of the Office of Minority Health and Health Disparities Prevention also serves as the Department's designated Language Access Coordinator.

The Office of Minority Health and Health Disparities Prevention is one of five program areas within the Office of Health Equity and Human Rights, which was established in August 2022 in the New York State Department of Health.

HEALTH EQUITY STRATEGY
Engaging the Community through Listening Sessions

In 2015 and 2016, the Office of Minority Health and Health Disparities Prevention conducted community-led listening forums in Buffalo, Rochester, and Albany, all of which have 40 percent or greater non-White population. The goal was to engage the community to hear about factors influencing health and well-being, how to improve the health care delivery system, how to enhance health care service delivery and utilization, and ways to improve the quality of life.

Participants emphasized the need for a more holistic system of health care delivery, where community residents have a say about the quality of care and what kind of system would best serve them. Participants also identified other critical issues including: health care access; cultural and linguistic competence; stigma; violence; community empowerment and advocacy; social, economic, and educational opportunities for upward mobility; and the importance of community-designed and community-led interventions that can contribute to improved health and socio-economic well-being.

Advisory Bodies Focused on Health Equity

Note: The list below is not an exhaustive list of advisory bodies overseen by the Department, but highlight examples of advisory bodies that have been structured to facilitate focused conversations on health equity. For more information on additional advisory bodies overseen by the New York State Department of Health (including those that prioritize lived experience with health inequities), click here.

INTERNAL (within New York State Government)

New York State Department of Health Advisory Committee on Health Equity and Diversity, Equity, and Inclusion
Meets monthly, overseen by the Office of Health Equity and Human Rights.

The purpose of the Department's Advisory Committee on Health Equity and Diversity, Equity, and Inclusion is to convene Department staff across all disciplines, offices, and bureaus to identify how best to advance efforts addressing health equity as well as efforts to improve diversity, equity, and inclusion within the Department. This internal Department-wide committee includes over fifty (50) Department Staff from different program areas and levels of leadership, including program directors, senior leadership, program support staff, research analysts, and more.

Interagency Taskforce on Health Equity and Diversity, Equity, and Inclusion
Meets quarterly, overseen by the Office of Health Equity and Human Rights.

The purpose of the Interagency Taskforce on Health Equity and Diversity, Equity, and Inclusion is to convene leaders from New York State agencies across all disciplines to identify how best to advance health equity as well as efforts to improve diversity, equity, and inclusion. The interagency taskforce convenes multiple State executive agencies and offices with the aim of fostering interagency collaboration and information sharing. The interagency taskforce includes at least one representative from each Executive agency or office that is responsible for advancing efforts in the areas of diversity, equity, and inclusion (DEI), and/or human rights.

EXTERNAL (Engages community stakeholders outside of New York State government)

Community Stakeholder Council on Health Equity and Human Rights

Meets three times per year, overseen by the Office of Health Equity and Human Rights.

The purpose of the Community Stakeholder Council on Health Equity and Human Rights is to create a forum where the Department and community stakeholders can share and discuss recommendations on how to advance health equity and human rights across New York State. Stakeholders participating in this Community Stakeholder Council inform the work of the Department through recommendations to advance health equity, uplift human rights, and better support marginalized and under-served communities. The Council consists of organizations from the community that can provide valuable insight into issues on the ground and help the Department identify ways to advance health equity and human rights across the state. This Council serves to inform policy and programmatic changes internally in the Department based on real-time feedback from community members as well as provide community with resources and information to disseminate with their networks.

New York State Health Equity Council

The Office of Minority Health and Health Disparities Prevention oversees the New York State Health Equity Council, formerly the Minority Health Council. The Health Equity Council works in three main areas: raising awareness about the health of racial, ethnic and other under-served populations; increasing the engagement of local grassroots communities in public health advocacy and research; and increasing the number of racial, ethnic and other underrepresented individuals that work in public health. Additional statutory charges of the Health Equity Council include advising the Commissioner of Health on sickle cell disease, and on any recommendations relating to the preservation and improvement of health equity.

Data Collection and Dissemination Efforts

Across the Department, there are numerous data collection and dissemination efforts that are used to track progress in eliminating health disparities and supporting the achievement of health equity.

New York State Health Equity Reports

To address health disparities, it is necessary to identify and measure them, which requires data. To that end, the Department has been providing state and county level data on health disparities. The Health Equity Reports are required by Public Health Law § 242. The Health Equity Report series presents data on health outcomes, demographics, and other community characteristics for cities and towns with a 40 percent or greater non-White population throughout New York State. Each town- or city-specific report contains data associated with the priority areas of the Prevention Agenda 2019-2024, as well as social determinant of health indicators, such as housing, educational attainment, and insurance coverage. Thirty-seven (37) communities have sufficient data to develop a report. These data can help communities to: identify disparities and their consequences; understand and identify priorities; mobilize communities; target health-related interventions; and promote health equity.

New York State Prevention Agenda Dashboard

The New York State Prevention Agenda Dashboard is an interactive visual presentation of indicator data to track progress in accomplishing the Prevention Agenda's goals at both the state and county level. It is a key tool for monitoring progress by communities across the state in terms of achieving the Prevention Agenda objectives.

- The state-level dashboard includes almost 100 indicators and trends can be tracked from year to year. For 47 indicators, data are available by major socio-demographic characteristics such as age group, race/ethnicity, sex, region, health insurance status, and level of education.
- The county-level dashboards include the most current data available for 70 indicators, which are grouped by priority area. These allow community partners, such as local health departments and community health centers, to aligned their work with statewide Prevention Agenda efforts.

New York State Health Disparities Dataset

The Health Disparities Dataset is a dataset derived from the Quality Assurance Reporting Requirements (QARR) system. Since its inception in 1994, QARR has served to monitor managed care plan performance and enhancing the quality of healthcare across New York State. Annually, health plans submit quality performance data, validated by licensed organizations, culminating in Managed Care Reports that include a comprehensive Health Disparities dataset, published since 2015.

Understanding the Health Disparities Dataset

This dataset provides detailed Medicaid Managed Care data for the QARR measurement year 2022, stratified by key demographics such as race/ethnicity, cash assistance status, and behavioral health conditions including serious mental illness (SMI) and substance use disorder (SUD). Other stratifications by age, sex, region, and Medicaid plan type are also available. Its primary objective is to pinpoint areas of disparity in health outcomes and quality measures among vulnerable populations. By identifying these disparities, we can effectively inform and implement targeted quality improvement initiatives aimed at promoting health equity and enhancing overall health outcomes across New York State.

Why Health Disparities Data Matters

Research indicates that disparities in healthcare access and quality contribute to poorer health outcomes, highlighting the critical need for accurate metrics that consider socioeconomic, racial, and ethnic factors. By stratifying data, healthcare organizations can better address the unique needs of diverse populations, track disparities over time, and enact strategies to bridge gaps in care and outcomes.

Accessing the Dataset

You can access the Health Disparities Dataset through the Department's public reporting system at the following link: Health Disparities Dataset. Other Managed Care reports and past year data can be found here: Managed Care Reports.

Who Contributes Data

Data for this dataset is sourced from the New York State Medicaid Managed Care program and includes contributions from Commercial Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These organizations report annually on applicable QARR measures which are defined by national stakeholders (e.g., National Committee on Quality Assurance) or New York State.

Continued Commitment

We encourage all stakeholders to explore this dataset and collaborate in our ongoing efforts to reduce health disparities and improve health outcomes for all New Yorkers. Questions about the dataset can be directed to nysqarr@health.state.ny.us.

APPENDIX C:

Department Case Studies: Putting a Health Equity Foundation into Practice

AIDS Institute: Health Equity Initiative

The AIDS Institute (AI) is based in the Office of Health Equity and Human Rights. The mission of the AIDS Institute is to eliminate new infections, improving the health and well-being of persons living with HIV, AIDS, sexually transmitted diseases, and viral hepatitis, and improving LGBTQ+ and drug user health.

What is the AIDS Institute's Health Equity Initiative?

In the spring of 2017, a small group of people came together to discuss health equity and its importance with the AIDS Institute Executive Office. This group came together as a small task force. This group decided to adapt a survey developed by the National Association of Chronic Disease Directors and distribute it across the AIDS Institute. The survey was used to determine the understanding of health equity and health disparities by AI staff. Based on the survey, the taskforce elicited four recommendations for the AI Health Equity Initiative going forward. In addition, the survey asked for volunteers to champion this work and the AI Health Equity Initiative was born. The four recommendations and goals from the survey were:

1. Develop staff skill and promote awareness through training, education, and the application of health equity principles.
2. Develop staff ability to measure an organizations' readiness to address the social determinants of health, and, to apply community engagement principles into our work.
3. Develop practices that promote health equity, as well as diversity and inclusion principles in hiring practices.
4. Develop policies that promote health and racial equity in all aspects of work.

The AI Health Equity Initiative seeks to answer the questions, "How would systemic interventions for health equity complement our goal to End the Epidemic? Can we address health inequities from all angles, including finding opportunities to be more culturally responsive in our approaches?"

AI Health Equity Initiative Mission

The AIDS Institute Health Equity Initiative is committed to improve health equity by understanding historical and contemporary experiences, implementing best practices, and strengthening workforce development and capacity.

AI Health Equity Initiative Vision

The AIDS Institute Health Equity Initiative vision is to be the champion for health equity serving as a catalyst for change, protecting and preserving the health and well-being of our communities, eliminating health disparities/inequities, and achieving health equity for all individuals in New York State.

AIDS Institute's Health Equity Initiative Core Principles (in line with American Public Health Association's Pillars of Health Equity)

- Be Explicit!
- Identify and Effectively Address Racism and Racial Implicit Biases.
- Adopt a "Health in all Policies" Approach.
- Create an Internal Organization-Wide Culture of Equity.
- Respect and Involve Communities in Health Equity Initiatives.
- Measure and Evaluate Progress in Reducing Health Disparities.

The AI Health Equity Initiative carries out its work through its three subcommittees:

- ***AI Health Equity Initiative Communication, Administration and Technology (CAT) Committee***

  This committee focuses on providing administrative support to the Health Equity Initiative by monitoring the shared mailbox and calendar, scheduling meetings, taking meeting notes, producing our newsletters to promote the work of the Initiative and various other acts of technical assistance.
- ***AI Health Equity Initiative Education and Technical Assistance (ETA) Committee***

  This committees works to provide assistance for AIDS Institute staff looking to build health equity capacity for the work we do every day. This includes providing input, reviewing materials, and offering educational and conversational opportunities for staff to discuss health equity and social justice.
- ***AI Health Equity Initiative Research, Evaluation, and Development (RED) Committee***

  This committee focuses on staying current on health equity research, conducting evaluation of the projects executed by the Health Equity Initiative, and monitoring funding opportunities to continue to expand the work of the Health Equity Initiative.

Bureau of Health Equity and Community Engagement: Small Wellness Mini Bids

The Bureau of Health Equity and Community Engagement is based in the Division of Family Health, within the Center for Community Health in the Office of Public Health. The Bureau's mission is to engage, build trust, and create partnerships with community-based organizations that are credible messengers and who are responsive to the needs of their community.

The Bureau of Health Equity and Community Engagement builds health equity into all aspects of its work, but this case study highlights its work on two specific funding opportunities: Small Wellness Mini Bid Cohort 1 and Cohort 2.

What was the challenge, or health inequity, the program was seeking to address?

1. The COVID-19 pandemic exacerbated existing health inequities in communities across New York State. These inequities were a result of structural racism and the historical and unequal distribution of social, political, economic, and environmental resources to rural, LGBTQ, disability, tribal nations, and BIPOC communities.
2. Organizations who were on the ground during the pandemic and are credible messengers did not have adequate resources to help mitigate these health inequities, and historically faced barriers to accessing funding opportunities from the Department.

How was a health equity foundation used to address the challenge?

1. The Department saw an opportunity to seek funding from the U.S. Centers for Disease Control and Prevention (CDC) to address the above challenges.
2. The funding opportunity was specifically designed to support communities that were hardest hit by COVID-19.
3. When Health Research, Inc. (HRI) received the CDC COVID-19 Health Disparities grant, the Division of Family Health created a new bureau, the Bureau of Health Equity and Community Engagement, to implement the grant. The Bureau's mission is to engage, build trust, and create partnerships with community-based organizations that are credible messengers and who are responsive to the needs of their community.
4. The Bureau of Health Equity and Community Engagement understood that simply posting funding opportunities would not be enough to engage new and non-traditional community-based partners. The Bureau also recognized that the process for applying for and obtaining funding from New York State Department of Health can be challenging, especially for organizations who do not have prior experience receiving state funding. To address this, the Bureau of Health Equity and Community Engagement employed the following strategies:
   - **a.** The Bureau released multiple procurements to support communities hardest hit by COVID-19. Two of these procurements focused on new and non-traditional partners and were small awards (about $50,000 per award). These Small Wellness Mini-Bids were released as two separate cohorts. The funding was to conduct wellness activities and improve COVID-19 health literacy. Small Wellness Mini Bid Cohort 1 included 70 organizations (62% were new to working with the Department). Cohort 2 included 111 organizations (92% were new to working with the Department). A total amount of $9.1 million was awarded between Cohorts 1 and 2.
   - **b.** The Bureau built equity into its procurement processes in the following ways:
     - **i.** Simplifying the language of the application itself
     - **ii.** Making it easier for organization to apply by utilizing the APPLY by SurveyMonkey™ platform to accept applications.
     - **iii.** Providing training and scoring matrices to Department staff to improve equity in application review.
     - **iv.** Based on the communities' feedback that the best way to learn about funding opportunities is word-of-mouth, the Bureau utilized Equitable Procurement Consultants. Their role was to advertise the availability of the funding opportunity and remove barriers for organizations to apply. These consultants were community-based organizations who were trusted, had connections with small, grassroots organizations, and knew the best way to engage potential applicants.
     - **v.** Hiring a diverse Bureau staff to provide enhanced technical assistance to new and non-traditional partners.
     - **vi.** Utilizing deliverable-based contracting to ensure that awardees are paid after each deliverable is completed. This is essential for small grassroots organizations who do not have funds upfront. To ensure equity, all awardees received a standard hourly consultant rate. The Bureau recognizes that all awardees have the same value, as each of their organizations provide a service that is extremely valuable to the Department, which is their ability to serve as a trusted messenger in their own community.
     - **vii.** Providing public health training and one-on-one technical assistance to awardees and paying for their time to engage in these activities.
5. The Bureau of Health Equity and Community Engagement understood that one of the most important measures of success was how organizations felt about their experience working with the Department. Organizations were given the opportunity to give feedback and tell the Department how they could do a better job supporting communities. The feedback received was then incorporated by the Bureau into subsequent procurements, processes, and communications to improve the communities' experience.

Bureau of Cancer Prevention and Control: Community Outreach to Promote Colorectal Cancer Screening Program

The Bureau of Cancer Prevention and Control (BCPC) is within the Division of Chronic Disease Prevention, in the Center for Community Health, in the Office of Public Health. The Bureau of Cancer Prevention and Control works towards cancer-related health equity through evidence-based programming and partnership building by directing resources to communities disproportionately impacted by cancer.

What was the challenge, or health inequity, the program was seeking to address?
Community Outreach to Promote Colorectal Cancer Screening (Colorectal Cancer Outreach Program) was developed to address cancer health inequities by supporting community-based organizations across New York State that are members of and trusted voices in populations that bear a disproportionate burden of cancer, including individuals who are Black, Hispanic/Latino, LGBTQ+, and/or reside in rural communities.

How was a health equity foundation used to address the challenge?
A Focus on Reaching Populations Affected by Health Inequities

While anyone can get colorectal cancer, differences exist. For example:

- New Yorkers who are Black are nearly 20% more likely to die from colorectal cancer than non-Hispanic White people and are also more likely to be diagnosed at a later stage.[49]
- LGBTQ+ individuals have higher colorectal cancer rates as compared to individuals who are not members of the LGBTQ+ community.[50]
- Rural residents have higher rates of colorectal cancer as compared to urban populations.[51]
- Colorectal cancer rates in adults under age 50 have risen more rapidly in Hispanic and Latino people than in those of any other racial and ethnic group.[52]

It is well researched that structural racism has led to persistent disadvantages in housing, employment, income, health, and health care access. In addition, the stress of prejudice, rejection, and discrimination affect health and may also increase cancer risk. In development of the Colorectal Cancer Outreach Program, BCPC chose to commit to focusing on populations disproportionately burdened by cancer as a result of health inequities related to racism and other forms of discrimination based on gender identity, sexual identity, and geographic location.

With regular screening, colorectal cancer can be prevented. Screening tests can find abnormal growths so they can be removed before they become cancer. Tests can also find colorectal cancer early when treatment may be most effective. However, in New York State, nearly one in four adults are not getting colorectal cancer screening as recommended. While a number of factors affect the likelihood of getting screened for colorectal cancer, studies show that ethnic and racial minority groups, LGBTQ+ persons, and rural residents face additional barriers to colorectal cancer screening resulting from systemic racism and discrimination. These include limited access to culturally competent health care, mistrust of physicians, and delayed or low participation in preventive health services.

A Focus on Supporting Credible Messengers to Deliver Key Colorectal Cancer Health Messages
Community-based organizations that are familiar with and embedded in the communities they serve are well-positioned to address barriers to cancer screening and improve rates among those least likely to get screened. Therefore, funding community-based organizations to reach populations of focus was a priority in developing the procurement for the Colorectal Outreach Program. To attract these smaller, non-traditional Department partners, BCPC developed a procurement using SurveyMonkey™ Apply, a simple online application system successfully used by other Department programs to reach these types of organizations and allow them to submit competitive applications.

49. Cancer Incidence and Mortality among Black Individuals, New York State, 2016-2020, New York State Cancer Registry, 2019.
50. Cancer and the LGBTQ Population: Quantitative and Qualitative Results from an Oncology Provers' Survey on Knowledge, Attitudes and Practice Behaviors, *J Clin Med*, 2017.
51. Rural-Urban Disparities in Cancer, National Cancer Institute.
52. Cancer Facts & Figures 2024, American Cancer Society.

Results
A competitive procurement was released in September 2023, and 12 community organizations were selected to implement the Colorectal Cancer Outreach Program. Each organization was awarded a multi-year contract totaling $225,000 for the period of March 1, 2024 – June 30, 2028. Awardees are small, nonprofit, grassroots organizations, all of which are new BCPC partners. Some grantees are receiving Department funding for the first time. Others are receiving multi-year funding from the Department for the first time. The program will serve nine counties across New York State.

Eligible applicants were not required to demonstrate knowledge of cancer; rather, applicants needed to demonstrate success working in their identified communities. As a result, the procurement attracted organizations with staff and volunteers who are members of the communities they serve with experience reaching those least likely to participate in preventive health. BCPC has begun providing technical assistance and training on public health and cancer basics, which has an additional benefit of building the capacity of these organizations to apply for future Department funding opportunities.

Program requirements include provision of colorectal cancer prevention and early detection education and connections to cancer screening services, as well as assistance with addressing barriers to cancer screening. Organizations will report on the number of individuals educated and number screened for colorectal cancer within a six-month period after participating in education. This data will allow BCPC to identify strategies that result in colorectal cancer screening and demonstrate how well the program is doing with accomplishing its goal of reducing colorectal cancer screening disparities.

Office Of Minority Health and Health Disparities Prevention: Race and Ethnicity Data Toolkit

The Office of Minority Health and Health Disparities Prevention is within the Office of Health Equity and Human Rights. The Office of Minority Health and Health Disparities Prevention was established by Public Health Law § 242 in 1992 and became operational in 1994. Over the years, it has aligned its work with other significant state and national initiatives, including the Department's Prevention Agenda, Healthy People 2030, and the National Partnership for Action. The Director of the Office of Minority Health and Health Disparities Prevention also serves as the Department's designated Language Access Coordinator.

What was the challenge, or health inequity, the program was seeking to address?
Historically, the race and ethnicity of the under-served population in hospitals and healthcare facilities was captured inaccurately, if at all. The COVID-19 pandemic highlighted the need to approach health programming from a health equity perspective by demonstrating that unequal distribution of and access to resources leads to disparate outcomes and drives disparities in health and healthcare.

Under the Department's COVID-19 Health Disparities grant, awarded by the CDC, OMH-HDP developed a toolkit to improve data collection. This toolkit provides materials geared towards healthcare staff, patients, and the community to improve race and ethnicity data collection. The Office's "Toolkit Team" is piloting this program in healthcare facilities across NY state.

How was a health equity foundation used to address the challenge?
For race and ethnicity data to be usable by state agencies, facilities must collect and submit known race and ethnicity (R/E) information for at least 90% of their patients to the NYS Statewide Planning and Research Cooperative System (SPARCS). This number is based on epidemiological recommendations for data analysis.

Many facilities are short of meeting this 90% goal. After receiving R/E reporting data from SPARCs for 277 facilities, OMH-HDP applied exclusion criteria to narrow their list to 23 hospital facilities.

To better understand the needs of these healthcare facilities, a select group of hospital facilities were invited to a listening session focused on the participation of organizations and groups playing a role in race and ethnicity data collection at these facilities, including frontline staff, providers, data managers, diversity, equity, and inclusion (DEI) specialists, and hospital leadership.

Sample topics that were discussed included:

- Are there any roadblocks your facility faces when collecting race and ethnicity data?
  — If so, what kind of resources (if any) do you think would best support your facility in improving this number?
- What Electronic Health Record data software system(s) do you use to collect and record this information?
- Has your facility had any issues transmitting and submitting data to the New York State Health Department Statewide Planning and Research Cooperative System (SPARCS)?

OMH-HDP's aim was to gain a comprehensive understanding of the unique challenges that facilities and healthcare organizations face in reaching this goal of 90% completeness. OMH-HDP plans to pilot the Toolkit materials to sites that can benefit from educational training and guidance on best practices in R/E data collection.

New York State of Health (NYSOH): Health Equity Workgroup

New York State of Health, New York's Health Plan Marketplace, provides consumers a one-stop shopping experience to enroll in high-quality comprehensive coverage, including Medicaid, Child Health Plus, Essential Plan (New York's Basic Health Program) and subsidized and unsubsidized Qualified Health Plans. Since the Marketplace opened in 2013, NY State of Health has seen a dramatic increase in enrollment, reaching 6.6 million enrollees in September 2022, and a commensurate reduction in the state's uninsured from 10 percent to 5 percent in 2019.

What was the challenge, or health inequity, the program was seeking to address?
The primary goal in standing up the Health Equity Workgroup was to better understand the ways the marketplace can be used to facilitate an equal opportunity for health. The hope was that the working group would be able to recommend practices, structures, and policies intended to reduce health disparities in New York State.

How was a health equity foundation used to address the challenge?
The workgroup processes were designed with a health equity foundation in mind. Some examples include:

1. Stakeholders were invited from a variety of backgrounds to participate in the workgroup. By including a diverse array of members who interface with consumers at different points in their journey (from navigators to providers), the workgroup was able to get a more holistic view of the consumer experience as well as a diversity of perspective in decision making.
2. While the workgroup had key focus areas for the workgroup, it purposefully was not overly prescriptive of intended outcomes or which policy levers would be used to achieve them. This not only allowed for more open discussion but ensured that the biases workgroup members could have as employees of the marketplace didn't color the workgroup outcomes.
3. Discussions were held regarding inequities vs. disparities and whether each workgroup recommendation would achieve the intended outcomes. This allowed for candid conversations about potential unintended consequences of well-meaning interventions.
4. The consumer was viewed as an active participant in their health journey – the workgroup discussed ways to support consumer decision making, such as improving data transparency to better inform a consumer's plan selection process.

Sexual Violence Prevention Unit: Bureau Health Equity Training Series and Health Equity Capacity Assessment and Action Plan

The Sexual Violence Prevention Unit sits within the Bureau of Perinatal, Reproductive and Sexual Health, within the Center for Community Health in the Office of Public Health. The unit's mission is to reduce sexual violence by implementing a public health approach. Within the Sexual Violence Prevention Unit is the Rape Prevention and Education Program (RPE), a Center for Disease Control and Prevention (CDC) funded program that was authorized through the Violence Against Women Act (VAWA). The Rape Prevention and Education Program aims to promote health equity and prevent sexual violence by addressing social factors like poverty and discrimination that contribute to the prevalence of violence by fostering meaningful engagement and coordination with communities while building sustainable infrastructure.

What was the challenge, or health inequity, the program was seeking to address?

1. Improving Bureau staff training and organizational policies and procedures to better address health equity within all of our programs with consistency.
2. Improving program specific activities to advance health equity with intentionality.

How was a health equity foundation used to address the challenge?

Bureau Health Equity Training Series (to address challenge #1)

In 2022, the NYS RPE Program awarded Michelle M. Osborne and Associates (MMO) a contract to deliver 'An Antiracist Health Equity Approach' 12-hour training series for over 50 staff within the Department's Bureau of Perinatal, Reproductive, and Sexual Health. This training provided staff with a strong foundational knowledge on how racism specifically shows up within public health to disadvantage people and lead to social and health inequities. Furthermore, this training provided staff with information and tools on the "inside-out approach" to focus internally on opportunities to improve priorities, policies, and procedures that advance antiracism with the ultimate aim of improving health equity.

Health Equity Capacity Assessment and Action Plan (to address Challenge #2)

In 2022, the NYS RPE Program awarded Michelle M. Osborne and Associates (MMO) a contract to complete an Antiracist Health Equity Capacity Assessment. The purpose of the assessment was to determine the NYS RPE Program's current capacity to enhance and expand health equity work, including an audit of RPE program staff and materials; a review of current data availability and use of available data; and training and technical assistance (TTA) on health equity. To conduct the assessment, MMO met with the RPE Program Director bi-weekly, delivered a survey to all funded and unfunded RPE Program staff and partners, interviewed all RPE Program staff within HRI and four other RPE Program subrecipients, and completed a deep audit of many core RPE Program materials including the website, external and public documents, internal unpublished documents, CDC documents, and contract materials. MMO provided several findings and recommendations in the form of an action plan on staff capacity, program design and implementation, TTA, and evaluation. This process has been critical to the RPE Program team and will continue to guide strategic planning for the upcoming grant cycle.