NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
JOINT MEETING OF THE PUBLIC HEALTH COMMITTEE AND THE HEALTH PLANNING COMMITTEE
FEBRUARY 8, 2023 10:00 AM
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Dr. Boufford Call our Public Health Committee of the State Public Health and Health Clinic Council to order. Welcome to everyone. I'm Jo Boufford. I'm the Chair of the Public Health Committee. My colleague John Rugge, who is the Chair of the Planning Committee will be speaking to you shortly, and Ursula Bauer, who's here next will be running the meeting basically has put this together. I want to thank Ursula and her team for putting this meeting together and really launching the next cycle of the prevention agenda. We're having a joint Public Health and Health Planning Committee because the prevention agenda is in fact linked to the CON process through the agreement a couple of years ago. We want to involve the Planning Committee there. I also want to mention other agencies who have been core partners of the prevention agenda in the previous cycles, especially the Office of Mental Health, Oasis and the New York State Office for the Aging, have really been what I would call core partners. I think the historic goal for of the prevention agenda has been focused on mental health and behavioral health, health and well-being. A little bit into the meeting, we will welcome Joanne Morne, who is going to help us tackle the area of health disparities and her new roles and responsibilities relative to inclusion and human rights as a senior leader in the department. Just to mention also other agencies, because we haven't really reviewed the prevention agenda. It's been three years since before COVID, so just for a lot of folks that are less familiar with the history of it and or all of us needing our memories jogged a bit. There are other agencies that have been really involved in something called the Health and all Policies Executive Order in 2018, which really asks all state agencies to look carefully at the health impact of their programs, policies and purchasing. Similarly, now the impact on aging on older persons and healthy aging. Within that group, we have really been fortunate to have a lot of support, especially for technical assistance on the prevention agenda at the county level from the Department of State. I want to call out Paul, who's been really helpful with that. Energy and parks have historically participated actively, been guests here at these meetings. I just want to mention them as well. The other thing to mention about the prevention agenda in this new context is it's a very important complement to the efforts on the Master Plan for Aging as a result of Governor Hochul's executive order to develop that plan, many of the members of that master plan group will be focusing a lot on services for older persons. We're going to be focusing relatively more on the conditions and communities, the sort of age friendly communities. We're looking forward to staying in close touch with them. Just as a reminder, each of the current goals of the prevention agenda has an aging objective, objectives, one or more objectives for older persons per our agreement before. It's a very logical partnership. We're looking forward to reconvening the Ad Hoc Leadership Committee sometime in early April. Ursula may have an actual date before the meeting's over. I wasn't 100% sure coming in here, but the membership is being dusted off and updating addresses and people that have moved on over the last three years. Invitations will go out or are going out as we speak. We should have that group recognition. They were very, very important in shaping the last round of the prevention agenda and give us an opportunity to have state level community-based organizations, professional associations and advocacy groups involved in our process. Finally, I just want to make one brief comment to link the Prevent Prevention Agenda to the Public Health Law governing

something called Community Benefit. It's really important to realize that hospitals especially are obligated to invest in community benefit to maintain their tax-exempt status. They submit community service plans every three years, along with local health departments who do community health assessments and community health improvement plan. I won't go into this in more detail at this point, maybe sort of towards the end of the meeting in terms of next steps. It's really important that we attend to the fact that not only is the community benefit linked to the prevention agenda part of the sort of very I think New York State doesn't have a lot of should or musts in its community benefit plan and many other states do. We're kind of looking at that. Similarly, we've had discussions about the link of descriptive material on the prevention agenda by hospitals. Before COVID, we had intended to try to extend that link to the other CON processes and ambulatory care and other areas. We've talked about that, and it may come up in John's committee as well about revising that language since it's been sitting there for about three years. Those are the opening remarks I wanted to make.

Dr. Boufford Let me turn it over to John.

Dr. Rugge It can be very brief.

Dr. Rugge It's an honor and a privilege for us responsible for planning to hear the updates and the progress we're making in prevention. If we can only do total job in prevention, we wouldn't need anything else, but we are at least making partial progress in a very positive way. I appreciate being here.

Dr. Rugge Thank you.

Dr. Boufford Let me now turn over the microphone to Ursula Bauer.

Dr. Bauer Well, welcome, everyone. This is the inaugural meeting certainly this year and since a couple of years of the Public Health Committee. We're delighted to have the Planning Committee here as well. This is the launch of the planning period for the next six-year cycle of the prevention agenda. It's also an opportunity for kind of a mid-cycle check in. We have a robust agenda today, a refresher on the prevention agenda, a check in of progress through 2021, and then an opportunity to learn more about how we can better integrate health equity action into our prevention agenda plan. We will have, I hope, opportunity for discussion to get guidance, ideas, feedback, input from the Public Health Committee and the Planning Committee for our planning process over the next 18 months.

Dr. Bauer I think with that we will launch into our program. Shane Roberts is going to facilitate the process and our first speakers are Shane and Eli Rosenberg and Dr. Trang Nguyen.

Dr. Bauer Welcome.

Dr. Roberts Good morning, everyone. Shane Roberts, Assistant Director for the Office of Public Health Practice. I'm joined by my colleague, Dr. Eli Rosenberg, who's our Director for the Office of Science. This morning, we are going to give you a brief refresher and an overview of the prevention agenda for 2021. I'm going to start with the overview.

Dr. Roberts I apologize.

Dr. Roberts I will start with a brief overview of the prevention agenda for 2021, and then I'll turn it over to Eli, who is going to do a progress update. The prevention agenda for year 2019-2024 is New York State's Health Improvement Plan, is the blueprint for the state and local action to improve health and well-being for all New Yorkers and to promote health in populations who experience disparities. It's based on a comprehensive statewide assessment of health status and health disparities, changing demographics and underlying causes of death and disease. The overarching strategy of the prevention agenda is to implement public health approaches that improve the health and well-being of the entire population and achieve health equity. As Dr. Boufford had mentioned, you know, it's in partnership with more than 100 organizations. This is the Ad Hoc Committee that we are currently assembling to start the new cycle of planning. For this 2019 to 2024 prevention agenda cycle, the five priorities that were identified were of the prevention of chronic diseases, promotion of health and safe environment, healthy women, infants and children, promote well-being and prevent mental and substance use disorders and to prevent communicable diseases. A brief overview of the submissions for this past cycle. 2019-2021 Prevention Agenda work plans were submitted by December of 2019. We would have had updates in 2021, but due to the COVID-19 pandemic, we did waive those for the counties and the hospitals. This past December the 2022-2024 plans we're doing. We have about 40% of those in so far. We're actively pursuing getting the rest. As you can see, this is a map of priorities selected by county. These are the local health departments. Nearly all, I believe, all but one selected to prevent chronic disease. That was closely followed by the promotion of well-being and prevent mental, and substance use disorders. The other priorities were selected less often. These two at the top were the ones that we have seen the most throughout all plans. We did receive about 121 plans by 58 local health departments, 165 hospitals. 77% of those were submitted as combined plan. That means that the LHD in the hospitals that were in the county submitted a combined plan together. About 41% of hospitals submitted a combined plan. I'll just do a brief update on state aid spending. We do have complete data for 2019. As you can see, the vast majority, and this is 2019. A communicable is in communicable disease control. Just a reminder for when it comes to state aid that this is after all other sources of spending, so grants and all this we pay. We're the payer of last resort. If you look at something like emergency preparedness, obviously counties spend a lot more on emergency preparedness than what we have here in this graph. We do have updated data for for 2020 and 2021. However, there are some larger counties that are not included in this data, just as we are still processing claims, but as you can see it still remains the the largest section of reimbursement. We do expect that to be the case after those counties come in.

Dr. Roberts I'll turn it over to Eli.

Ms. Monroe Thank you for your presentation. I'm wondering the very large green parts of the pie.

Dr. Roberts Yes.

Ms. Monroe Do you think they would have been that large if COVID hadn't occurred?

Dr. Roberts They're certainly larger. I would say that they are traditionally always the largest section.

Ms. Monroe Pardon me.

Dr. Roberts Traditionally they always are the largest portion of spending prior to COVID, but certainly after COVID, more so.

Ms. Monroe Thank you.

Dr. Boufford I just wanted to ask, because you're talking pretty fast.

Dr. Roberts Sure.

Dr. Boufford I haven't been used to seeing the state aid cycle here, which is really useful. Can you describe I think you said it was, how does it relate to, say, federal pass-through funding? Because we know federal funding funds things like the MCH, chronic disease prevention, etc. Can you just sort of clarify, is this in the Governor's budget meaning state aid or is it some other mix of source of funding sources?

Dr. Roberts Sure.

Dr. Roberts I don't want to misspeak, so I'll defer to Sue if I do misspeak. This is our Article 6 state aid funding. We reimburse of 100% to a certain amount for each county for these specific categories. And then after that amount, it's I believe it's $0.36 on the dollar. Basically, that's what we do through state aid. Any other funding that they have, they would have to use that first before they could get reimbursed through state aid.

Dr. Boufford For the offices within Ursula's remit, within public health, like the Office of Chronic Disease or Maternal Child health. Are there federal funds that come to them for work? There is then this other source of federal funding that would come for some of those targeted programs, which arguably would also be available through a mechanism that the department would control relative to other grantees, presumably?

Dr. Bauer I think one of the key points here is this is what the state spends on local health department activity after all other sources of funding have been exhausted.

Dr. Roberts I will turn this over now to Eli to do a progress update.

Dr. Eli Rosenberg Thank you.

Dr. Eli Rosenberg Good morning. I'm going to present some data that's through 2021, as was said. This is really me speaking on behalf of really a whole team, particularly Dr. Wen and Steph Mac here to represent as well and their team and the Public Health Information Group. This just represents a high-level summary of where we're at on 99 indicators across those five priority domains that Shane presented and then the sixth domain that are overall indicators of well-being. We'll go into some detail, but so this is the highest-level overview that you can imagine across 99 indicators. We'll see some of those indicators. Again, it's so much we're going ro able to cover it today, but fortunately all of this is available online on the prevention agenda dashboard. For people that have the actual Power Point, there's a link there. We can provide the link as well. When we look at our indicators, we see that 29 or 29% are ones for which the target has already been met, which is great news. An additional 18 are improving on the road hopefully to meeting that target in the current year span through 2024. Unfortunately, 19 have worsened. About 32 haven't really significantly moved. They're unchanged. When we break that out into the five priority areas to the right and then the one, I mentioned, which is sort of the overall summary health, the one that's on the left here, which is improvements in health status

and reducing health disparities. Those overall indicators. We can see that you can sort of see the distribution of progress across all of these. Each domain has areas where we've met the target and each of course has ones where the target has not been met yet or worsened. The red being the worsened. We'll dive into just a few of these again. It's very hard to cover all of it today. This just simply zooms in on the detail of the 70 indicators not met, so taking out that bright green. Again, there's six priority areas, improving health status and reducing disparities, those overall metrics of prevention and health, but then we also have prevention of chronic diseases, healthy and safe environment, promoting the health of women, infants and children and then promoting wellbeing, preventing mental and substance use disorders and prevention of communicable diseases. This for the first three of those areas, this sort of lists all of the indicators that have been met. I'm not going to read all of these out loud. Again, these are all items that were developed for the current cycle. We fortunately have met the indicators for all of these in these first three domains. Again, that first one is really those summary measures of prevention, prevention of premature deaths. We're making progress on deaths before age 65 years, for example, or preventable hospitalizations as well we're making progress on. This shows that the indicators that have been met on the latter three domains, so looking at women, infants and children for that promoting well-being and mental health and substance use disorders and the and the prevention of communicable diseases. I'll just say, you know, optically you can see there's already some clustering of things really looking at the prevention of communicable diseases. A lot of the progress there is around STI prevention, for example. I know it's a lot packed into these. We'll dive into just a few. Again, everything else is online on the dashboard which is updated annually. Just to pick on one, we'll look at patients who received at least one buprenorphine prescription for opioid use disorder. The green line represents the prevention agenda 24 target. The red line is the actual observed information. This is looking at rates, again, rates per 100,000 ages adjusted of receiving at least one prescription for opioid use disorder. Now, when one sees a graph like this, you should also keep in mind, well, is opioid use disorder itself increasing? We think that there have not been. When we look at increasing levels of buprenorphine prescription, we think this is actually outpacing the background level of opioid use disorder or there's actually some survey evidence to suggest that it may be on the decrease a little bit. When we see an increasing number of buprenorphine prescriptions, this does to us suggest that we are achieving that target and we've in fact exceeded that target in the most recent years of 427 per 100,000, compared to the 24 target of about 416 per 100,000. This is despite the impact of the COVID pandemic that we'll look at a little bit later on overdose deaths where we do see unfortunately an impact in deaths, which we'll talk about in particularly during COVID. This really is, we think, a good success story even though there was disruption in care during the pandemic, telehealth efforts, for example, were expanded, which allowed people to initiate and continue on their buprenorphine. This just zooms in on that just by regions. I was looking at here we see sort of a continued progress above that target for New York State outside of New York City, so that's good news. This just shows a county level distribution. Obviously, there's a lot going on. It's so small on the screen. I apologize. We'll have to do some zoom ins on this in the future. Optically, the yellow means you're in the third and fourth quartiles of the upper half of the county distributions. The dark blue means in the first quartile of counties. There's a green line and the red line. They're very close in this graphic, but that's showing the target and the New York state average. You can see where counties are below that or you can see particularly this cluster here in the New York City area is below the target that was set for statewide. As it says here, some of this may be attributable to sort of the modality used regionally. New York City historically has emphasized methadone treatment over buprenorphine, and that could explain some of the geographic heterogeneity.

Dr. Ortiz My practice as an NP and an out of reach medical in Ithaca, we specialize in OUD. I have to tell you; telehealth has just shifted everything we've done. Pre-pandemic we were in about 22 counties. Now, we're in 46 counties.

Dr. Eli Rosenberg Amazing.

Dr. Ortiz Mainly because people can access it. I mean, almost my entire caseload says if they cannot do it via telehealth, they wouldn't be on view. I do want to say that it is significant that we keep it via telehealth.

Dr. Eli Rosenberg Wonderful. Thanks for sharing that.

Dr. Eli Rosenberg The next category are indicators that have not been met, have not achieved that 24 objective, but are improving. They're on the right pathway. This shows for those first three of the six domains those indicators. This next slide shows it. Sorry, we will zoom in on one here, which is adults who have a regular health care provider. We'll show those data in a moment. Here are the indicators that haven't been met but are on the right trajectory for the latter three areas.

Ms. Monroe When you say above or below or however, is it strictly mathematical of the averages two and I have three and I'm above. Is there a certain level that I have to meet in order to assume or to be declared as above?

Dr. Eli Rosenberg I think it will depend on which figure in which metric and so forth. When we're looking here, this is the for example, at the county level. It's truly an above below sort of thing. Half of the counties are going to always be in the upper. Half will be above average. Half will be below by definition. When we talk about worsening or improvement, there are sort of I think there is a statistical significance criterion. I defer to my colleagues to say what the criterion specifically is.

Dr. Nguyen For most of the indicators that we have detailed data, we do statistical testing, comparing and for the data that we don't have enough information, a small sample size, then we just do the absolute math.

Ms. Monroe Thank you.

Dr. Eli Rosenberg That's a great question. The difference is important. By definition a quarter of our counties will always be in the blue. It's really important to also see, well, where are they relative to the target? You could be blue, but over the target and you're doing well. This just gives an example of one of those indicators that's getting close to achieving the 24 prevention agenda targets. This is adults who are seeing a regular health care provider, age adjusted. We see that the 21 estimate was 85% just almost touching the objective of 86.7%. This is data from our telephone-based survey, the BRFSS, the behavioral risk factor surveillance system. When we sort of dive a little deeper, we see that that achievement that or getting close to that achievement there is heterogeneity by race ethnicity that that these improvements are not equally seen across groups. This is a zoom in from our dashboard. The green line, again, showing that objective 86.7. What we can see here was that target is actually already been met for white non-Hispanic New Yorkers. When we look at Black non-Hispanic New Yorkers that achievement of that target is lower. It's 86.3. Still welcome that it's very close to achieving the 24 target, but the group that's really left behind here are Hispanic New Yorkers who are on the lower...What do we call

that color? A brownish/reddish line as well with about a 74.5% estimate for 2021. We have work to do here.

Ms. Soto I have a question here in New York City regarding this data about the individuals having a regular health care provider. What are some of the challenges that individuals are encountering that prevent them from having a regular health provider?

Dr. Eli Rosenberg Clearly, I think access to health insurance would be part of it. I don't know if we have further breakouts in the BFRSS on reasons that are sort of co-located with this. Do we have a report on that? Do we also have a follow up around reasons?

Dr. Nguyen I don't think that we have questions about why they don't have regular health care providers, but we have health insurance status, I think, which we could cross it to see if how much you know, the difference between having health care, health insurance and then having regular health care provider. That's something we could do.

Dr. Boufford The question was kind of connected to Ms. Soto's question, which is, you talked about there being a question on health insurance. I think Latinos are relatively probably the least well insured in the state, as I recall. Do you also ask about the source of this regular provider? Because it strikes me I'm going to turn to John here in terms of his primary, our mutual primary care concerns that I think we know a lot of primary care practices were lost during COVID and others. I wonder, do we know who or just the patient says, I have a regular or the person on the phone says I have a regular provider? Do you inquire a little further as to who that is or where it is taking place?

Dr. Nguyen I would have to go back to check to see. I haven't seen that, but I don't think that's in the core question of the BFSS. If it is a module like that, it will be it's a state to ask. I'm going to have to go back and check. We have income. I think we could also look into income to see lower income and then we have type of insurance. We probably have Medicaid. These are the things that I could think of right now.

Dr. Boufford I think the issue, one of the issues would be so many, I just maybe more in the city. A huge amount of ambulatory care is provided at a hospital based in better care services. I'm just curious as to whether there's a way of thinking about going forward, learning more about primary care provider or the person's perception that I go to this place when I'm sick.

Dr. Nguyen I see.

Dr. Nguyen Thank you.

Dr. Nguyen And also, I think the telehealth during COVID that, you know, we have an increase in having regular health care providers.

Dr. Boufford Good point.

Dr. Nguyen Is probably telehealth help with that.

Dr. Nguyen Thank you.

Dr. Boufford Folks in New York need to speak up because you're very tiny on my screen.

Dr. Boufford Andy, if you have any questions, please speak up.

Dr. Torres Good morning, everyone. I hope to see my colleagues tomorrow in Albany, but I'm enjoying the presentation. I do have a comment. I made a note. As I'm looking at Slide 19 and Slide 16, something in reference to the unchanged and progress for individual indicators. I must tell you that leading a not-for-profit organization in the Boogie Down Bronx, I'm constantly looking and evaluating the effectiveness of the communication between the non-for-profit and the health care institution. I'm very saddened to report that there remains a disconnect. I wonder. I don't wonder anymore. I know that this has an impact on statistics and things not improving on certain platforms and maybe for a future discussion strategy that we could perhaps look at supported at the state level so that the not-for-profit sector can have more of an active role and voice and respect with the health care institutions that are providing services to the clients that we're seeing. We don't want to see those train wrecks coming in because there's a lot of wonderful work that could be done to just address prevention.

Ms. Monroe I just have one quick question before we go on. There's been a lot of discussion lately about how Asian Americans have been lost in data. I assume based on this, that they're included in other non-Hispanic. Have you done anything to break that population out so we can really look at their health issues?

Dr. Eli Rosenberg I have a twofold answer. The second half involves you because I know of your particular involvement in this issue here in New York is sort of tracking insurgent improvements and tracking populations in Asian populations. One piece is I mean, just to answer sort of this question and sort of the last one. This is a limited data source. It really gives us a high level. The limited telephone survey where we get sort of some high-level pictures and more detailed racial, ethnic breakouts can be challenging as well as sort of crossing those and really coming up with other factors and coming up with deep explanations. How can we most completely explain what's going on with Hispanics, for example? There is additional work going on in the department around Asian race. I think you guys have both been involved in some of those efforts. Is there anything that we could report on here?

Dr. Eli Rosenberg Not to put you on the spot.

Dr. Nguyen I think the BFSS question has Asian as a specific race report. We group them and the other non-Hispanic due to the small number, but I think we could for this, the type of indicator like having regular health care provider wishes that everybody answer. We could break down for the Asian in the future when we do need assessment, we could break it down. Yes, with the BFSS. I think we could also try to see on the year that we have data at county level. If New York City has substantial number of surveys, we could also break now by region because we have a very diverse population in New York City. Regarding collecting additional race for Asian group, the department has been working on a plan to assess what data says that the health care providers report to the department that they can incorporate additional questions on the Asian subgroup like Chinese. I believe that at least ten subgroups in the data collection. I think we are very close to finalize the plan. I'm not sure on the implementation timeline, but we could go back and see.

Dr. Eli Rosenberg I think you're overseeing this process. I think we're on the verge of really collecting and being able to give a much more nuanced data on Asian subgroups.

Ms. Soto There's another group that I'm interested in is the Native Americans. I understand that sometimes when you're gathering data, the populations either could be small and or the challenges of obtaining that data. That's another group that Native Americans that have major health disparities and a major access problem.

Dr. Boufford Joanne Morne to comment on that.

Ms. Morne Sure.

Ms. Morne Good morning, everyone. I am prepared. I was going to provide a brief update on this tomorrow during the Office of Health Equity and Human Rights update. What I can speak to, though, is legislation that was signed into law about a year ago. It's bill number 6639. What it speaks to is the implementation of a collection of demographic information specifically focused on Asian and Pacific Islander individuals. To the additional comment as it relates to Native Americans, we certainly agree with you as far as looking at demographics and looking at the ability and opportunity to present data that's representative of all individuals. I know that this can be challenging in different areas, particularly as we look to update our data sources. I don't want to steal anyone's thunder, but I think that tomorrow there will also be some additional updates as far as personnel that has joined to help us move along in some of this work.

Dr. Boufford I think one of the advantages or opportunities, I'll put it this way of the prevention agenda is so much of the work is done at county level that it might present the opportunity to really look at counties in which we know tribes are located, whether they're federally recognized or not, etc. just because it probably wouldn't be statewide, but there would be areas where one could identify that sort of thing, I think. These are important comments because we're getting everything out on the table in terms of our forward planning.

Dr. Watkins Dr. Rosenberg by chance data was collected by a phone survey for this particular question here?

Dr. Eli Rosenberg The whole thing.

Dr. Eli Rosenberg This is our implementation of a long running CDC program. It's been continuously adapted in their methodology over the years to appropriately adapt to cellphones and all the changes in the ways that people communicate. It's probably still imperfect as your face is telling me, but this is sort of a very common platform that every state sort of rolls out in the same methodology and lets us make apples to apples comparisons and so forth. They might be really rotten apples still from your face. Yes, that is the methodology. Again, this is just one input. Only some of the indicators are BFSS source. We have obviously a number of other data sources that are not sample surveys that inform these indicators.

Dr. Eli Rosenberg Try to advance here.

Dr. Eli Rosenberg The not so good news are those indicators that have not been met and indeed they're worsening. We'll focus on obesity is one example here in the prevention of chronic disease area. This slide is showing those indicators that are worsening in the first three zones and then this is for the latter three. We'll also look at overdose deaths involving an opioid. We'll also look at childhood immunization series as well completion. The Prevention Agenda 24 target was to hit a 24.2% of adults who are obese.

Unfortunately, what we've seen is a worsening. In fact, in the most recent year, we're moving away from that target with an estimate of 29.1% up from 26.3 in 2020. Maybe some of that's COVID, too. I know I did a lot more sitting around at my desk in the 2020-2021 period if that is indicative of anything. Just as we showed a breakout before by race and ethnicity, we're showing that here again. We're showing that again. For all groups, we're really seeing this is the three key tracked groups that we've been talking about here. All are above, unfortunately, that the 24.2% target, but we still see important differences by race and ethnicity. Black non-Hispanics in 21 were estimated to have the highest percent with obesity at 36.8%, followed by Hispanic adults at 33.5%, then non-Hispanic white adults at 28.5%. Disparities that we know well, and unfortunately, all three groups saw an increase from that 2020 to 2021 year. Turning for a moment to overdose deaths involving an opioid. This is showing the rate per 100,000. in looking at the years 2017, 2018, 2019, there was actually some progress being made here in New York. Actually, that was really reflective of a national trend before COVID of seeing at least some leveling off in the unfortunately, what had been a very, very large increase in the decade before. We had seen sort of some real improvements in overdose deaths. Unfortunately, those trends have reversed. What we see here was a 42% relative increase from 2019 to 2020. That's going from 14.9 overdose deaths per 100,000 to 21.2. Again, this is following a period of improvement, which unfortunately has increased. I think and since the COVID pandemic, both fatal and non-fatal overdoses are increasing. This is just showing the fatal data. Non-fatal data is a bit more complicated to gather, but we have efforts underway. Looking at this by region. At the highest level, looking at this as so breaking out in New York City versus the rest of New York State outside of New York City. What we see really is that both New York City and the rest of state are actually on the wrong side of that target, exceeding the 14.3 per 100,000. New York City saw a very large relative increase of 46% from 2019 to 2020. We saw a 37% increase in the rest of the state outside of New York City with a 37% relative change going from 17.3 to 24.3. These are troubling trends somewhat may be attributable to COVID. Some of it also is reflective of the supply. We can talk more about that. There's increase in increase in fentanyl in the drug supply certainly is a factor in this trend as well. This is showing that display where we're looking at the all the counties. Again, apologies that the print gets so tiny. Again, optically those blue bars are the low quartiles. In this case because it's an undesirable outcome, it actually becomes the upper quartile. There's a little bit of mental gymnastics or we do we want to reduce overdose deaths. The blue bars are jumping. They're in excess of the target in excess of the state average, many of them. Those are our counties with the highest age adjusted overdose death rates involving an opiate. These are some of those highest quartile counties written out here. This is an area, obviously, of much focus for many of us in the room, for many in the department, in both the Office of Public Health and the office that Joanne leads as well. This is a major, major sort of department wide issue that we're all focused on. Jumping for a moment to another area of concern. We're not hitting our objectives. Unfortunately, we're seeing troubling declines. This shows the percent of children that are current age two who have achieved the 4313314-immunization series. This is the recommended series of vaccination that children are supposed to be achieving by their second year of life. What we see here is territory lost. Unfortunately, from that high point in 2019 at 67.9% of children achieving that, and which is, you know, getting rather close, was getting rather close to the 70.5% prevention agenda target. Unfortunately, we've seen year over year declines to 63.8% statewide average for the most recent reporting year of 21. This is based on our immunization systems, both here in rest of state, our system, and then the city's citywide immunization registry. When we look at a county breakout, we see some very concerning pockets of under vaccination. The highlights here show some of those pockets those counties in the lowest quartile of achievement of the two-year-old series objective. We see that Rockland and Orange County in the Mid-

Hudson Valley have the lowest coverage of 39.1% and 43.3% in Orange County with other counties, Sullivan in the same region, Essex and Franklin, Seneca Yates counties as well. We also see that there are areas in in the city, particularly in Brooklyn with low coverage as well. These areas, some of these counties have experienced, unfortunately, outbreaks of vaccine preventable diseases, notably the 2018 to 19 measles outbreaks in Rockland, Orange, Sullivan and in New York City and most recently a polio outbreak in the same regions as well. As everyone's familiar with the concept of herd immunity, you can't have herd immunity with coverage like this. Unfortunately, when our guard gets to this level, we see a return of eradicated diseases. The polio outbreak is the first large scale community outbreak since eradication in 1979 and an area of much of my personal attention, a lot of our attention here in the department. There's definitely much, much work to be done on this topic. Unfortunately, we've seen an erosion of vaccine confidence during the prevention agenda period, particularly catalyzed during COVID for all the many reasons associated with mistrust of public health that we're all familiar with. We see an erosion of vaccine confidence, not just in the COVID vaccine program and willingness around things like boosters, immunization of people's children with COVID-19 vaccines, but now we're seeing it creep into and accelerate some erosion of coverage of the routine immunization series. This just provides a detail here of basically what I just said. This is showing that trajectory in Rockland County. Again, we've seen just in a few years a decline of 50% of two-year-olds achieving the target to 39.1% achieving that target. It's a very, very high vulnerability when we have coverage like this. When there's an introduction of something like measles or polio, you can see substantial community spread. Unfortunately, this is the reality that we're dealing with. We have a number of efforts underway to address. It's really an area of focus for us in the future. This is a list of indicators that are somewhat stable, as it were. We have not met the target. We're not seeing a significant change in any direction. These are stagnant issues that we still want to achieve progress on. This is for the first two areas, and this is for the next three. Because we don't have any communicable disease ones that are not statistically changes.

Dr. Eli Rosenberg Thank you.

Dr. Boufford Thank you very much.

Dr. Eli Rosenberg This is really a full teamwork. I'm just the spokesperson.

Dr. Boufford We see the team. We appreciate all of you very much. I particularly appreciate the fact that we have an expert now in charge of continuing to look at this data for us and updating the website and really moving forward. This is terrific because I know a lot of local health departments and hospitals really depend on the prevention agenda data because it's so easily accessible and understandable in the dashboard. It's really great.

Dr. Boufford I wanted to raise an issue and then maybe we'll see if any last questions because we're a little over time here. We have plenty of time at the end because I'm not going to wrap up for 30 minutes, but I do want to just honor 10- or 15-minute leeway. I hope Joanne Morne doesn't have to leave us a little bit early, but maybe I'll have the council members question and I'll just come up with something later.

Dr. Boufford Kevin, you're looking at me as if you have a question.

Dr. Watkins Well, I was looking at these indicators that have not been met and not statistically changing, and most concerning is prevent chronic disease. I notice that all local health departments, if not the majority local health departments, has chosen to

prevent chronic disease as one of their priority areas. I looked at the funding source and the funding source seems like it's going to communicable diseases. I think we just need to re channel where this funding is going. I know that local health departments are not getting state aid reimbursement for preventable diseases like chronic disease. For instance, we used to take blood pressure checks. We're no longer getting reimbursed for our nurses to do simple things like blood pressure checks or even having health fairs where we used to get reimbursed for those where we can check for diabetes. We could do other screenings like osteoporosis screenings. All of that has just gone out the door, but yet we still see these large numbers of chronic diseases that continues to show up in every county. I think that we can reduce these numbers if we start that prevention method all over again and have local health departments reimburse for assisting and at least some of these preventive measure preventive health measures as well.

Dr. Boufford I don't think there's any issue more important nationally and certainly locally than the relative investment invisibility of especially with COVID kind of pushing out some progress is being made actually on chronic disease prevention and then COVID sort of took over the stage.

Ms. Monroe Dealing with Article 6 a lot, I just want to explain why that changed, Dr. Watkins. We were allowing that for many, many years. We realized that what was happening is our public health nurses were doing these clinics. They're giving the person their blood pressure. They walk away. What if it's very high? They're not doing anything about it. We realized all we're doing is getting numbers and people are walking away and we have no follow through of what's actually happening. We realized we needed to stop doing that and get the education out there and promote why you need a primary care doctor, why it's important to get your blood pressure checked, this sort of thing, your blood sugar, etc., because all we were doing prior to that was just getting the number, getting the blood pressure number, getting the fingerstick number and the people are walking away. We weren't seeing any improvement at all with that. We purposely changed the way of thinking of what we wanted the local health departments to do for that situation. They do have blood pressure cuffs in every CVS office now when you go in. They have home fingerstick checks that you can do. Years ago, they didn't have those things. We really felt we needed to spend our money more on education and outreach than actually doing the physical test.

Dr. Watkins I might want to beg to differ. We are normally at our county health, at our county fairs and although we don't get reimbursed, we still have our nursing, staff who do blood pressure checks. We come up with a blood pressure that we think is need for emergency services we'll refer them immediately to the emergency room. I mean, we may have an ambulance there that we will take them to an emergency room, but we can redirect health departments to have them to follow up with high blood pressures or high blood sugars and see if there is a way that we can have that follow up reported back to local health departments, even if we can have our nurses to follow up with those patients who've been identified with these high levels of measures that could be taken care of by a local physician.

Ms. Monroe I hear what you're saying, but that happens sometimes, but often people don't even give them their names and they walk away. The nurses are like, oh my God, this person is not going to follow through with this. There's almost a liability because they took that high blood pressure and they're not being able to do anything about it.

Dr. Boufford I think this is a great example of the kind of dialogue we need to have between local health departments and the department going forward in terms of some of these strategies, because I was going to, one of the things I was going to notice a little I'll defer that, but I think this conversation is a really important one in terms of what local health departments can do or cannot do to address the concerns that are being expressed from the state point of view. Where should we put our resources? Where should we put our investment? I think it's a really important conversation.

Dr. Boufford Dr. Otiz.

Dr. Boufford We're going to wrap this up in 10 minutes. I'll just get these questions out. These are important. We're not going to get all the answers today, but we want to get the questions today.

Dr. Ortiz I'm just thinking conceptually, is there a way that we can map across the three levels of prevention what is reimbursed, so that we can begin to see if the reimbursement matches the expected outcome of what we want? Because I agree with Dr. Watkins, I'm a little concerned that primary level of prevention focus only on education isn't fully utilizing what primary prevention is for. If we expect that secondary prevention to handle at all, that's not going to occur. We're sort of missing the gap between getting to tertiary level prevention where he's trying to get them to care, but we're missing the notion of early diagnosis and treatment is important. You're right, we may need a better system from which to document it, but I'm concerned that education isn't the only thing. We need some behavioral modification after also. I keep thinking conceptual, like, can we map what is being reimbursed across each level of prevention, so we can start to track some of the outcomes with it?

Dr. Boufford One of the things I'd add to that, which I think this is kind of you've led into the comment I wanted to make, is I think it's really important also that we begin to develop indicators for the sort of primary prevention area. I mean, what availability of fresh fruits and vegetables in a city? The availability of open space to have exercise? We're not really anywhere yet in there. That's where some of our sister agencies, it was at least imagined before our two-year interruption here that we would really be able to look at this. I love that. I think that's a great suggestion, is look at primary, secondary and tertiary prevention, because right now a lot of our endpoints their mortality statistics, risk factors, visits. There's sort of health care delivery centered. I think one of the challenges going forward is can we look at some of these areas where we're still kind of dependent on the delivery system or vital statistics to know what happened and move them upstream? We haven't really thought about that or talked about that recently. After I think for the next iteration, it’s really equally important to the sort of actions that would be taken because it could steer strategy. Look to the new team to really help us come up with some of those.

Dr. Boufford Dr. Soffel, did you want to say anything?

Dr. Boufford In New York City, I'm giving you a last chance.

Dr. Boufford Any comments or questions?

Dr. Torres We'll have many more, but I really appreciate the depth of the presentation and the key points. It was just refreshing to see the data and comparing it and we'll evaluate.

Dr. Torres Thank you for making the points that you made, Dr. Boufford.

Dr. Boufford It's a great start. Thank you for everybody for putting this together. I know it's been a challenge, but I'm also glad that I think you're, you know, also having the new Data Science Officer. I don't know what the right term is. I remember you were introduced by the Commissioner at one of our meetings a few times ago. I'm glad to see the collaboration on this because we really want to mainstream the prevention agenda and the kind of routine data collection and analysis as part of the department's work.

Dr. Eli Rosenberg I think getting the information out in new and better and cooler ways, but also ways that really influence getting pieces into the scientific literature, helping to make sure that our data informs federal conversations, guidelines, all of those things are changes that I think we're starting to do. There are also some really nice technological changes coming on board that the dashboard itself is going to get a facelift. Some of the graphs look...you can tell that they were made by older technologies and we're really trying to bring everything forward. There's a lot of really great work underway on the team.

Dr. Boufford That's great.

Dr. Boufford I think one, I'll just mention this. One of the things we had been pursuing again before COVID was a point person in each of the other departments that was looking at what they were doing. I mean, one of my fantasies has always been could we get the cooperating health influencing agencies, I call them, to look at the programs they have at county level and map the same way. We did that once with ag and markets. The local health departments were saying, gee, we have a real food desert here. Somebody saying, I don't understand that because I have ten fresh fruit markets in your county. I think really beginning to think about how county resources could be mapped that could inform local health directors as we've been working to get the mental health folks and the aging folks and the substance use prevention people and the local health literally in meeting each other sometimes in some counties. In other counties they work really closely together. It's a real opportunity, again, to kind of resurrect a bit of that structure and think about how we could bring resources from other agencies into the work yet.

Dr. Nguyen Thank you, Dr. Boufford.

Dr. Nguyen I think before COVID, we had the map and then the resources for programs that are funded by the state department like contract for nutrition and we organize it by the prevention agenda area so that the local health department and hospital can easily find those local contractors like week different type of funding from the state. I think what you just said gave me idea about how we could do outside of the department from at the agency as well as from the private sector. If we can have these data, we can provide it in one stop shop place.

Dr. Nguyen Thank you.

Dr. Boufford Sort of.

Dr. Boufford I was thinking, I have been in government myself, I couldn't imagine an agency had any agency not having county level inventory of what they done for those counties across the state at the end of the year for the Governor. I mean, it's sort of unimaginable that that data isn't being collected in ag and markets and energy and other places that we could tap into so that we can't find it ourselves, but it's there. That's really exciting.

Dr. Boufford Let's switch gears, if I may. I want to introduce Joanne Morne, who is our Deputy Commissioner for Health Equity and Human Rights. I've had some conversation with her. I think for those of you that are not that familiar with the prevention agenda, one of our big areas of wanting to do better has been the area of disparities in health equity. Every Prevention Agenda Coalition, if you will, at county level, the partners between the local health departments and the hospitals are asked to identify two out of the statewide goals that they're going to work on that are most relevant locally, but also to address an area of health disparities specific to their county or their geographic area. Many of them over the years. I'm just going to right off the last two have really asked for technical assistance in this area. I think they're very committed. They often have multiple stakeholders around the table that represent advocacy groups, interest groups, community-based organizations, as Dr. Torres mentioned earlier, that are working with vulnerable communities, but just really haven't had the support and the technical assistance to figure this out. We are delighted that we... I think we have one stop shopping on health equity and health disparities here. We welcome you to this conversation.

Ms. Morne Thank you again for the opportunity. I'm glad to join you. I think that for some of you, you have heard a bit of the presentation that I'm going to do just in offering a background as far as the Office of Health Equity and Human Rights, which became a part of the department this past Summer. I want to start by saying and just sort of underscoring, following the presentation by Dr. Rosenberg, in that the advancement of health equity and the work that is done across the state to reduce disparities is one that is long standing and as persistent as the disparities themselves that we're trying to address. I think that I don't see anything novel or new when I point to our continued work and need to look at partnership as well as social determinants of health in recognizing that the barriers that are presented to individuals and an individual's lives absolutely are impacting the ability to access the care that's available. The example that was given in that, if we look at our other sister agencies and state agencies and sometimes, we have conversations and they say, but we have X, Y, or Z. Well, having X, Y, Z and having access to X, Y, Z are two very separate things. We continue to work collectively to try to address that and to make meaningful change. Let me acknowledge my colleague sitting in the back, Casey Griffin, who's here, because I certainly can't speak and move slides. It'll never happen. Casey is going to help me today.

Ms. Morne Next slide.

Ms. Morne Just as a reminder, the Office of Health Equity and Human Rights is made up of existing offices within the New York State Department of Health That includes the AIDS Institute with a portfolio specific to treatment and prevention for HIV, sexually transmitted infections and viral hepatitis, as well as continued work that is focused on LGBTQ health and wellness and drug user health and wellness. The Office of Minority Health and Health Disparities Prevention, which has a portfolio that addresses specifically the work that's being done across the department related to the reduction of disparities. A huge component of the office is looking at language access and coordinating language access across the department and in partnership with our other sister agencies, The Office of Gun Violence Prevention, which is intended to look at the prevention of gun violence through a public health lens. The developing Office of Diversity, Equity and Inclusion, with the intention of working within our department to ensure that all of the DOH staff and all of the work that we do are focused and centered in health equity. That means it is not an addendum, nor is it an addition. It is the core and starting point of what we are all doing.

Ms. Morne Next slide.

Ms. Morne As it relates to the prevention agenda and as I'm sure you've already been discussing; we know the vision is looking at New York as being the healthiest state in the nation for people of all ages. We also know that within that vision, the challenges we face have been certainly centralized in certain communities, including Black communities, Hispanic communities, and as I'm often reminded and more recently, engage in many conversations on our rural communities. Again, what we point to is often the barriers that individual people experience as it relates to access. That said, when we talk about health equity and we look at the issue of race, we know in and of itself that race is not the barrier. What is the barrier, though, are within the communities that are centralized when we talk about the disparities that people experience, often are the poorer communities, often reflecting Black and Hispanic individuals?

Ms. Morne Next slide.

Ms. Morne Integrating equity into the prevention agenda. Again, I want to underscore there has been a lot of work across New York State and through the prevention agenda that really has brought together multiple partners in looking at the opportunity of advancing equity. The onset of this office, if you will and our work together as we join in partnership is really looking at what we can do to continue to enhance and expand so that we can address the areas not achieved as shown earlier by Dr. Rosenberg, but also look at the opportunities for sustainable change. As you know, the funding cycles that we have within the department are cycled most often between 3 to 5 years. While we are fortunate that many of our funding opportunities are long standing, we also know that we have not consistently or in a sustainable manner, been able to advance equity and reduce the disparities that we continue to discuss. In looking at the slide itself, improving health status and reducing disparities, preventing chronic disease, which was discussed earlier, promoting a healthy and safe environment, looking at opportunity to promote healthy women, infants and children. Certainly, if we point to the maternal mortality report, we recognize where the disparities still exist with racism being underscored in many, many of the untoward outcomes that should not have occurred. Promoting well-being and preventing mental and substance use disorders. Preventing communicable disease. I would say, and I'll look across the table to our partners, that our work together centered within the prevention agenda is a great opportunity of creating a framework with consistent goals and objectives for ourselves within state, as well as with our partners within community to focus and move forward.

Ms. Morne Next slide.

Ms. Morne With that, of course, we know there are cross-cutting principles. Again, none of these are novel. They are what has been proven and tried and true. Certainly, looking at the opportunities, one of addressing health. Continuing to look at the opportunities within our health systems, in our health processes that can remove barriers. If I were to use HIV screening as one example, in 2010, it took a huge amount of partnership and planning to remove what was being reported as a key barrier both to providers as well as to individuals. That was related to consent. Continuing to make HIV screening something as exceptional. With the changes that we've seen, we were able to increase the number of individuals who are being screened, decrease the missed opportunities within provider settings and increase efficiency. If we go across and look at the other images that are here, we see community engagement, which I'll touch on in a later slide. We see evidence base as far as interventions, but I don't want that to supersede the benefits and the

opportunity that present themselves within grassroots interventions as well. I had an opportunity yesterday to speak on what I thought was a key barrier for the community. One of the key barriers that I feel we are currently dealing with is related to how we award funding and how funding is allocated. The grassroots community-based organizations do not necessarily have the same capacity to be competitive in funding applications as larger institutions often are. If we look at the social determinants of health, which I'll touch on again and ironically the reference to the prevention with secondary primary tertiary, which was discussed earlier, and then looking at our opportunity to expand in how we represent who we represent. I think this conversation also came in earlier as we talked about demographic and data that are representative of individuals who are Asian and Pacific Islander as well as Native American and most recently, we've been engaged with the Office for People with Disabilities in looking at how we can create messaging, outreach, education and awareness with the intention of decreasing discrimination and stigma against individuals or patients who do present with disabilities. This is one of the first for New York State that we are moving out in that discussion to balance equity with a specific community and population.

Ms. Morne Next slide.

Ms. Morne I put these slides in, certainly not because I believe anyone in this conversation needs these definitions. One of the questions that we most often are asked in New York State is what is our definition? As it would turn out, the definitions are included within the statute. That statute is the one that actually originally put into place the Office of Minority Health and Health Disparities Prevention and now supports the Office of Health Equity and Human Rights. Within those definitions, there's a definition for social determinants of health. You see the life enhancing resources. I know there's always a lot of discussion and debate about the reference to social determinants of health as opposed to using other references, which at the end of the day for me is about the basic needs. Basic needs that people must have in order to be able to get through a single day, much less adhere or participate in any type of health care decision making. I point to all of the ones we often are talking about and certainly have been underscored in the Governor's state, state of the state and budget. Housing being one specific example.

Ms. Morne Next slide.

Ms. Morne Again with reference to Public Health Law Article 2 F looking at the definition of health disparities and the measurable differences. I used the example here of disparities related to HIV and AIDS. I specifically use this example because in New York State, New York State has supported prevention and treatment of HIV in such an amazing, phenomenal way as far as the state dollars that historically have been allocated, when you compare it to other states. In addition to that, HIV has significant federal funding. HIV also is founded on the premise of harm reduction as well as always looking at the issue of equity. Yet still today, we have glaring disparities in New York State, in spite of a very centralized, focused campaign on ending the HIV epidemic disproportionately impacting Black and Hispanic individuals. I point to this to say or maybe to underscore the point that was made earlier, that, you know, at times we think it's because we need more resources. We need more funding. I don't deny that that's always the case. I'll never say we don't. I would also point to that we need something else as it relates to our philosophy and our policy and how we move forward, because despite the 40 years of response to HIV, I still point to you to the slide within the slide that speaks to the disparities that we experience in our state.

Ms. Morne Next slide.

Ms. Morne And then, of course, health equity, achieving the highest level of health for all people, addressing avoidable inequalities and addressing certainly the disparities. Looking at health equity and recognizing that within health equity, there are multiple other forms of equity in moving into the seat and becoming more familiar across the department I've learned a lot. I have learned a lot about the areas that perhaps I haven't historically been as focused on, such as the environment and climate change, understanding the direct impact that that has on the areas within the prevention agenda that we are looking to move forward and advance in a positive way. In order for us to achieve equity, we have to, as I said from the beginning, really have an honest discussion and look at our opportunity to impact determinants of health.

Ms. Morne Next slide.

Ms. Morne Guiding principles as far as addressing disparities, all of which you would find within the existing prevention agenda. I'm sure as you continue to talk about the the next update to the prevention agenda, looking at the opportunities to reinvest within our neighborhoods. Community stakeholders are the most effective, important partner that we can have at the table. Having the voice of community from the beginning and not in the middle or at the end is key to how we hope to be able to partner with our colleagues in advancing prevention agenda goals and objectives, which speaks to the second speaker there, where you amplify community voice addressing again the determinants of health, employing individuals. In New York State, we have multiple programs that look at the opportunity for individuals with lived experience or otherwise referred to often as peers, to be able to engage in purposeful work for a livable wage. That said, we have many more opportunities in which we can build our workforce by engaging with individuals who have lived experience in the areas that we're trying to improve. Community driven investment which I've spoken to already and then investment in our youth. If I were to refer to the executive budget and to the state of the state, certainly we know that there is a huge focus, appropriately so, on aging. I try to deny it, but I know I am aging. We are all aging. I want to sort of balance that by also noting that we have to give priority to the development of our youth, recognizing that they too, have lived experience that can contribute to the decision making that we are influencing. I think it's important for us to recognize that in partnering with young people, they are able to offer us insight into what their expectations are, which may look very different than what our existing or past interventions have been. I also applaud us on the opportunities that have been made through legislation and law to provide youth and the example I'm about to share runaway and homeless youth with opportunities to provide that consent in order for them to be able to access care, including sexual health care.

Ms. Morne Next slide.

Ms. Morne I wanted to offer an example of how we use the information that's provided working from the prevention agenda, using the data that is available to us, working with our collective teams, and certainly with Dr. Rosenberg. One of the documents that you can find within the DOH website is the 2021 health equity report. This report is specific to presenting data as it relates to health outcomes, demographics, other community characteristics that influence and impact the outcomes of which we're focused on. It also, though, does not provide a full statewide lens, but it does speak to the very specific areas that seem to be most impacted and have the residents that we are absolutely focused on based on the historic disparities. The information that we are able to gain from a report

such as this is to understand and identify priorities and emerging issues as we move forward. Mobilizing communities, being able to prioritize health related interventions, and, of course, promoting health equity.

Ms. Morne Next slide.

Ms. Morne This is my last slide. I want to end really, again, speaking to the power of community voice and community stakeholders and in a meaningful way, and also in a way that values not only the time that's presented, but the often personal and intimate information that is shared in order for us to make larger, broader policy decisions that actually can effectuate change. Community engagement is the ability to advance equity, its ability to increase access to the support, care and treatment that we're speaking of. It can help to promote anti-stigma and anti-discrimination and also certainly continue to promote the human rights that should be afforded to all of the individuals we serve.

Ms. Morne Next slide.

Ms. Morne A huge thank you. I want to just underscore again, the partnership that we share. I'm looking at my colleagues across the way. We wouldn't be where we are as far even though I understand we have many, many areas to look at and we have gaps to fill. However, we also have a number of achievements that can be pointed to over the years, including within the last two years. We wouldn't have been able to achieve what has been accomplished if it wasn't for the partnership that we share. I see the Office of Health Equity and Human Rights with an ability to provide the expertise and understanding that we have but understanding that the office is not intended to be the sole expert, if you will, in the department. The office is intended to bridge and work with all levels of the department to advance these prevention agenda and other goals as defined.

Ms. Morne Thank you.

Dr. Boufford Thank you very much.

Dr. Boufford I'm going to let people have a chance to question you. I just want to sort of emphasize two parts of your presentation, Joanne, that I thought were really important. One is Slide 6, which is sort of the perfect slide to look at in terms of the challenge left of the green, if you think about indicators that we might start to use in terms of going forward. Thank you for that. I think that's terrific in addition to the primary, secondary, tertiary buckets. The other was the last point you made, which I think is around the question of community engagement, because what's often missed and I think it's a slide we've asked to be presented when we do the updates each time, which is who is at the table in your community and your county? Very often we've asked for slides, so people, the local health director and the hospital leadership that are in partnership in that particular area. Who else is around the table? I hope we can get even more emphasis on that, because I think it's an existing infrastructure that often is not realized or recognized that would be a perfect place to look at. Are the right people at the table? How do we help local health department hospitals engage communities effectively?

Ms. Morne Absolutely.

Ms. Morne I want to say and I hope my colleagues, the rest of the team is probably holding their breath, but if there's nothing else that we can do but help organizations and facilities engage community stakeholders in a meaningful way, then I'll be happy with that.

I say that because and with all absolute respect, many of us have found ourselves privileged to sit in certain seats, and as a result of that, we have an obligation, a responsibility to speak on behalf of individuals. I do see that as distinct and different from having a community stakeholder discussion. I would encourage us to create the spaces and look for the opportunities in which individuals who are utilizing the health care systems and or not able to utilize the health care systems but are presenting to us through different other doors or ways be the ones that we bring to the table, because that's how we're going to meaningfully impact change. I'm not suggesting that we haven't done that. I'm hoping that we can continue to do that and do it even more.

Dr. Boufford That's great.

Dr. Boufford Dr. Soffel.

Dr. Soffel I want to start by saying in training in 2010, I worked for Tom Duane, who was then the Senate Chair of the Health Committee. This conversation that you reminded us about, stigma around HIV testing took up huge amounts of my life in that year. I'm glad that we had a successful impact. That's really encouraging. I want to come back to what you were just talking about; around how do you effectively bring communities and stakeholders into conversations. I want to remind all of us of one of the things that we learned where there some efforts to do community outreach, but for many community-based organizations and community-based providers and community stakeholders, the amount of time and resources that were required to be effective participants was simply out of reach. If you are a small CEO with three staff people, you don't have the resources to allocate a person to a community stakeholder process unless perhaps there are resources being provided to you to free up that person's time to allow them to participate effectively. I want to sort of flag for all of us that participation is, in fact has a cost to it. If we really are concerned about community input and community engagement, resources should be accompanying that so that those community-based organizations and participants can actually effectively participate in the conversation.

Ms. Morne Absolutely.

Ms. Morne People's time has value. I think that more recently in recent years, I have seen much more intention around that and making sure that we do reimburse people. I don't think we have a consistent policy that people can work to anticipate. I do agree with that. The other point that I'll make is that oftentimes similar to our own work situations, you see the same people at any number of meetings that we provide for them to attend and speak at. I think we have to. We, the collective we have to look at that as well and look at what efficiencies we could offer to communities in some of these discussions. Are there ways in which we can partner to make those for meetings become one with an efficient agenda?

Dr. Boufford I think this issue, which we have an opportunity to emphasize even more, is Joanne's outlining in the prevention agenda I think are very relevant to two really important areas of the waiver. One is the heroes, which is the idea of a reasonably representative planning activity that unfortunately is not. It's in other Medicaid geographic areas, not necessarily the counties or the other areas of prevention agenda, but it's the prevention agenda, as mentioned as a potential organizing platform or something that should be connected. Similarly, along the lines of what Denise was mentioning, the issue of the networks, which is another feature of the waiver which proposes, I think, to try to address some of the capacity weaknesses that were identified relative to helping people in different geographic areas, CBOs in different geographic areas to be able to come together. I think

again, it's sort of like the partnership with the Master Plan for Aging, the partnership with the part of dealing with the heroes in the audience can be really valuable kind of using the work. I mean, the prevention has been around for about 15 years now. We're in our fourth cycle. There is a stability there that hopefully we can really show our stuff relative to these other opportunities that are coming up.

Dr. Boufford Dr. Watkins and then Ms. Monroe.

Dr. Watkins One small example, if I could, into that discussion when the time is right.

Dr. Boufford Won't you go ahead if it's on this point?

Dr. Watkins Sure.

Dr. Watkins I was just going to say I fully agree with everything that's just been said around sort of really getting community voices together. Just as one example, you know, I'm driving from here to Sullivan County after this, where there is in partnership with the county. We're bringing together a new coalition, specifically around the vaccine preventable disease situation. To be honest, we've been working on this situation for six months and there is no progress without the community voices. Supporting those coalitions has been key. To the point earlier on, you know, we're doing this at night because there's providers and there's parents. We are making sure we have all the voices at the table has been essential. Actually, one of the most important agenda items on tonight's agenda, which is our forming the first formative meeting, is who's not at this table and really making sure that we're being expansive with that. Also, to the last point on that, these are unfunded efforts, we really do need to make sure that we're supporting these kinds of community coalitions because there is zero progress without it.

Dr. Boufford Thank you.

Dr. Boufford Ms. Monroe and then I think Dr. Torres wants to speak in New York City, but after. Ms. Monroe.

Ms. Monroe Thank you. Thank you all for the data.

Ms. Monroe I have two comments.

Ms. Monroe One is, there's no question that communities coming together are powerful. I also think there's a lot of work that can be done at the state level with the organizations that fund the communities, not just health. Because, for example, if I get most of my funding from OCFS and a little bit of money from health, you're asking me to rethink how I do all of my work. I'm got big incentive to do that by OCFS. Now, I'm not picking out that specifically, but I think at the state level with an office like you have, I would like to see there much more initiative in working with other departments that fund these same community organizations and who need to be pulled into alignment with what it is we're trying to do. I worry sometimes that when we talk about social determinants of health instead of social determinants of life, organizations that don't see themselves in the health business opt out. I don't think we can afford that. That's leadership. That can only happen at the state level with other state organizations. My last comment, and this shows my own bias, is related to older people. I appreciate that we need to invest in our youth, but if you look at where the money goes to serve people and if you look at the chronic disease that we have, I am concerned about the lack of attention for older people in a lot of this work.

There's an old saying that money for children is an investment and money for older people is an expense. I think that's how we look at it. We want to reduce expense, but we don't want to make an investment in what early aging or preventing aging could be about. In both presentations, I would like to see more emphasis on preventing the consequences of unhealthy aging, and I think that would free up money for that investment in children and would also be something that would serve a significantly large and ever-increasing population in New York. Those are my two comments.

Ms. Monroe Thank you.

Dr. Boufford Thanks, Ann.

Dr. Boufford I think just to reiterate again and again, these are often just sort of disappeared, but we in the last round of launching the prevention agenda, there was a lot of conversation with the broader aging concerned community, including AARP, was very active and there was a real push, I think, to have a separate goal or a priority area on aging. After a lot of conversation, we agreed it would be better if we integrated aging objectives under each of the priority goals for the prevention agenda, but I think with the master plan and others, we need to lift those up and think about them in a different way than we have before just to pick up on Ann's comment.

Dr. Boufford Dr. Torres.

Dr. Torres Good morning again. I enjoyed the presentation, and my colleague was pointing to Page 9 as I was raising some points. I'm looking at the graphic on Page 5, Slide 5 says Community engagement. That sounds so nice, right? Just this morning I was talking to interns within my organization, and we were talking about the importance of cultural competence and cultural humility. We were going back to a classic that some of us may remember. The spirit catches you and you fall down. I think that there needs to be a reference to understanding how communities respond to various messages, outreach at times, engagement clinic, non-clinical setting and so forth. Having this point incorporated in our approach so we can have hopefully a more successful outcome, not just with the Hispanic population or the African American population, but the diversity that we are experiencing and the changing demographics in our communities.

Dr. Lim I'm so grateful that you said that because I was going to say something along the same lines. I think both health literacy and cultural literacy has to be more of a backbone. In psychiatry, for example, you have something called the cultural formulation. It's a good start. It's a holistic way of trying to not impose your own values, but understanding the person's cultural beliefs about their illness, about society. I think if we can figure out ways to sort of standardize against this concept of a cultural formulation and then what are the next steps to be able to concretely engage the individual, the communities based on a larger cultural and values understanding that may help provide some of the steppingstones to actually meeting the goals, more concrete types of things.

Dr. Lim Thank you very much, Dr. Torres.

Dr. Boufford Any other comments from members of the Public Health Committee or the Planning Committee that are here?

Dr. Boufford Dr. Heslin, do you want to jump in here?

Dr. Heslin Just for the record, first Deputy Commissioner, Chief Medical Officer for the department. I think that you raised a very good point about cultural competency. I think that we also, as we look at cultural competency and communications to Ann's point, we have to look at generational competency and communications. We have six generations currently in the United States and they all consume information differently and value it differently. If we're going to be able to work on an effective agenda, we have to have mixed communications, but able to be not only assessed but also delivered in a thoughtful way. Just as a thoughtful suggestion to expand it beyond culture to generational as well.

Dr. Boufford Thank you.

Dr. Boufford Any other comment?

Dr. Boufford I think we're on to hear about the future from Dr. Bauer. Her early thinking about the future and how we move this forward.

Dr. Bauer Thanks, everyone.

Dr. Bauer What an exciting and information rich launch to our planning efforts for the next six-year cycle of the prevention agenda. Looking ahead to 2025 and 2030 as well as have this mid-point check in on our progress to date for the current cycle. Thanks to the Public Health Committee and the Planning Committee for being part of this kickoff. In planning for the next six-year cycle, of course, in addition to our partnership with the Public Health Committee and the Planning Committee we'll also be soliciting input and action from Department of Health Programs and staff, our colleagues in state government, local health departments and hospitals, which of course are the main engines of the community health improvement plans across the state. The Ad Hoc Leadership Committee, which Dr. Boufford mentioned, and another committee comprised of statewide and community organizations, advocacy organizations, state agencies and so many others that can bring their specific voice and expertise to bear on public health problems, whether that's aging, which we've talked about, cancer prevention, hunger prevention, a critical social determinant, substance use disorders and all of the upstream drivers of the public health challenges that we face. The Ad Hoc Leadership Committee is large. It really is meant to bring in part that community voice into the planning process and mobilize boots on the ground to help accomplish our work. This morning we had some rich background on the prevention agenda and an update on the progress that we've made or frankly, where we've fallen short from 2019 to 2021. We had a wonderful presentation on health equity, which entails creating and strengthening the conditions in which all people can achieve their highest level of health. The prevention agenda and public health can contribute to that urgent health equity goal. Part of our work as we plan the next cycle is figuring out how we can achieve more meaningful progress toward a more equitable society. Today, one of our goals has been to hear from you all and I've really been inspired by the rich participation and conversation. Based on what you've heard today, based on your own experience, your research, your practice, based on your prior experience with the prevention agenda. All of that is critical to our planning for the next six-year cycle. As we plan over the next eighteen months it'll be especially helpful to hear from you what information we should be looking at. We've gotten some hints of that today. What gaps we have in our information that you need to help us in our planning. How much of the prevention agenda does current strategies, priorities and focus areas? Even the vision should be retained. What might be overhauled? What needs to be tweaked or modified? How we proceed with those discussions? How should we best use the experience and expertise of our stakeholders, including, as Dr. Boufford mentioned, our state agency

colleagues, but also community members? How do we engage them either through the Ad Hoc Leadership Committee or through other forums at the local level? And of course, top of mind is how to best integrate health equity considerations into our planning process so that the next cycle of the prevention agenda really embraces and delivers on that overarching goal. Just a note on the Ad Hoc Committee, like the Public Health Committee it plays an outsized role in prevention agenda planning in terms of providing ideas and feedback on the vision and priorities, the focus areas, even the indicators that we're tracking. It particularly can guide us in how we can better motivate and empower local action to strengthen our impact and how we can activate community and organization members to participate in their local prevention agenda, partnerships and collaborate across the state. As Dr. Boufford mentioned, we are refreshing the membership of the Ad Hoc Committee, which hasn't met for a number of years. I don't have an exact date, but we're looking for early April, that first week in April for our first meeting. As we heard this morning, there are many urgent public health threats and ongoing public health crises that demand our attention across New York. As New York's health improvement plan, the prevention agenda help set our strategic agenda, mobilize partners and galvanize support to make progress in the priority areas. If we spread ourselves too thinly, though, across the myriad public health threats and crises that we face, then we're challenged to make progress in so many areas. Similarly, if we focus on just a few, we risk backsliding on recent progress or allowing important problems to fester. Figuring out how to focus resources to create the greatest impact across the widest swath of concerns is a tension and a challenge that we face. Our current five priorities; preventing chronic diseases, promoting healthy and safe environments, promoting healthy women, infants and children, promoting well-being and preventing mental health and substance use disorders and preventing communicable diseases are each very broad and very complex priorities. Within each, we have numerous specific outcomes, numerous indicators. We're focusing on sugary drink consumption, on radon testing and mitigation in homes, on depression screening in the postpartum period, binge drinking, HPV vaccination, and on and on and on. We're tracking dozens of indicators across various public health concerns with varying degrees of difficulty to improve with varying levels of resources to bring to bear on the problem and with varying levels of evidence for proven or best practices to support action. Broad categories have an advantage of helping everyone see their work and the prevention agenda. They can help galvanize action across a very wide field. They may not actually help us make substantial and meaningful progress in any one or a few areas. Last year, 2022 was the 15th year of our prevention agenda activities. We've grown a lot over that time. We've made changes to the prevention agenda over that time. For example, we've extended the cycle to six years from four to encompass two, three-year CHA and CSP cycles. We strengthened collaborations between local health departments and hospitals. We've guided partners toward those proven and promising interventions. Generally, we've expanded rather than narrowed the public health challenges that we address, the number of indicators that we track and the potential strategies that we implement. As we begin the planning for the fourth cycle of the prevention agenda, it may be the right time to ask how well the prevention agenda is serving the department, the state and our residents across the state as an organizing framework for advancing public health and as a tool to effectuate real public health improvements, including decreasing disparities in health status and achieving health equity. We may want to build into the 2025 to 2030 implementation cycle and evaluation of the prevention agenda to help inform then the next planning cycle six years from now. Thinking to the immediate 2019 to 2024 implementation cycles, as you know very well, we suffered a major disruption to our routine public health activities, to our ability to convene and to plan and our ability to make much needed progress against long standing public health threats. That disruption, of course, was the COVID-19 pandemic. In addition to those disruptions to our ongoing

public health activities, the pandemic also took a toll on the public health workforce, on the nation's confidence in public health and the public's willingness to heed public health advice. As we consider our progress in the first wave of the current cycle from 2019 to 2021, we keep those disruptions in mind, and even frankly, the 2022 to 2024 wave will likely feel the ongoing effects of the pandemic, especially as the public health workforce begins to recover and as we struggle to rebuild our public health infrastructure and get to some kind of new normal. As I think about the next six-year cycle, two options among many are top of mind for me. We could revisit the 2019 to 2024 priorities and focus areas, recognizing that we had a major disruption and we lost time to actually make effective progress over the course of that cycle. We could double down on key public health crises that were exacerbated by the pandemic. While there are many prevention agenda indicators that have been trending in the wrong direction for some time and then got worse between 2019 and 2020, some concerning ones to me are obesity and food insecurity, overdose deaths involving opioids and then children aged twenty-four to thirty-five months who are not up to date on the recommended vaccine schedule. We saw data showing our trends for each of these today. Each of these would benefit from a full court press approach where we mobilize and concentrate the efforts of state agencies, of local health departments and hospitals, community and statewide organizations and community members to make the most progress. Each of these is also driven by inequities across race and ethnicity, rural and urban geography, education and income, among others, and would benefit from a robust equity approach. As we heard from Deputy Commissioner Morne, the specific details of an equity approach are not at hand. We have some critical guiding principles for how we can move forward, but the roots of many of the longstanding inequities in our society actually predate even the founding of our nation and have been institutionalized by policies and practices that we chose to adopt and we're continuing to adopt that disadvantage some and advantage others. Progress toward equity involves dismantling those pernicious structures and working to acknowledge and right past wrongs. It means equalizing the conditions for health for those who have experienced injustices and structural disadvantages. Public health has an important role to play in exposing and mitigating the effects of these inequities, but undoing centuries of laws and policies and practices that have harmed whole populations takes a whole of society effort. Public health needs to be part of that effort to transform our state and our nation. We can be a voice for change, but we'll only succeed in partnership. Working across government, working across community, working at every level will be critical to our success. We heard this morning that the overarching strategy of the prevention agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. We certainly have our work cut out for us. As we embark on the planning phase for the next six-year cycle of the prevention agenda, I do encourage us to consider the tools and the resources that we have, the most urgent issues that are before us and where we can have the greatest impact, and then develop that full court press approach to make real, sustainable, meaningful progress in those areas. I've been delighted with the conversation that we've had here this morning. It's this dialogue with the Public Health Committee, the Planning Committee, the Ad Hoc Leadership Committee, our partners across the state and our residents, our community members that will help us build a robust next cycle for the prevention agenda.

Dr. Bauer Thank you.

Dr. Boufford Thanks very much.

Dr. Boufford I think you've raised some very interesting issues for the committee. I sort of seriously think we may not have to make a choice between whether we revise the existing

or really focus on some of the areas that our colleagues that you feel are the most important and where we can have the most impact. I think going back to this one value. We started out with twelve priority areas and went down to five a few years after that in the same spirit of what you're talking about, Ursula, because it was just too much. On the other hand, part of the choice of the larger banner headlines was to allow for sort of sub objectives or sub areas. I think us to simplify, as you suggest, really simplify the numbers. Some people have said that. I think Kevin's mentioned that when we've had some offline and talking with some of the colleagues would like to see maybe fewer objectives under those or even emphasizing certain ones that communities can pick from. If a committee solved the problem of childhood vaccination, they wouldn't pick that. We wanted to provide enough degrees of freedom under the general heading so that there would be that option of local choice. I don't see anything inconsistent in the suggestion of having a set of fewer objectives, simplifying the process, really updating the evidence. I mean, part of the initial goal was looking at objectives where there was an evidence-based intervention and that was kind of part of what was provided after the first cycle, because the feedback from local health departments is we're so busy and strapped, we don't have time to look up this stuff. Find the national, international standards for us and help us think through with that. The State Department of Health responded very well, but that information is now four or five years old. Some of the evidence, as you point out, that's available or come forward may indicate we want to focus on this objective because we know we could have an impact on it. I think you've raised some really important considerations. I don't think it's an either or. I think it's kind of a both and. Hopefully anyway, although I have to... The one story I like, this came up with the Ad Hoc Committee. We did not have the fourth objective, which was focused on mental health and wellbeing now is what it's called, until the Ad Hoc Committee met. How can you have a statewide health plan without mental health being included? The answer was simple because mental health was another agency and the Ad Hoc Committee said, that's ridiculous. As a consequence of that, we've had really core partnership with the Office of Mental Health and Oasis over time and now ageing, obviously, has been involved in the objective setting and hopefully we'll be even closer involved going forward. I think the sort of level of are we providing an umbrella for the concerns is one way in which the Ad Hoc Committee can be very helpful. I think it would be really important for you and your staff of experts in these areas to sort of re help us revisit which objectives really make sense currently relative to the evidence that's available. I don't think there's going to be a particular objection. I think similarly, you had raised a question. We had an earlier conversation. Could we maybe pick one thing out like childhood vaccination or something, immunization rates that we wanted to feature as a uber goal for the prevention agenda. I don't think that's inconsistent at all with the kind of thinking we have. I think everybody who's been involved in this from the beginning really wants to make a difference and have the impact. I like your suggestions of doing both and taking guide from the experts as we think about how best to move us forward. I think it's a really great opportunity.

Dr. Boufford Let me see if there are any other comments.

Dr. Boufford Dr. Ortiz.

Dr. Ortiz I'm just curious, you know, probably selfishly, but also thinking about need is that are we underutilizing the amount of health education students that we're trying to educate in helping to serve some of these health care gaps or health education areas? I have 800 students who have to do hours, right? I'm thinking in my head what I push the Program Director to do is that if the students at Community Health Nursing have to do hours, find the areas where the health department needs a project completed so that the students can

learn about project and about its use for the state, but that they're getting their hours, but that people on this side can direct them, that they don't have to do it all alone, right? I keep thinking if, you know, every College of Health Sciences did that and partners with them. Can we ease some of that burden so they can actually meet more of the expectations then? I mean, I agree we can't do everything, but if we harness like my built-in educational resources, we could probably do a lot more I would imagine.

Dr. Boufford That's a great idea. I think it's really interesting that you raised that issue of the Health Sciences Education Organizations, because for a period of time there was a group of Deans of Public Health that were meeting. They sort of stopped meeting as a group. I mean, I think I know in New York City, and I think the Deans of Medicine and Dentistry meet regularly, but these other groups don't. It may be an opportunity, as you say, to get some of the Deans of Health Sciences and the Deans of Public Health. We have the same problem. We're sort of begging on doors, please, can we have our public health students get an opportunity to work with you? I think that's a great opportunity for what had been sort of missing, bringing in that education sector. I really like that.

Dr. Boufford Ms. Monroe.

Ms. Monroe This has been a really interesting day. I appreciate it..

Ms. Monroe Do you want me to go?

Dr. Boufford Go ahead.

Ms. Monroe It's been a really interesting day. One of the things that I'm not clear in terms of public health is what are the incentives and the consequences for communities or hospitals not reaching these goals? A lot of health care is designed around incentives and lack of incentives. I don't know what those are in public health. If they're not clearly defined and clearly understood by those part we need, those folks we need in this effort, I don't know that will get the traction we need to get. As I said, I just may be naive or not know what they are, but I haven't heard anything. I don't know if everybody responded when I think Dr. Roberts presented, how many were provided their data on their achievement or lack of achievement. I don't even know if that's 100% or if not, everybody did. Was there any consequence for not providing your data? I start with that in terms of if we expect organizations to meet these goals and provide effort to meet these goals, I think there needs to be some application of traditional ways that we incent and have consequences. Otherwise, it's just a nice thing to do and I'm not sure we'll get the traction we need.

Dr. Boufford It's a really important point. I think part of the answer to both your questions probably, I mean, the entire process has really been voluntary. I congratulate the organizations that have really taken this seriously and done it. The question is, are we now because we are in a position, obviously, opportunity potentially to change the rules and think about incentives with both financial incentives as well as teeth move it at least the next step. Maybe we can go a little bit beyond the voluntary. Sometimes when you could define the incentives and the teeth you can get people to be, shall we say, more voluntary to avoid the teeth. We'll see how we go.

Dr. Soto I also wanted to speak.

Dr. Boufford Yes, I'm calling on you.

Dr. Soto I was able to participate in the crafting of the 2024 prevention agenda. I was pleasantly surprised over the one hundred organizations that worked on it. Things that I initially didn't have any connection to health in my mind, like agriculture, housing and transportation. I thought it was very comprehensive on how we viewed and how we wanted to make New York State a healthier state. Couple of times this morning people brought up the importance of funding and resources in order to address these priorities. I see something a little bit along the lines of what was talked about just now. It's manpower. We have a severe shortage of many health professionals, one of which Dr. Ortiz works with is nursing. If we're going to make an impact and there are shortages in certain areas, that we're conscious of that and what can we do to increase that manpower? There are collaborations. The New York State Deans do meet and so do the Dental Schools through the Association of New York Medical Schools. We need to think about what the needs are, discussions about the aging health professionals. Who's going to fill those slots when those people retire? Also, the issue of, you know, many health professionals who dealt with COVID got burnt out and they stepped away. I think in our discussion and developing the next priorities that we do give some thought on how some of this is going to be addressed and how we can increase and diversify the health care workforce.

Dr. Boufford Thank you.

Dr. Boufford Dr. Watkins.

Dr. Watkins I thought maybe I'd just answer Ann just a little bit regarding what type of resources or what type of penalties are assessed to local health departments and hospitals if they do not meet their goals. I don't know if it's not meeting the goals, but for us, every three years we are required to prepare a community health assessment, a community health improvement plan. I think that's tied to our article 6 funding or our state aid. Local health departments do their best to make sure that they submit a community health improvement plan every three years so that they'll get that state aid. Tied hospitals to make sure that they work with local health departments to make sure that the community health assessment is and the community health improvement plan as part of a hospital plan as well. You have the whole community working together. I do think that you brought up a good point that now that we've identified our priority areas, then maybe there should be an incentive associated with trying to at least meet some of those priority areas that we've identified or at least meeting some of those goals that we've told the state that we were going to try to work on in order to meet some of those goals and objectives. Maybe there can be some funding tied into that as well. I think it's a great idea.

Dr. Boufford Other comments from council members, committee members?

Dr. Boufford These are great suggestions. I think some of them are more challenging than others. I want to wrap up.

Dr. Boufford If I may, I think we can wrap up.

Dr. Bauer Any public comment?

Dr. Boufford Opportunity for public comment?

Dr. Boufford Here in Albany, starting Lloyd Bishop from Greater New York Hospital Association, who is a regular partner on the prevention agenda over the years.

Dr. Boufford Are there any members of the public, Dr. Torres in New York City?

Dr. Torres We're checking right.

Dr. Boufford Thank you.

Mr. Bishop Hi. Lloyd Bishop. I'm the Senior Vice President for Community Health Equity at the Greater New York Hospital Association and I think a member of the Ad Hoc Committee.

Dr. Boufford Absolutely.

Mr. Bishop Just to answer Ann's question a little more. Although there might not be anything in New York State, the federal government was part of the Affordable Care Act did put in place a requirement for hospitals nationwide to do community health need assessments every three years. That is the requirement now was actually built on New York's program and California's and the handful of other states that have in state requirements. I just wanted to express support for the work that we'll be doing together. Greater New York, we and our members, we have workstreams in all of those areas that are mentioned community service planning, community benefit reporting, racial and ethnic data collection, disability access, all of those things, social determinants of health. We're looking at the community service plans that have been submitted to the state. They also send copies to us. We're starting to review those to see what the priorities have been chosen and how we can support our members, including on addressing health disparities. That's something that we're really going to be focused on because it is an area that people have asked for technical assistance on. I just wanted to say that and say that we look forward to working with this committee, with the department on all of these issues as the prevention agenda is updated for the next cycle.

Dr. Boufford Thanks very much.

Dr. Boufford Anybody in New York City?

Dr. Torres With members of the public in New York City do not have a comment.

Dr. Boufford Okay.

Dr. Boufford Thank you.

Dr. Boufford Let me just wrap up with a couple of comments. One is to again, thank Ursula Bauer and her team for helping pull this together for us. A terrific session, really important. Thank Joann Warren for participating and I'll thank you in advance for all of the work you will do with us going forward. I will come after you if we don't know. I'm only kidding. I really appreciate it. I think you can get a sense of how committed the members of the Public Health Committee and the Planning Committee are to this effort and great ideas, which is even more important. I wanted to wrap up with a couple of partially in response to Ann's just to put a couple of things on the table. I was looking back at our last meeting that this group had. We didn't meet in March of last year. We sort of, I guess, aspirationally set an agenda of issues we wanted to touch on as a committee going forward, probably without appropriate regard for the issues that we didn't know at the time. I think some of the issues that Ursula's raising in terms of the challenges for the department, but I just did want to mention for purposes of the Public Health Committee two

areas. I mean, one Dr. Soto just mentioned, which is the public health workforce was an issue that the Public Health Committee was very concerned about. We heard a presentation on the Public Health Fellows Across New York Program, I think that was really important. I mean, again, we may want to revisit that. But also, I know there has been a project counting public health, the public health workforce in New York State. We may want to have a presentation on that at a future meeting because it really helps identify where some of the dilemmas are. It's not a problem that we can solve really as a state, but we can certainly try to understand it better and see how we might provide support. I think the other issue that the Public Health Committee certainly has been really concerned about is the maternal mortality issues. About six years ago, actually, developed a white paper which launched essentially the Governor's commission on maternal mortality. Again, we want to hear an update on that. We know the folks within the department are doing a great job and obviously the work of the commission's agenda, but just so that we flag keeping those two items going forward. I think the others that we said we were going to do we mentioned them already, which was working with other agencies and other things that Ursula has raised. I do want to come back to one other area that which is I mentioned it briefly at the beginning, which is the community benefit. I think one of the areas just to kind of revisit our engagement there, part of it really starting in 2008 with that cycle of the prevention agenda. We were really trying to encourage hospitals in local health departments, as Dr. Watkins mentioned, to perhaps use the same community health assessment because joining forces and I know a number of hospitals are investing resources and the quality of that assessment. I think partnership around that assessment and sharing that assessment. I think the last time I saw those data; we were about 41% of the sort of prevention agenda partnerships. At least we're using the same community health assessment, which is great. We want to push that needle a little bit more. The overlap in the Community Service Plan and the Community Health Improvement Plan linked to the prevention agenda. We were also, I think in that 40 to 50% range. It depended on the variable. I think some of the priorities were especially the communicable disease priorities and some of the others were much more overlap. I think all of that has been voluntary and it's been moving, but we have an opportunity, I think, to bring it more into focus and to emphasize. I know a number of hospitals invest in a very large amount of money and doing those community health assessments. I think a joint effort would be cost effective for everybody. Obviously, the local health department probably doesn't have the resources to do all the things they like to do. That's one sort of voluntary area that was really dating back to the 2008 cycle. Beginning in 2013, the Commissioner had asked hospitals to submit their Form 990 with their Schedule H Community Benefit sort of participation I guess to the state and had a really, I think, useful conversation to say that the hospitals in New York are particularly have been hard hit by it our generous in providing unreimbursed care. There are very high uses of the graduate medical education part of the community above the Schedule h categories. We weren't talking about any of those because we didn't want to even think about challenging what is spent there. I think the one category that we were very interested in is the community health improvement category, which is very from the definition of it. Again, with the Internal Revenue Service all again, there are no teeth if it's not reported, but that is an area that potentially could be funding invested in the prevention agenda at community level because of the commitments there. I think that the goal in that 2013 was to understand that investment and then to begin to align it with the goals that the hospitals have signed on to locally that they're working on anyway. I think we're in conversation about reactivating the letter of the invitation. All of that information is public domain. There are no secrets about it, but reactivating it. I think one of the things we want to do, and especially with the waiver coming up with the heroes and the SDN's and obviously the new application for waiver is going to be I think hospitals are going to be particularly hard hit because of withdrawal of

the COVID, sort of COVID support funding from the feds and others. We want to kind of see where that one category of community benefit, which has been that category is small relative to the overall expense. It sort of really orders of magnitude smaller. What we can do to increase it there and to get that alignment going as part of the next round of this conversation. We may, hopefully, we'll be able to come up with agreements on some resources there that can be more aligned to providing the funds, at least the incentives, which I think are really important, especially for local health departments and these partnerships that don't exist that are needed but are not so far supported. Those are just sort of things that we're thinking about going forward. As Ursula said, it's complicated, but I think there are a lot of members of the council. There are numbers of us that have been very committed to this activity for a long time. Our hospital partners have been really pretty indispensable in this process. A lot of the resources of the Ad Hoc Committee were really about communication to their constituencies, that's why we were sort of defining those members as state level organizations that could reach out to their health plans. The Medical Society of New York State's been involved, the business council in and out, not as much as we like, but really thinking about that and how they can be mobilized for some of the support that's needed, the incentives that are needed to make this thing go forward. It's a very exciting time, I think. Ursula shouldn't worry. She's got a lot of fellow travelers that want to help and work with the department staff, but we will depend on you for the expertise, the analytic expertise going forward. It's going to be really important.

Dr. Boufford John, do you have any final comments?

Dr. Boufford John, saving his firepower for the afternoon, I think.

Dr. Boufford Anyway, thank you very much. We'll look forward, probably the next time this group will get together will be in conjunction with the Ad Hoc Committee meeting. We'll be working with Ursula's staff in the meantime. We'll keep the committee involved, the Public Health Committee involved at the pace in which the department feels we really need to review, advise, etc. We're looking forward to working with everybody together.

Dr. Boufford Thank you all very much for coming and being here.

Dr. Boufford We stand adjourned.