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TRANSCRIPT

Jo Ivey Boufford Good morning, everyone. I'd like to call this meeting of the Public Health Committee of the State Public Health and Health Planning Council to order. I'm Joe Ivey Boufford, Chair of the Public Health Committee. On behalf of my colleague, Dr. John Rugge, who you'll hear from in a little bit. We have a privilege to call this joint meeting of the Public Health Committee and Health Planning Committee, which will even continue into the afternoon. I want to remind council members, staff and the audience that this meeting is subject to the Open Meetings Law is being broadcast over the internet. These webcasts are accessed at the Department of Health's website at NY.Health.Gov. The On Demand webcast will be available no later than seven days after the meeting for a minimum of thirty days and then a copy will be retained in the department for four months. Some suggestions or ground rules to follow. This is synchronized captioning. It's important that people not talk over each other. The first time you speak, please state your name and briefly identify yourself as a council member or DOH staff in order to help the broadcasting company in their recording. Finally, please note that the microphones are hot mics, meaning they pick up every sound. Please avoid rustling papers next to the mic and obviously be sensitive to personal conversations that you don't want other people to listen in on. The record of appearance form. For the audience there is a form to be filled out before you enter the meeting room. It's outside this door. It is required by the Joint Commission on Public Ethics in accordance with Law Section 166. The form will also be posted on the Department of Health's website under Certificate of Need. In future you can download it and fill it out in advance. We thank you for your cooperation with all of these ground rules. I'm going to open with a few remarks and then turn it over to my colleague, John Rugge and Dr. Bauer. This is the third meeting of the Public Health Committee called post-COVID. Our first meeting was March 1st, 2022, and we identified in that meeting a number of agenda items that the Public Health Committee wanted to examine/look at with our colleagues over the ensuing months, which included obviously the new cycle of the prevention agenda, as well as some individual issues like maternal mortality, public health workforce, the effects of the waiver on public health and community benefit, among others. We'll be trying to touch on a number of these items as we go forward over the coming months. We'll start with maternal mortality today. The second meeting of the Public Health Committee was on February 8th. We had an initial review of the prevention agenda progress for about the first year for 2020 and some initial soundings from the Department of Health on their own internal leadership review of the prevention agenda and consultations with other organizations. On April 3rd, the Ad Hoc Committee for the Prevention Agenda, which had been revitalized thanks to a lot of yeoman's work by the staff and Dr. Bauer's team. We had thirty plus organizations represented, which are state level nonprofits, advocacy groups, professional associations and other interested parties really operating at state level that are invited to participate, multiple programs from within the Department of Health and a number of departments that have traditionally worked with us on the prevention agenda, such as the Office of Mental Health, Oasis and the Department of State. This meeting today is the sort of next step in this review of the upcoming prevention agenda cycle. Our next meeting of the Ad Hoc Committee will be on July 13th. We'll be scheduling at least two more of those meetings over the next three

months. We're looking forward to this discussion with the Public Health Committee to inform that meeting.

Jo Ivey Boufford Today's agenda, we're going to basically get back into a rhythm that the Public Health Committee had had historically, which is meeting its primary responsibility, which is overseeing the prevention agenda. In addition, we had always selected one critical public health issue after some discussion that we wanted to pay attention to, specifically using this, if you will, platform, public platform, bully pulpit and the interest of our council colleagues to raise its visibility. The first of those issues before COVID was related maternal mortality. The council issued a white paper in 2016, which I think was not inconsequential and leading to the Governor's Commission on Maternal Mortality. We're happy today to revisit that update, that report hearing from Kristen Siegenthaler, who's Director of the Division of Family Health in the Department to give us an update on the current statistics. Also, progress on some of the recommendations that have been made by this council and similarly updates on the Governor's Commission. We thought that it was also really important to talk about the availability of family planning and abortion services, given the national issues and New York State's historical championing of women's health. The second issue on today's agenda, Tina Kim, who's Deputy Director of the Office of Health Equity and Human Rights and the Department, is going to be giving us an update on the New York State Health Impact Equity Impact Assessment. These two keys into an issue. Obviously, we have been very interested in the prevention agenda context in the challenge of health disparities in dealing with inequities going forward. We are very excited about Johanne Morne and her staff joining our conversations from the beginning with the goal of providing a conceptual framework for work there that local health departments have been asking for, for some time. Our third area will be presentation will be from Dr. Ursula Bauer, who's Deputy Commissioner for Public Health and her team. They will give us further updates on the internal Department of Health leadership review of the prevention agenda and the results of some external consultations and review of statewide health programs of other states to raise some critical issues for the discussion by the Public Health Committee today with the idea of shaping the agenda for the July 13th Ad Hoc Committee meeting. I just want to make one comment additionally before we begin today so people have it in their minds. We are also linked to the Master Plan for Aging, Adam Herbst, who will be presenting to the full council on Monday. We don't have a presentation today of the Master Plan, but there are nine subcommittees of the Master Plan. One is the Committee on Health and Wellness, which I'm Co-Chairing with Dean Linda Fried of Columbia University. That committee really is a perfect venue for a crosswalk, if you will, from the prevention-oriented recommendations that we want come out of the Master Plan for Aging with the focus our objectives or the management of the activities relating to older people in the prevention agenda. At the last round, there were a set of objectives under each of the priority areas for older adults over 50. The Master Plan is dealing with 65 and older, sometimes 60 and older, depending on the databases. It's a really nice opportunity to cross fertilize those activities. We will wrap up at 1:00 for public comment. Any public comment opportunities would be there at 1:00pm and then we'll finish by 1:15pm, so that those that are continuing this afternoon with the Planning Committee can have a lunch break.

Jo Ivey Boufford Without further ado, let me turn it over to my colleague John Rugge for his opening remarks.

Jo Ivey Boufford Thank you.

Dr. John Rugge I can only say the morning belongs to Dr. Boufford and Health Planning and really glad to be here and participate. This afternoon we will look at planning activities and try to coordinate all that together.

Dr. John Rugge Thank you.

Jo Ivey Boufford Dr. Bauer.

Dr. Bauer Good morning. Thank you, Dr. Boufford. Thank you, Dr. Rugge. Thank you, members of the Public Health Committee of PHHPC. Really glad to have all of you here today. My Office of Public Health team is also delighted to be here. I really don't have much to add above Dr. Boufford's comprehensive introduction. We're really looking forward to the presentations from our Division of Family Health on maternal mortality and from the Office of Health Equity and Human Rights and the Hospital Health Equity Assessments. Both of those can certainly help inform our thinking around the prevention agenda. Then, as Dr. Boufford mentioned, we'll move into a presentation to help our thinking around the prevention agenda. Dr. Shane Roberts and Zahara will provide us with an overview of other state health improvement plans to help really stimulate our thinking on how we can approach the prevention agenda.

Dr. Bauer Without further ado, we will jump into the Maternal Mortality presentation. I turn things over to Dr. Siegenthaler.

Dr. Kirsten Siegenthaler Thank you.

Dr. Kirsten Siegenthaler Thank you to the Public Health Committee for inviting us. I'm Dr. Kirsten Siegenthaler. As I mentioned, I'm the Director for the Division of Family Health. I am joined today by...

Dr. Marilyn Kacica Dr. Marilyn Kacica. I am the Medical Director in the Division of Family Health.

Dr. Kirsten Siegenthaler We'll be jointly presenting to you. As I mentioned, yes, we were first going to review, revisit because it's been a couple of years and COVID obviously impacted how much we could focus each of the parts of the department on non-COVID work. Thankful to the committee for having an interest in maternal mortality. It's incredibly important. The white paper that was published in 2016 included recommendations for action, as well as a summary of data at the time. Recognizing that New York was faring very poorly out of the fifty states in the United States, and that the United States itself was faring very poorly out of industrialized or economically advantaged countries, and that there were stark disparities between Black and white birthing people. The white paper identified three opportunities for change to integrate preconception and inner conception care into routine outpatient care, assess and address pregnancy planning and prevention of unintended pregnancy, as well as institute systems and protocols for early identification and management of high-risk pregnancies. I'm going to share some data about what we've seen related to these three areas. I'm also going to share some new quantitative qualitative data that have become available since the white paper. You'll see the department's work to support these three opportunities woven through the presentation, along with some new areas of focus based on this data. First, I'll share with you and I'm sorry it's not quite as pretty as I would like it to be, but I wanted the substance to be present. From the pregnancy risk assessment management system what we're looking at here is the percentage of women who discuss family medical history before pregnancy.

The good news is that we've seen an increase in that. There is definitely more of an integration of family planning into a medical visit. That positive information, especially based on some of the findings you had in your white paper, The next one, again, I'm sorry, it's kind of small, the title, but the percentage of live births resulting from unintended pregnancies. The good news here is that we are seeing a decline that has continued sort of year over year based on the most recent data that we have. We're keeping an eye on this because we think it's very important. We'll talk about some of the work that we've been doing around this area investments. Unfortunately, it's not all good news. The next one is the percent of women with gestational diabetes as the top graph and the ones with high blood pressure is the bottom graph. We are seeing some concerning trends where it was flat and now it's gone up quite a bit in terms of the health of the pregnancy. Some mixed data, but I wanted to be able to share this. This is all publicly available, and it is information that we track. As you mentioned, I mean, what we had was that we were in 2010, 46, 2018, state improved to 30th. As of the 2022 Americas Health Rankings, we are now 15th. While some of that is a result of other states unfortunately doing more poorly, we have made improvements overall in our state. This is some of the trend data in maternal mortality. You can see that the bottom line is the U.S., and the U.S. has sort of steadily increased and New York has been sort of a little more... Actually, it declined, but it's actually more sort of even overall year over year. A lot of that has been driven by the declines in New York City, which is that top green line. That's somewhat good news. The next one is looking at maternal mortality as reported by race. Unfortunately, stark disparities continue to exist by race, ethnicity, and particularly though for Black birthing people compared to white birthing people. You can see that the red line is Black birthing people in the U.S. The orange line on the very top is Black birthing people in New York State compared to the lower lines, which are white birthing people. Rightfully so, we really wanted to look at that data and try to understand what was happening as a result of these racial differences. Since the white paper was released and we'll talk a little bit more about it when we talk about our activities, the Maternal Mortality Review Board was implemented and began meeting and has since reviewed all of the cases of maternal death, a pregnancy related maternal death from 2018. You'll hear more about they're working on a new report that will come out with data from 2019 and 2020. We anticipate that will be the end of this year, but for now, I have sort of, you know, 2018 data available. The largest blue bar on the left is for Black birthing people. The ratio of pregnancy related mortality is five times that for white birthing people. We wanted to look even more closely because we hear time and again that it's because the Black birthing people are not as healthy, that they're not insured, and that they have other conditions that are, you know, leading to this discrepancy.

Dr. Kirsten Siegenthaler the next slide, what you'll see is by insurance type. On the left side is Medicaid. The blue bar is among Black birthing people. The right side is private insurance. When you look at it, you're seeing that despite having private insurance, Black birthing people are multiple times, I believe, three times more likely to die than those who are white on private insurance. Again, we're isolating some of those factors that people will cite as the reason for it. Yet we're still seeing that trend. If such were the case, we would see that blue bar be much closer or equal to the other bars in that right group. Again, now we're going to look at education level. As we look at the far left is high school or below, the middle is some college or Associate Degree, and the right is bachelor’s degree or higher. What we see are stark differences that carry through across education level. It's not a reflection of individuals who are not educated. We continue to see challenges. The next one is from body mass index. We'll often hear that it is likely because people are overweight and therefore, they're more likely to be unhealthy during the pregnancy. Yet we see that the trend carries across all of the weight groups from what would be considered

sort of thin to normal to overweight to obese. We see the continuing trend. Again, each of these and there's a little red no at the bottom says that they're very small cell size. Taken together, there is sort of a picture that's being developed here regardless of sort of the individual cell size. Again, we're working on data from 2019 and 2020. The goal will be that we will have even more robust data. The difference previous to this was we were doing more aggregate level analysis and now we have a team who is meeting of multidisciplinary clinical experts, reviewing cases in an in-depth manner. They're really being able to go into this data. We can parse out some of these factors that people sort of anecdotally were citing as the reasons why a Black birthing person would be a greater likelihood to have a poor outcome. Yet that's not what we're seeing. We don't have enough data to model it, but the next step would really be to understand, like what are the contributing factors? When we consistently see race as the factor. The final one is cesarean deliveries on the right versus vaginal deliveries on the left. We're seeing a continued difference even among vaginal deliveries where there's a twice as greater likelihood of death. Among caesareans it's a four times greater death. As a whole, that's very concerning. To the point, we did couple this data with something called Voice Your Vision, which was the Department of Health with the Commissioner leading it at the time, Dr. Zucker went out into the community. We partnered with community-based organizations. We provided them money/funding to really recruit and engage individuals who are Black birthing people to talk about their experience. They actively recruited. We had a very open conversation with them. We didn't leave them with questions. We just asked them to voice their vision. The common sentiments are captured up here. We had a team that did some qualitative analysis that they were feeling disrespected by providers. They felt like they were not getting their questions answered or their concerns addressed. There was insufficient time with providers. They didn't get individualize care. They didn't get enough information to make proper decisions. They were feeling pressure to agree to certain medical procedures. There was a lack of social support during the prenatal and postpartum periods. These voices came from 244 women who were recently and currently pregnant, as well as families who had experienced some adverse birth outcomes. They had some suggestions, right, is that they wanted to increase health care professional awareness of racial disparities in health outcomes. They wanted to train health care professionals on the impact of implicit bias. Although, we're transitioning to structural racism on health care outcomes. Increased provider support during postpartum period. Increase availability of social supports including birthing classes, doulas, midwives, community health workers. They wanted increase availability of community sources such as home visiting services with nurses and community health workers. These are sort of the new data that became available since the 2016 report. This was, as you'll see, not that we left the old work, but that we really emphasized and added in the initiatives that Dr. Kacica is going to share.

Dr. Kirsten Siegenthaler I can advance the slides.

Dr. Marilyn Kacica Since we last met with the committee, there has been a lot of effort that has happened. I think a lot of those discussions drove the direction that we were going in, as well as the Governor's emphasis in 2018 that implemented the task force at that time. Some of the initiatives that you can see here that we have been working on and I'll talk a little bit more in detail, are using the perinatal quality collaborative infrastructure that we had in place to work on issues that were facing women who were dying, hemorrhage, opioid use disorder and neonatal abstinence syndrome and the Birth Equity Improvement Project. How we use our home visiting programs to support the community, perinatal regionalization system and regulations to ensure access and quality care. The Maternal Mortality and Morbidity Advisory Council, which was established in law in order to provide the community focus on recommendations. The Maternal Mortality Review Board that was

established, as Kirsten mentioned earlier, to really look at each maternal death and look at the circumstances and make recommendations to prevent future deaths. We're involved in a postpartum depression study. There's a lot of education and training that we are doing. Also, the reproductive health investments and how they contribute to our efforts. As I mentioned, the New York State Perinatal Quality Collaborative had a project that was longstanding. It started in November of 2017 and ended in June of 2021. Approximately 65% of hospitals volunteered to work with us in this project. We found as far as one of the outcomes was that among patients with obstetric hemorrhage, the transfer to higher care, including the intensive care unit or a higher-level hospital, decreased by almost two thirds and hysterectomy is decreased by 29%. Definitely morbidity was decreasing based on this project. When we look at optimizing the treatment of pregnant and postpartum women with mental health conditions and substance use disorders through our project, we wanted to make sure that birthing people who presented to the hospital were associated with follow up and care. The most recent project data showed that 85 to 90% of these patients were linked when they left the hospital to either medication assisted treatment or other treatment that was recommended at the time of discharge.

Dr. Marilyn Kacica The New York State Birth Equity Improvement Project. What resulted also from one of the task force recommendations to institute implicit bias training in all health care facilities. I think since that time we learned a lot, as Kirsten mentioned, that we've evolved from just implicit bias training with what do people actually do as far as change to anti-racism training. We have been working with birthing hospitals across the state to really have them take a close look internally to see how both individual and systemic racism impacts birth outcomes at their facility so that they can take actions to improve both the experience of care and improve the perinatal outcomes of Black birthing people in the communities that they serve. We launched this project in the middle of COVID in January of 2021, and we're quite surprised and impressed that hospitals really volunteered to do this very difficult work. Currently, we're working with 73 New York State birthing facilities because we have also two birthing centers working with us. That represents almost three quarters of the births in New York State. The strategies that we focus on within the project to effect change locally are to make sure that there's an organizational commitment to anti-racism anti-racist efforts through leadership and governance. I think we all know if leadership doesn't buy into a project, not much gets done. We want to make sure that facilities are accountable, and each person is accountable in this work. It's very important that there are respectful patient partnerships with Black birthing people. We work a lot on that. We found that facilities didn't really use the data that they had. We wanted to make sure that they actually stratified their outcomes by race, ethnicity, gender identity and language in order to drive improvement, because each facility will be a little different depending on the community that they serve. As I mentioned, we are using the perinatal quality collaborative structure. We have a very broad equity curriculum. It emphasizes both structural and systems change within the facilities to promote equitable care.

Dr. Marilyn Kacica Participating facilities are collecting and using patient experience data stratified by race ethnicity. We instituted a patient reported experience measure that each birthing person at discharge fills it's a series of just ten questions that talks about their individual care. We can stratify that by race/ethnicity. We have it in domains associated with autonomy, respectful care, etc. Each facility then can look at it and see where they need to improve. They receive their data back monthly in order to have real time improvement. We've learned from both our maternal mortality reviews and work within the community that home visiting is that connection for support in the community in order to improve access to care. There are several initiatives that we have. One is the Perinatal

and Infant Community Health Collaboratives. This was started in July of 2022. It is a community health worker model. We anticipate about 128 community health workers working on this. We're also funding a data management information system and Center for Community Action, which does train and TA looks at the data and then also makes recommendations as to what to focus on. There was the reauthorization of the Federal Maternal Infant and Early Childhood Home Visiting Program. This was in December of 2022. It really looks at evidence-based home visiting programs such as Healthy Families, New York and also the Nurse Family Partnership. This is for the next six years. These programs really provide education, screening for necessary risk factors, referrals for at risk families in low-income households. It really also focuses on maintaining insurance coverage and receiving recommended prenatal postpartum and well childcare. Our board really emphasized that connection between a facility and going into the community to make sure that people are not lost. The Maternal Mortality Morbidity Advisory Council. This council works collaboratively with our board. It reviews the boards findings and addresses structural and social determinant factors that impact maternal health outcomes. It's a very diverse council. Its Commissioner appointed. The members come from very many disciplines, so they'll be community members, people with lived experience, perinatal network professionals that work in community-based organizations. There are midwives, doulas, home visitors, physicians, representation from the board to this committee to have a connection, nurses and social workers. We have worked very hard with this committee the last year. We've had over twelve meetings to look at the board recommendations, and then this committee is coming up with its own recommendations from a more community aspect that we believe will be out this Fall or or at the latest at the end of the year.

Dr. Marilyn Kacica as I said, the Maternal Mortality Review Board was established and this board meets more like six times a year. They review individual cases and from each case come up with recommendations on how that case could have been prevented if it could be. These reports are due every two years by law. The first report was delayed, but we anticipate a report at the end of this year that will encompass the years 2018 through 2019 and 2020. One of the things that the board wanted to do was not only wait for these reports to come out, but if they saw an issue, they wanted to have an issue brief that could reach providers in the community in a timely fashion. We were seeing that in our reviews that mental health conditions were really increasing and contributing to maternal deaths. We wrote with an Ad Hoc Committee from the board and then published this report, and that was out this year. We're currently in the final process of writing one on substance use disorder. It really takes the form of a case review that is made up from multiple cases. What an individual provider can do when they see a person like this that will improve their outcomes. The other thing that we did was we developed naloxone brochures because we were seeing birthing people dying in the home where people did not know what to do to prevent the death. We did one for the birthing person and also for their families. That was simple, pointed them to resources, pointed them step by step, how to intervene and also how to get naloxone.

Dr. Marilyn Kacica the committee for that 2018 report started out with 236 recommendations. We pared that down to 155 recommendations that were for pregnancy related deaths. The executive committee of the board worked with us to propose the final 14 key recommendations for New York State. They were further divided by facility level, provider level, system level. I've outlined here. I've outlined the different recommendations that were made and then if there is progress or work being done associated with them.

Dr. Marilyn Kacica Do we have time to go through them all?

Dr. Kirsten Siegenthaler Do you want us to go through each of them or you have the slides?

Jo Ivey Boufford I'm hearing from what you're saying, we're going to have a lot of good progress reports to hear about the results of some of these interventions over the next month. Just please, maybe just continue at the higher level you're working on.

Dr. Marilyn Kacica Sure.

Dr. Marilyn Kacica the next thing that we were working on for many years is to strengthen the New York State perinatal system.

Dr. Marilyn Kacica Can you hear me now?

Dr. Marilyn Kacica Was to strengthen the New York State perinatal system. We worked on this with an expert group to propose new regulations, but the regulations are expanding the regionalized system in New York State to incorporate birth centers, including the midwifery birth centers as the first level of care to formalize the relationship between RPCs and their affiliates for training, consultation, quality improvement through an affiliation agreement to strengthen the requirement for transfer agreements with higher level perinatal hospitals and then strengthen the requirements for all levels, including birthing centers, to improve maternal and neonatal outcomes. In our focus with maternal mental health, we're as I mentioned, we're currently working with OMH, conducting a postpartum depression screening protocol and tools review. This was mandated in legislation. We are currently in the last phases of finalizing that. We have worked closely with Project Teach and OMH to really advance and promote their maternal mental health programs through Project Teach. We've included them in our coaching calls for our collaborative. We've done webinars to promote it and to make sure ACOG promotes it also. In 2022, we saw that 128 pregnant and postpartum patients had consults provided. There's more work to be done, but we're trying to, of course, promote that because it's a valuable resource. I think as far as additional actions, we have increased provider training through Project Teach and also public education. We worked with the CDC on the Hear Her campaign to cobrand it and include that across the state in our social media.

Dr. Kirsten Siegenthaler Great. I also want to highlight a few of our reproductive health investments, given the importance that individuals have broad choice in whether or not to start a family. Through state investment, increased investment, but also through re-entering the federal Title 10 program, the Department of Health was able to amend 34 of our core contracts that we had in place. We're able to extend the length of them as well as to add value, which was important because they had been level funded for so many years. Yet the costs of staffing and the infrastructure had increased as well as used the funding to expand the overall network by adding three contracts that represented nine additional family planning sites in counties such as Erie, Queens, Manhattan and the Bronx. Overall, we've had an investment in our family planning structure for core family planning visits, which include contraception intended as a pregnancy, but also includes STI screening as well as cervical breast screening are offered at those sites.

Dr. Kirsten Siegenthaler in addition, as you may have seen, we just passed the one year anniversary of the Dobbs decision, which greatly impacted individuals nationally to access abortion. In New York it has remained legal. The state has invested $25,000,000 of which the Department of Health was able to award $24.1 million to 51 organizations that have 127 clinics statewide. Every area of the state was covered. This funding was originally an

emergency appropriation. It's now been carried forward into the enacted budget. This will be a more permanent safety net for abortion services. We think ensuring that people have the broadest of spectrum to access to their reproductive care is critical. We're thankful to the Governor and legislature for that as well as the department. We focus on our Office of Public Health Initiatives. We had a lot of that. I want to share some other slides. Our Medicaid program was also partnered in the listening sessions. We have monthly calls with them. They review the data as well. I won't go through each of them. You'll see here the recommendations that you heard earlier from The Voice Your Vision, as well as the Maternal Mortality Review Board, are reflected here; so dual coverage, midwifery, parity, community health worker coverage, nutrition counseling, lactation counseling, expanded prenatal testing, remote patient monitoring, which is quite amazing and great to see, as well as a strengthening of the perinatal care standards and an increase in reimbursement for both family planning, as well as our procedural abortion services. Recognizing the importance that the reimbursement be sufficient to sustain the system.

Jo Ivey Boufford And then two more minutes, if we can, because I want to leave time for questions.

Dr. Kirsten Siegenthaler This is my last slide.

Dr. Kirsten Siegenthaler We're working with our Office of Primary Care and Health Systems Management as part of the broader strengthening of New York State perinatal regulations. There was a law that was passed and allows for standalone midwife led births. These are centers where midwife leads the birth. Part of the regulations that were released May 31st also include a Section 10 NYCRR 795. The purposes of these updates are to allow for the sort of rules around establishing the allowance for the establishing have been statute. This is the regulations that support the statute.

Dr. Kirsten Siegenthaler That is the end. That is sort of a comprehensive walk through of the many facets of the department's work to support maternal outcomes.

Jo Ivey Boufford It's fantastic. Really, really helpful. I think we'll want to come back in the Fall to get the results of your 2018 interventions for 2019/2020. That's really exciting.

Jo Ivey Boufford Let me follow up on just a couple of questions and see if my colleagues have questions ask them. I wanted to ask about inclusion. One of the other issues we were concerned about was sort of mainstreaming some of the concerns of women's health, but family planning, maternal mortality, women's health concerns in things like value-based payment, things like some of the thinking about Medicaid rates. You mentioned some of those. Could you talk a little bit about the degree to which you feel like women's health issues are kind of beginning to get represented as part of the normal way of doing business rather than having to remind people what about the women's health issues?

Dr. Kirsten Siegenthaler I mean, I think there's a strong emphasis, as you saw in the global package for Medicaid on supporting health. In terms of value-based payment, there was an original sort of roll out of sort of different packages for value-based payment. The maternal package was not taken up by facilities. I know that our colleagues and Office of Health Insurance Program have been doing a lot of work, though, to better integrate the value-based payment for maternal outcomes, specifically not women's health, but maternal outcomes. I think that would be a good topic to revisit. We can ask our colleagues.

Jo Ivey Boufford Our Planning Committee Chair is here.

Dr. Kirsten Siegenthaler We can work with our colleagues.

Jo Ivey Boufford When he wraps up the dental problem and all of the emergency room back up, we'll take that on.

Dr. Kirsten Siegenthaler I mean, we are members of the clinical advisory group, so we participate with our Medicaid members on that as well as a children's clinical advisory.

Jo Ivey Boufford Just my last question before opening it up. It relates to the reimbursement issue. I think I may have missed it, or I should know this, but I don't know, so I'm going to ask you. Some states have now passed a one-year coverage of Medicaid around for pregnant persons following through for a year after the delivery. Where does the New York State stand on that at this point?

Dr. Kirsten Siegenthaler We are proudly a member of one of those states.

Jo Ivey Boufford Wonderful.

Dr. Kirsten Siegenthaler We now have twelve-month postpartum coverage for individuals so they do not have to transition to other forms of Medicaid or other insurance for the twelve month period because. I think that was largely driven out of our listening sessions, our task force and also Maternal Mortality Review Board that that twelve-month period is so important to have full comprehensive coverage.

Jo Ivey Boufford This is great.

Dr. Kirsten Siegenthaler We are a proud member of that growing list of states.

Jo Ivey Boufford Pretty good club to be in.

Dr. Kirsten Siegenthaler Took advantage of that opportunity.

Jo Ivey Boufford Denise, did you have a question?

Dr. Soffel Good morning. Denise Soffel, fellow council member and committee member. I have two questions. I'll ask them both and then you can answer in wintertime. One is, I'm interested in what you can say about the Medicaid doula initiative, which I know had two sites. I want to say one was Erie and one was Brooklyn. I think that's right. My understanding is that the Brooklyn site has had a sputtering beginning. I would love anything that you can say about how that's going and whether there's any outcome information about the impact of that initiative. My second question has to do with perinatal networks. I've done a lot of work with the prenatal networks over the years. They are incredibly well connected to their communities. I'm interested in how your maternal mortality initiatives are interacting with those local perinatal community networks and whether there are any resources that could be pushed out to them to help them do the work that they're doing on the ground in some of our communities with great disparities.

Dr. Kirsten Siegenthaler Sure.

Dr. Kirsten Siegenthaler for the dual coverage, there was a Medicaid budget initiative that happened. Effective January 1, 2024. Medicaid will expand coverage of dual services for all pregnant individuals. There will no longer be a pilot. Part of that was a substantial increase in the rate of reimbursement for doulas. My understanding is that was one of the challenges of the pilot project. The successes have been captured, acknowledged and identified through various initiatives. We've heard the importance of dual support and so has Medicaid. That coupled with an increase in the rate will be the driving force going forward. Again, it's anticipated to be effective January 1, 2024, when it's a benefit for all pregnant individuals and the rate is increased.

Dr. Kirsten Siegenthaler Your second question is about perinatal. The Department of Health, through a state appropriation, invests millions of dollars in our perinatal networks through the Perinatal and Infant Community Health Collaborative. It was formerly known as the Maternal and Infant Community Health Collaborative. We have been working to make our language as inclusive as possible. Perinatal covers the same information. That program was actually expanded in 2022 through additional funding from the state to support maternal mortality or address maternal mortality. Of course, there's opportunities to further expand it, but we have a fairly significant and we can share. I didn't include it in here. We have a map where all of the health workers that are funded through our program, but there is a network of other community health worker and other home visiting programs. I can also share a broader map because in addition to pitch, we fund nurse family partnership. We also, through funding to the Office of Children and Family Services, support their broader funding in Initiative for Healthy Families New York. There are a number of different home visiting programs that we are working very hard to make sure that they're coordinated and collaborative in the communities in which they're located and continue to look for where there are opportunities for growth, which we think there will be given that community health worker benefit that Medicaid will have. That now, in addition to public health grant funding practices, could actually hire community health workers and be reimbursed for those services so there's a path forward for supporting a broader access to community health workers within clinical settings.

Jo Ivey Boufford I think one of the issues that came up in the revision of the regulations are perinatal networks a while ago was the relative lack of attention to women versus babies. High risk babies were being tracked, transferred, etc., and perhaps high-risk women were not being attended to in, in the same way. It was really trying to balance a little bit, balance the attention. I think the rebranding is part of that effort.

Dr. Kirsten Siegenthaler Strengthening our perinatal system.

Dr. Soffel Can I just ask one other quick follow up?

Dr. Soffel I'm interested in how the perinatal networks are filtering up their grassroots experience and information into this larger Department of Health project to sort of step back and take a statewide look at the concerns around maternal mortality.

Dr. Kirsten Siegenthaler Sure.

Dr. Kirsten Siegenthaler We just we work really closely with the New York State Perinatal Association. We just presented to their association in June, and we meet twice a year with their board. We hear from the association that really represents a lot of our perinatal networks. In addition, because they are our contractors, we have quarterly calls with them as well as receive quarterly reports and data from them. There is a very open loop for

communication, both for us to share information, which was invaluable during COVID as well as for them to share information back to us. In addition, we did receive federal COVID money, and one of the projects that we've initiated and is undergoing right now is actually a community, a practice of community health workers who worked during COVID. It's nine community health workers who are active during COVID from different parts from outside of New York City. They are providing us with sort of more feedback on a debrief of what happened during COVID. What what are they need? How could we do it better? We've created a number of opportunities, both very structured as well as somewhat novel and becoming structured to receive this feedback to them.

Jo Ivey Boufford Ms. Soto has a question, and I think we'll probably have to wrap up at this point.

Jo Ivey Boufford Dr. Kim, do you have any questions?

Nilda Soto Nilda Soto, council member. I have two questions. In the beginning of your presentation, you had a chart that showed, I believe it was from 2010 to 2015, and how New York State had greatly improved in its ranking. I was wondering what the contributions to were that? Because the time period seems to be very short. My other question is about the maternal mortality board. It's stated that they review cases and make recommendations. Does the board have any ability to take actions and institute fines in terms of the board?

Dr. Marilyn Kacica as far as the board, no. They're instituted in order to do the deep dive, you know, get the information and make recommendations. They have no regulatory authority, but they do make recommendations to the Commissioner and to the Governor for them to take action.

Dr. Kirsten Siegenthaler in order to have a very open and engaged quality improvement process, it is not a litigious one. The records themselves and the individuals participating are protected. That was very important to the statute that was put in place for the Maternal Mortality Review Board. It is not part of any kind of litigious action. As Marilyn said, they have identified when deaths are preventable and they make recommendations that are at multiple levels, at a system level, at a facility level, and then at a provider level. In the slides, you'll see some of the work we're doing to now implement those recommendations. There's some in parents' activities that we're doing. We haven't worked on all of them yet because we just got the final report published in April of 2022.

Dr. Kirsten Siegenthaler and then to your first question about the data, I mean, unfortunately, some of it is due to the relative performance of other seats. There are other states where maternal mortality, you know, certain states in the South, Alabama, Louisiana, where they have maternal mortality rates that are in the thirties, and we are around 719. They are about twice the rate of mortality as New York State. Other things, you know, I do think are the investments in maternal mortality, the awareness that's been raised, the engagement of the hospitals in the different initiatives, whether it be for our quality improvement or the Maternal Mortality Review Board. We present routinely to different groups and have, as Marilyn said, I mean, at least eight to ten webinars a year with our hospital groups. We have very strong participation by our American College of Obstetricians and Gynecologists, District two, which is New York, as well as Greater New York Hospital Associations and the Hospital Association of New York State, so Haney's and the Greater New York. I think it's a recognition by the system of the importance of this, or certainly about a number of very high-profile individuals who have had bad outcomes,

who have really gone public with the importance of listening to women and birthing people through the birthing experience. I mean, I think we still have a long way to go because we would like to eliminate the disparities and certainly eliminate the deaths.

Jo Ivey Boufford This is really terrific. I'm going to have to wrap this up so we can stay more or less on time. I do want to raise a couple of issues for a future discussion. I think one of the things that the council has seen not too much recently, but one of the historic issues you raised about the stereotype, I guess, of maternity services, but there is clearly has been consolidation and reduction of beds, maternity beds, and some of it has been ascribed to reimbursement. Some of that under Medicaid now maybe is being partially addressed. I think it'd be important to hear more about that, what some of the implications are. Also, just the overall issue of access in rural areas and what we need to know about that, what some solutions are working, where there's maybe some good practice that's going on, because I think it links to the birthing centers questions to the role of midwives in other areas in general. Those are just two areas I think maybe we could bring up in a future time. We'll talk about... I really congratulate you on linking to the Medicaid process and your colleagues and OHIP, because it's just really, really important in similar ways that you're doing with the Office of Mental Health. This is great. This is terrific. Thank you so much. We'll have you back as an ongoing agenda item for the Public Health Committee.

Jo Ivey Boufford Thanks.

Jo Ivey Boufford Is Ms. Kim on?

Jo Ivey Boufford There she is.

Jo Ivey Boufford The next presenter on behalf of Dr. Morne and the Office of Health Equity and Human Rights is Tina Kim, who's the Deputy Director of that office.

Ms. Tina Kim Hi, everyone.

Ms. Tina Kim I just want to confirm that you can hear me.

Jo Ivey Boufford We could until you said, can you hear me? We didn't hear the me part, but hopefully it'll work out.

Ms. Tina Kim I'm driving up to Albany. I wanted to make sure you could hear me. As for everyone, I'm not going to be on video because I would like to make sure I'm driving safely, but I'm so happy to be on with you. Thank you, everyone, for your time. I just quickly wanted to acknowledge members of the Health Equity Impact Assessment Team and Unit based in the Office of Health Equity and Human Rights. On the line with us, our fearless leader, Deputy Commissioner Johanne Morne. We also have our new Director of the Health Equity Impact Assessment Unit on the line with us. She began on Thursday. We are so excited to have her on board. I also want to acknowledge other staff members Annie, Heidi, Casey, and we also have colleagues from OPCHSM that we have closely been partnering with through the planning and implementation of this program. We just want to acknowledge the great amount of collaboration and work that has gone into the Health Equity Impact Assessment Program. Again, my name is Tina Kim. I am the Deputy Director here in the Office of Health Equity and Human Rights. We are responsible for implementing the Health Equity Impact Assessment requirement tied to the Certificate of Need application. I'm happy to start with a background.

Ms. Tina Kim Next slide.

Ms. Tina Kim As many of you may be aware, there was state legislation that was passed in the 2019 and 2020 legislative session that required for a Health Equity Impact Assessment to be filed with a Certificate of Need application to the Department for Construction or substantial reduction of a hospital or health related service. The legislation passed both houses. The Governor signed the piece of legislation on December 22nd of 2021, and there was basically another companion legislation introduced in the following legislative session which clarified the types of changes that would require a Health Equity Impact Assessment and effectively pushed out the date of the law going into effect on June 22nd, 2023.

Ms. Tina Kim Next slide.

Ms. Tina Kim Just to give a landscape, the Health Equity Impact Assessment isn't something that New York State, as much as we are a leader in many areas of public health and health care delivery. It is not being newly implemented in New York State. Health impact assessments have been around as a tool and a framework for quite some time. Economic agreements, market regulation, public policies, noting that it is a good tool to apply in the various areas of work. Health impact assessments are a framework to help decision makers consider potential health consequences for proposed projects. It's only recently that there's been a subfield of health impact assessments called Health Equity Impact Assessments that have developed. While there is no legislative requirement for Health Equity Impact Assessments to be tied to applications submitted by health care facilities anywhere else in the country, there were a number of domestic as well as internet. Health departments, for example, that have applied Health Equity Impact Assessments and health impact assessments in their respective areas. The legislation changed for three points, which I wanted to highlight from the get-go with a goal or the intent of the Health Equity Impact Assessment legislation and everything that we have developed, or this requirement was based on the following. The intent of the Health Equity Impact Assessment is to understand the health equity impacts of a specific facility project. There is wide recognition that there has been work done to think about health equity impacts broadly by facilities and health care systems at large, but the purpose of the legislation here in New York State is to understand those impacts specific to a project that the health care facility is going to undertake. It is to be a focused assessment on impacts to medically underserved groups. On the slide there, you will see the list of medically underserved groups that were named in the legislation. The Health Equity Impact Assessment must be conducted by an independent entity. While there is equity focused or equity trained staff that are hired and employed by health care systems to think about health equity, the purpose of the assessment is to get at a unbiased, objective written assessment, which is to be conducted by an independent entity. There must be no conflict of interest between the independent entity and the facility. The regulations that the department has put forward outlines our expectations of what it means for an independent entity to not have a conflict of interest with the facility. Another key component of the Health Equity Impact Assessment is that there must be meaningful engagement of community and stakeholders. The legislation does quite a bit in terms of specifying the scope and the contents of what the Health Equity Impact Assessment needs to include, which is reflective in the various program documents that we have issued for this program.

Ms. Tina Kim Next slide.

Ms. Tina Kim Just to make everything kind of culminate into what the purpose of of the Health Equity Impact Assessment program is and as well as our vision, we want to standardize the practice of assessing whether and if so, how facilities project will improve access to services or in health care, improve health equity and reduce health disparities. In our vision, from the perspective of the Health Equity Impact Assessment Unit here in O'Hare is to create cultural change where there are dedicated efforts to understand health equity impacts, and that that would be the norm or standard practice in the industry and have those impacts be considered and meaningfully incorporated into the planning and execution of health care facility projects.

Ms. Tina Kim That slides.

Ms. Tina Kim Under the legislation, there are facilities that are subject to the Health Equity Impact Assessment requirement. They are namely Article 28 facilities, which includes general hospital, nursing homes, certain diagnostic and treatment centers and midwifery led birth centers. The reason why I said certain is because of the next bullet, not subject to the Health Equity Impact Assessment requirement are diagnostic and treatment centers, whose patient population is 50% or more Medicaid eligible or uninsured. That's a combined percentage of the patients mix.

Ms. Tina Kim Next slide.

Ms. Tina Kim Who will conduct the Health Equity Impact Assessment? As per the legislation, an independent entity will be responsible for conducting the Health Equity Impact Assessment on behalf of the facility. That means in terms of our regulations that we've put forward as a department, an individual or organization that has expertise and experience in the study of health equity, anti-racism and community and stakeholder engagement and preferred expertise and experience of health care access and delivery of health care services. Below outlined what we, through the regulation, have defined as what it means for an independent entity to not have a conflict of interest with a facility. If an independent entity is hired to compile or write any part of the facilities when application that is being submitted for a project, then they are not eligible to compile the Health Equity Impact Assessment for that specific project for that facility. If the independent entity has a financial interest in the outcome of the project application. So, for example, if there is a member, if there is an individual or employee of that independent entity that sits on the board of directors or controlling advisory board for that facility, then they would not be eligible or they would have a conflict of interest and would not be able to conduct the Health Equity Impact Assessment for that facility. Lastly, if they've accepted or will accept a financial gift or incentive from the applicant for the cost of performing or conducting the Health Equity Impact Assessment. They would not be eligible as well.

Ms. Tina Kim Next slide.

Ms. Tina Kim in terms of program implementation, we've done a number of things to get ourselves ready. The law went into effect last Thursday, and we have done a number of things to get ready. In addition to the regulations that will be going before the full council next Thursday, we have established a Health Equity Impact Assessment unit here in the Office of Health Equity and Human Rights. The Director, who is on the line, has started and is responsible for pulling together the full team of staff dedicated to reviewing and analyzing the information coming in from the Health Equity Impact Assessment. There will also be additional staff hired throughout the department to help with the implementation of the requirement here in the department. We have implemented technical changes to the

application system so that it can accept health equity impacts of the documents within the CON application. We have launched a Health Equity Impact Assessment web page on the new Office of Health Equity and Human Rights web pages, where that could be the centralized place for us to provide document updates on the program and offer a centralized point of contact. Lastly, last week we issued a number of program documents related to this requirement. They have been published online on our web page and as well as the CON web page, so that applicants can review and begin talking with independent entities and getting Health Equity Impact Assessments pulled together for CON applications submitted from here on out.

Ms. Tina Kim Next slide.

Ms. Tina Kim We quickly wanted to take some time and talk about the structure. You may have already seen the program documents, one of which was highly anticipated by the public, which is the template that is the standard format that the department has issued for facilities to complete for the Health Equity Impact Assessment. Information coming in through that template will be reviewed by the department in a standardized manner and wanted to provide kind of a high-level background on the structure that we've taken. Tying back to the jurisdictions and the health departments that we have looked to in other parts of this country and as well as in other countries, how they have implemented and put out the assessments. They are typically done in a stepwise structure. In ours, it reflects a five-step structure within our template. The first section is called scoping. First, the independent entity, is going to work with the applicant to use data and identify the populations affected. Specific to New York State, this is where the identification of specifically the medically underserved groups within the service area are identified. Secondly, is its potential impact. Having scoped out the demographics and the key populations within the service area, what are the positive and negative health impacts of the planned policy program or initiative? In our case, the facility project. The third step is mitigation. Based on what has been scoped out and the potential impacts that have been identified, what are some evidence-based ways that the independent entity can offer for the facility to reduce the potential negative impacts, as well as amplify the positive impact? The fourth step is monitoring. Based on everything to date and the mitigation strategies that have been identified, how will the facility monitor the implementation of those mitigation strategies and identify ways to measure success for the mitigation strategies that are implemented? Fifth, dissemination. In our template, we do not ask questions specific for how the independent entity will disseminate the findings of the Health Equity Impact Assessment. Basically, the weight of the law that has dissemination covered the legislation requires for the applicants to post to the Health Equity Impact Assessment as well as a CON application publicly on its website. It also requires for the department to post a copy of the Health Equity Impact Assessment and the CON application on its on its website. The way that we have done that operationally is through the system. We have allowed for public viewing of the CON application along with the Health Equity Impact Assessment that will be submitted to the department.

Ms. Tina Kim Next slide.

Ms. Tina Kim This is a cheat sheet of the structure of the template and how many questions in each section. Section A is an executive summary section asking for a high-level summary of the CON project and as well as the Health Equity Impact Assessment findings. Section B is where the crux of the Health Equity Impact Assessment is to take place. This is the five steps that I have gone through. There are a number of questions associated with each of those steps. I do want to mention here, tying back to my remarks

earlier about how much the legislation specifies the scope and contents of the Health Equity Impact Assessment. I do want to note here that well over two thirds of the Health Equity Impact Assessment template is specified under the legislation. We wanted to make sure that in order for us to follow as other jurisdictions and subject matter experts have opined in terms of how Health Equity Impact Assessments are to take place in order to fully realize the five-step structure, there were a number of questions that were added for the independent entity to answer. That's in Section B. Lastly, Section C is where the facility leadership will find having reviewed the Health Equity Impact Assessment and offer a mitigation plan for the potential impacts that were identified in the Health Equity Impact Assessment.

Ms. Tina Kim Next slide.

Ms. Tina Kim in terms of the submission requirements, starting last Thursday, CON applications that are submitted to the department cannot be considered complete without the following Health Equity Impact Assessment program document. The requirement criteria, which we'll walk through questions for facilities to answer on whether a project will require a Health Equity Impact Assessment or not. The requirement criteria form closely follows what we have articulated in the regulations as to which project will be subject to the inclusion of a Health Equity Impact Assessment. The template as I walked through and there are data tables, which is a separate Excel document that have been provided by the department. There is a conflict-of-interest form which asks questions about the relationship between the independent entity and the facility to identify conflict of interest. Lastly, the redacted CON application, because this is to follow the legislation's requirement for the CON application to be posted, but to the extent that there is sensitive information either in the CON or the Health Equity Impact Assessment, we are requesting for the applicant to submit a redacted application that will be posted publicly.

Ms. Tina Kim Next slide.

Ms. Tina Kim In terms of our priorities from here on out, now that the law is in effect, we are going to be presenting to the full PHHPC to the full council next Thursday for permanent adoption of the regulations, as we have presented as Deputy Commissioner mentioned in her remarks at the Codes Committee meeting last week. We received a number of public comments through the 60-day regulatory public comment period. Forty-three official letters were submitted. Based on that, there was a determination that we are going to be... We have asked for the council to permanently adopt the regulations as we have presented it back in March and April. That's what we will be doing next Thursday. Another key priority is to continue recruiting and adding on to the Health Equity Impact Assessment Unit. We have a number of staff that have been trained and onboarded and ready to go, but we will be hiring additional staff to make sure that we can fully meet the anticipated workload of the Health Equity Impact Assessments that will be coming into the department. We are committed to monitoring the implementation of this program and engaging stakeholders as we have been over the course of this last year, and we will monitor the active piece of legislation that is being considered right now in the Legislature. This legislation would require for the scope of the Health Equity Impact Assessments to consider the impact on availability and provision of reproductive and maternal health services in the service area CON project is implemented.

Ms. Tina Kim I believe that's our last slide. This one is showing our main web page and as well as the program documents that are online and as well as our program contact.

Ms. Tina Kim I will pause there for questions.

Ms. Tina Kim Thank you so much.

Jo Ivey Boufford Thank you very much.

Jo Ivey Boufford Your last connection of your broadening scope to deal with maternal impact is something that follows on exactly the conversation we just finished having on maternal mortality and perinatal health. Thank you for that. We will look forward to supporting that effort.

Jo Ivey Boufford Are their questions from colleagues here?

Jo Ivey Boufford I don't see any.

Jo Ivey Boufford Rochester?

Jo Ivey Boufford I can see a shape in Rochester. Is there anyone in Rochester that has a question about this presentation?

Jo Ivey Boufford Thank you.

Jo Ivey Boufford I have one question. Actually, Tina, you mentioned the entity for whom the third-party assessment is being done can't pay the third-party assessor. Who will then, in fact, be paying these independent entities that do this review?

Ms. Tina Kim Thank you for that question.

Ms. Tina Kim I should have clarified. We anticipate that health care facilities will either need to pay for an independent entity to conduct the Health Equity Impact Assessment, or there may be individuals or organizations that are already in a contract, some type of contractual agreement with the facility, and may have the expertise and the experience to do the Health Equity Impact Assessment and by way of their existing contract work with that facility to submit it. What I meant by the financial gift is that there must not be some type of extraordinary gift outside of the payment for the service being done, some type of extraordinary gift or payment for the independent entity. We basically just don't want any bias. To the extent that any gift is given to an entity or to an individual, we don't want that to influence. Basically have, you know, for the independent entity to create a more favorable Health Equity Impact Assessment than they typically would if they were just simply contracted to do the assessment.

Jo Ivey Boufford I see.

Ms. Tina Kim Yes.

Ms. Tina Kim Thank you for the opportunity.

Jo Ivey Boufford It was the gift issue, I guess, that I missed in passing, as opposed to just the overall reimbursement. That makes sense.

Jo Ivey Boufford I guess the only other observation I think is interesting is depending on the context of the provider's report, it could be very useful information to really begin to

understand what kind of disparities are going on in the broader community in addition to the project specific activities for purposes of informing our work on disparities statewide. It's very promising.

Jo Ivey Boufford Dr. Rugge has a question.

Dr. John Rugge Is there an available list of qualified vendors for doing these assessments?

Ms. Tina Kim Thank you for that question.

Ms. Tina Kim The department is not issuing a list of vendors that would be considered Health Equity Impact Assessment. That was very intentional, especially for this first year of implementation, because we may not be aware of every single individual or entity that could meet the qualifications, that could see themselves and could be considered qualified to do this. We did not want to create a prescriptive list that could potentially be narrow. Also, in recognition of the fact that in terms of the availability of individuals and entities to do this type of work, that it could be varied across the state. This is something that in terms of a list not issued at this time. We have articulated our expectation in terms of the regulation as to the independent entity and their relationship, but we kept it pretty broad.

Dr. John Rugge I apologize if I missed that.

Dr. John Rugge The department has a process for qualifying prospective investigators.

Jo Ivey Boufford No.

Dr. John Rugge No.

Jo Ivey Boufford She's saying they're not doing that at this point.

Dr. John Rugge Okay.

Johanne Morne Hi, everyone. This is Johanne. I apologize for not being on camera, but just to add to that clarification. As Tina said, it was very important to us to allow for the providers to be able to work with organizations that they felt met the definition. We tried to very clearly state parameters or framework within which a independent contractor should be selected.

Jo Ivey Boufford That answers your question, John.

Jo Ivey Boufford I don't see any other questions.

Jo Ivey Boufford Thank you all very much.

Jo Ivey Boufford I hope you aren't actually driving the car and doing that. If you are, you're really quite superwoman. Very impressive. Very impressive presentation. Thank you for making yourselves available, all of you that the team. We look forward to further discussions from you.

Jo Ivey Boufford Thanks very much.

Ms. Tina Kim Thank you.

Jo Ivey Boufford We will now shift over to the third item on our agenda, which is a report out from the Office of Public Health from the state on current, the work that Dr. Bauer and her team have been doing, kind of looking at other statewide improvement plans, looking at leadership and of an internal group that's been reviewing the prevention agenda and beginning to hear about their reflections and hopefully posing some questions to the committee for discussion.

Jo Ivey Boufford Over to Dr. Bauer.

Dr. Bauer Thanks so much, Dr. Boufford.

Dr. Bauer Thanks, Tina and O'Hare and of course, Kirsten and Marilyn. Really appreciate the rich information in our meeting today.

Dr. Bauer As Dr. Boufford mentioned, we're now turning our attention to the prevention agenda and our continued input gathering to inform our thinking about the best framework and approach for the 2025 to 2030 cycle. A large component of the planning process is bringing in those stakeholder voices and obtaining stakeholder input. At this point, we've had at least one conversation with the Public Health Committee, with the Ad Hoc Committee, with the Health Equity Council, local health departments, the internal DOH steering committee and the hospital associations. We've obtained a variety of input, ideas, brainstorming questions, suggestions and requests for information. One of those requests for information that really cut across a number of groups has been what are other states doing? Today, Dr. Shane Roberts and Zahra Alaali will provide a brief presentation on our review of state health improvement plans across the country, including healthy people.

Dr. Bauer I turn it over to you, Shane.

Dr. Shane Roberts Thank you, Dr. Bauer.

Dr. Shane Roberts As Dr. Bauer said, I am Shane Roberts. I'm with the Office of Public Health Practice. I'm joined by my colleague, Zahra.

Zahra Alaali Good morning, everyone. My name is Zahra Alaali. I am the Prevention Agenda Coordinator.

Dr. Shane Roberts This afternoon, I'm going to give a brief overview of what the state health improvement planning process is and some background. Zahara is going to give a very broad overview of what the analysis looked like of the fifty plans, the fifty state health improvement plans, and the plan for Washington, D.C. that we evaluated. The state health improvement planning framework is a framework for states to assess health priorities. It's through marshaling a broad coalition of stakeholders and resources and implementing evidence based and data driven interventions. The prevention agenda is New York State's health improvement plan. The reason why the state health improvement plan planning process is important to states is that it is a requirement by FAB for accreditation. That along with a state health assessment and the strategic plan for a health department are three requirements that states have if they want to be accredited. Maintains the guidance for state health improvement planning. Among that guidance, there is guidance for both the shot and the ship frameworks. They provide examples from all states on those aspects. New York State is actually held up as the example for their dashboards within the

prevention agenda. Describes state health improvement planning process as follows. State health departments should address the needs of all citizens. The ship addresses the leading health issues that are identified by the state health assessment. The purpose is to give direction to how the health department and the community can improve health within the jurisdiction. It's really a stakeholder driven process. Stakeholders set the priorities and develop and implement projects that address them. The plan is reflective of the contributions of a multisector team from across the entire state. It is not solely the responsibilities of the health department, but really this broader coalition of stakeholders. The process is really grounded in Healthy People 2030. If you look at Healthy People, 2038, you really think of it. That is the nation's health improvement plan. When we started out to do this analysis, the first thing we looked at was Healthy People 2030. What we really were interested in our what is the goals of this state health improvement plans and what frameworks they're using and then what their priorities are. We use the same sort of lens to look at Healthy People 2030. The vision for Healthy People 2030 is a society in which all people can achieve their full potential for health and well-being across the lifespan, with a mission to promote, strengthen and evaluate the nation's efforts to improve the health and well-being of all people. Healthy People has its own objectives and priorities. Here you can see that there are many, many objectives within Healthy People 2030. They are in five broad categories. Those categories are; health conditions, health behaviors, populations, settings and systems and the social determinants of health. It also really sets aside three priority areas, and those three priority areas are; health equity, the social determinants of health and health literacy.

Dr. Shane Roberts I'm going to turn it over here to Zahara now to give an overview of the analysis.

Zahra Alaali Thank you.

Zahra Alaali In general, we reviewed fifty-one and this included fifty states and Washington, D.C. We assessed them for a goal statement, priorities, guiding frameworks and innovation. For the analysis, we conducted preliminary thematic analysis to identify patterns among these priorities.

Zahra Alaali In this slide, you can see some examples for the goal statements. At the top we have New York State vision for the current prevention agenda cycle. Our vision is New York is the healthiest state in the nation for people of all ages. Apparently, we are competing with California to be the healthiest state. The next example here we have Vermont. Their statement is all people in Vermont have a fair and just opportunity to be healthy and to live healthy communities. Basically, their goals focus on health equity. The best example here we have Mississippi. Their statement is, all Mississippians living healthier, longer lives due to a thriving public health effort supported by active and committed citizens and organization. They focus on the collaboration efforts here to accomplish. Moving to the guiding principles and frameworks. The results shows that the guiding principles and frameworks used for the development, implementation and monitoring varied from one state to another. The majority of the states use the social determinants of health as a guiding principle. This is followed by the second top selected guiding framework was Healthy People 2030. Some states selected different frameworks such as health equity, mobilizing for action through planning and partnership framework, or what is called as MAP. The last example here Collective Impact Model.

Zahra Alaali For the priorities, we identify 253 priorities across the fifty-one plans. We categorize them into forty-seven unique category and then twenty-eight priority is included in two or more. We identify nineteen priorities unique to a single plan.

Zahra Alaali In this table, you can see the top ten selected priorities across all the fifty-one. Mental health was the top priority. 65% have mental health as a selected priority. The second top selected priority was maternal and child health, followed by health care access, chronic diseases and substance misuse. Nearly all included health equity as a central guiding principle in their plans. However, there were nine jurisdictions selected health equity as a separate individual priority. Among the top ten most selected priorities, the table I'm talking about here, half of the priorities were health factors, and the other half were health outcomes.

Zahra Alaali In this slide, we have a map that shows different states, but basically, we identify that different jurisdictions or states have a different focus for their priorities. Some of them, they have exclusive model that focus on health outcomes and others they have exclusive model that focus on health factors. Some states offer a hybrid model of priorities in which they have health factors and health outcomes. If you look at the map, we have red states and we have the blue states. 82%, the blue states we are talking about here have at least one priority that was health fact or social determinants of health. The red states here, it is a total of nine states or jurisdiction use exclusive health outcome or disease model. This includes New York.

Jo Ivey Boufford Can I just stop you for a minute just to get a clarification? You mentioned, what's a health factor versus I understand what a health outcome is, I guess. What's a health factor?

Zahra Alaali We are going to give some examples in a few minutes.

Jo Ivey Boufford It's coming. I have an associated question How are they defining social determinants of health? Maybe you could answer them both later, which is fine.

Zahra Alaali Again, just going back to the last point, we have the states here in total nine. They have exclusive health outcome or disease model, including in New York. It's worth mentioning that the prevention agenda was guided by the county health ranking measures which include both health outcomes and health factors. Meanwhile, the prevention agenda focus only was health outcome priorities. None of the health factors were included in the priorities.

Zahra Alaali Here's a few examples about the health outcome priorities. We have a New Hampshire state. They have a health outcome focused priority, including tobacco control, obesity and diabetes, heart disease and stroke and more eleven priorities, basically.

Zahra Alaali Here is the example of the health factor we are talking about. This is Connecticut. They have health director focus model. The health factor examples here is access to health care, economic stability, health, food and housing, community strength and resilience. Ohio State, for example, has a hybrid health outcome and health factor model. They included different priorities. For example, for the health factor, we have community conditions, health behaviors and access to care. For the health outcome priorities, we have mental health and addiction, chronic diseases, and maternal and infant health.

Zahra Alaali I will hand it back to Shane to go over the recommendations.

Jo Ivey Boufford Can I just again, I just want to raise the question of the distinction between a health factor and a social determinants of health, because to me, they're kind of the same depending on what person's definition you use. Maybe you'll clarify that as well. Sorry.

Dr. Shane Roberts That's a great question.

Dr. Shane Roberts The health factors are the social determinants of health. Health factors are those upstream things that are having an impact on the health outcomes. That language comes from the health rankings model. If we look at the continuum that they have in that chart, which unfortunately I did not include in this presentation, which I should have, that is it starts with the health factors and then goes to the health outcomes. The guidance that is provided encourages states to incorporate both. I think New York State, while it probably is addressing both, our priorities are strictly focused on health outcomes. There are other states that do that as well. We are evaluating these different models as we did the analysis. Some of the states, as Zahra said, really do have a focus exclusively on those health factors, something to that exclusively on the health outcomes. You have states like Ohio here who do like a hybrid model which has a menu of both.

Dr. Shane Roberts Just to summarize the presentation and then we can move onto questions. The planning model encourages a multisectoral collaboration in drafting a plan that incorporates the social determinants of health in addressing and identifying priorities. As we had mentioned, there's a significant majority of states that are really focusing on health factors, at least in part. New York is still a health outcome-based model. What we are recommending is that the prevention agenda is, you know, be a bold and innovative agenda grounded in health equity and built upon a framework that addresses social factors that determine health status. This includes meaningful community engagement. We're really asking, you know, that the Ad Hoc Committee to support the prevention agenda be given a charge to advise the department and how to ensure that health, equity and social factors determining health status are foundational to the 2025-2030, New York State Health Prevention Agenda priorities. That is our presentation.

Dr. Shane Roberts We're happy to take questions.

Jo Ivey Boufford Dr. Bauer, you want to add anything before we end up with questions?

Dr. Bauer No, I think let's jump in with questions and get some input from the Public Health Committee building on the feedback we've gotten from others and the new information that we've just heard about other state approaches.

Jo Ivey Boufford Dr. Watkins, do you have anything to say from Rochester since you've been sitting there patiently? Dr. Watkins, do you want to say anything? You have a question?

Dr. Watkins I couldn't unmute myself.

Jo Ivey Boufford As our local Health Director, we want to hear from you.

Dr. Watkins Absolutely.

Dr. Watkins I see that our priority areas are just health outcomes in New York State. From your investigation, you have indicated that other states are using health factors. Is it your recommendation that we combine the two or that we continue with what we are currently doing, just making sure that those outcomes are addressed?

Dr. Bauer Thank you, Dr. Watkins.

Dr. Bauer We're happy to make a recommendation. We're also eager to hear from the Public Health Committee and from our other stakeholders. I will say just kind of summarizing at a high level, what we've heard from a variety of stakeholders is really engaging and empowering community voices, strengthening the conditions that allow communities to thrive. That really moves us to those health factors. Collaborating with those outside of public health. Of course, we need to be doing that for both, but that particularly calls out the health factors. We heard a lot about supporting rebuilding of public health and public health, trustworthiness, if you will, so that engaging deeply in communities, solving community problems. Many of those are the health factors, the social determinants of health. I'll just mention two more showcasing health equity is something we heard over and over again and addressing historical and contemporary injustices. I think what we're hearing from the various groups that we're engaging with and including some of the discussions we've had with the Public Health Committee is really incorporating those health factors, those social determinants of health and how we do that in a way that's going to help us mobilize and build a constituency around thriving communities.

Jo Ivey Boufford Just to mention just contextually, one of the issues of multisectoral, which I think is really, really important. I mean, one thing to remember in the current structure, obviously these objectives haven't been revised since 2019, 2018, so there's a lot of work that needs to be done whatever the new framework is. I would be interested in your thinking about how to go about connecting to other sectors, I mean, there is the 2018 Executive Order that Governor Cuomo issued that called on all the agencies in the state to really address the issue of the health impact of their programs, their policies and their purchasing actually. That mechanism has sort of been sitting quietly, I would say, since COVID, the onset of COVID, but was mentioned again by Governor Hochul when she sort of launched the Master Plan on Aging process. I didn't know if there was a thought to going back to that group or in terms of the multisectoral approaches. It strikes me that that's going to be pretty critical to getting those broader determinants addressed in terms of community conditions anyway.

Dr. Bauer Absolutely.

Dr. Bauer I think we do have a lot to learn from other states and that's one recommendation that the Health Equity Council made is that we really reach out to figure out what other states are doing. I'll share one example from North Carolina. They have ten objectives, if you will, ten priorities in their state health improvement plan associated with each priority is a community advisory board. The Community Advisory Board is made up of community members. This is statewide. They're a big state geographically as well. It's facilitated by a Department of Health employee, but it's led by an employee of the agency which has the authority to drive that particular issue forward. That could be Office of Mental Health. That could be Department of Housing and Community. Resilience. Could be Department of Environmental Conservation and so on. That's one way to bring in other departments to actually lead the charge on a particular priority of the prevention agenda.

Jo Ivey Boufford I mean, I guess one of the issues would be what exists in New York already. You don't necessarily see that structure is potentially helpful in this process, or it could build on that sort of North Carolina? You could build on it or revitalize it or whatever.

Dr. Bauer We're open to whatever the committee recommends. We're bringing some ideas to the table. We've heard ideas from others. Happy to move forward with your recommendations.

Jo Ivey Boufford Okay.

Jo Ivey Boufford Dr. Lim.

Dr. Lim Sabina Lim, council member and committee member. I just have a question in your analysis of the other states and the other states, particularly where they had that hybrid model. Have you found; however you want to define success, that states that had that hybrid model where there's an explicit focus on health factors or social determinants of health along with outcome measures, were they more successful, less successful? Because it's sort of an interesting way to approach it, right? I think the way we are approaching it is we're addressing social determinants of health and health factors within all our priorities. Did you find that there's a difference in states that have sort of explicitly said, we're going to focus on these particular sets of health factors because ultimately that's going to show up in results in the outcomes measures? I don't quite know if that's not how they approached it, but if you can comment on that.

Dr. Shane Roberts Sure.

Dr. Shane Roberts Thank you.

Dr. Shane Roberts We didn't really look at any way to measure the states as successful or unsuccessful in this analysis. It really was about what their planning process was. I think that because the states are so different it's hard for us to look at that. They measure their success internally. I do think it would be valuable for us to go back and maybe look at the state health rankings and how the states rank compared to their different models. That's something that we're happy to do and bring back. I will say that one thing that is New York did fall in the state health rankings because of the shifting in the way that calculated the more to a health factor-based model. We were I think, what? We were at ten and we were now down it at twenty-three.

Dr. Bauer Shane, I think it's correct to say that many of these shifts were made, a lot of states align with the Healthy People schedule. The shifts would have been made in 18, 19, 20 as they're looking forward to the next ten-year plan. It would be premature to look at outcome data. That is an issue that we have asked as well because of course we don't have data showing the effectiveness of our approach. One of the things we've been discussing with the department's internal steering committee is, how do we evaluate the prevention agenda approach that we take? We certainly monitor our outcomes. Globally, as Shane mentioned, our ranking has fallen, but we don't know how to assess our overall approach.

Jo Ivey Boufford I just I have to say, if we can't assess the ranking of other states, it's hard to say that the prevention studies failed relative to the ranking of New York over the last year.

Dr. Bauer Certainly, no one is saying---

Jo Ivey Boufford Just to be fair.

Jo Ivey Boufford I just think it's important if we want to have an open discussion about models as to what do we know and what worked and what didn't work. I think we're getting good feedback from the users as to what's working for them or not working for them. The comparators are always really, really helpful.

Jo Ivey Boufford Dr. Soffel.

Dr. Soffel Hi. My question is around what you learned, if anything, about how different states think about consumer input and consumer involvement as a stakeholder entity, how they define consumer, how they tap into community to assure that they are getting community input in a meaningful way, whether there's any effort to compensate community organizations for the time and effort that they spend in participating in the process, and whether there are any lessons about that for New York.

Dr. Shane Roberts The process does vary from state to state. That was not part of our analysis. We did review, many different community engagements plans in many different models. I'm not as familiar as Dr. Bauer is with North Carolina, but I do believe that their community stakeholders. These boards that Dr. Bauer was talking about, those are paid members.

Dr. Shane Roberts Am I correct, Dr. Bauer?

Dr. Bauer The members of the North Carolina Community Advisory Boards are paid for the time and of course paid for any travel and associated expenses. They felt reimbursing for time that people invested was particularly important for helping people really fully participate.

Dr. Shane Roberts Again, we did look at the different states. States are required to document their community engagement process just as New York does. We do have access to that documentation. That's all public. That is an area whereas we continue to work through this process with our own work with the Ad Hoc Committee, that we will be looking at other states to determine the best processes that that we can use to help New York.

Jo Ivey Boufford Can I build on this Denise's question?

Jo Ivey Boufford It's really, really interesting. Is the North Carolina model, I guess a question about the levels of community engagement? Is the North Carolina model a statewide advisory board for each of the priorities that they've chosen? Is there a more local process in some other states? Because part of what we'd imagined, I guess, for the current structure was that there would be at the local, you know, sort of the county level there would be consortia and partnerships, which we know has been challenging, but challenging between the hospital and health system leadership, which has an obligation to do a sort of community health assessment and develop a service plan with the local health department and has a similar obligation and bring other stakeholders in. It's much harder to without. We haven't had a lot of the technical support for that process. I guess I'm interested in the local versus state level engagement, I think to follow up on Denise's question, because it's really intriguing and interesting.

Dr. Bauer Thank you for that.

Dr. Bauer We do have a local process, and North Carolina does as well as I understand it. As I mentioned, each indicator has that statewide community advisory board. It's really at the state level to drive both the policy agenda as well as the sort of community level interventions. I don't want to get fixated on North Carolina. There are many states that are doing interesting things. It was a good exercise. We thank the Health Equity Council for prompting us to take a look. I do want to maybe draw attention to the community health rankings as kind of a global tracker, if you will, of state progress, because that set of metrics shifted to really focus states more on the health factors. That's one of the reasons that New York declined so precipitously from I think ten to twenty-three or something like that. If we're going to continue to look at those, those rankings we'll want to figure out how do we address some of those health factors, the social determinants of health that drive health outcomes and that we can hopefully intervene on.

Jo Ivey Boufford I just want to get the language straight. What used to be called Index County Health Rankings are Community Health Rankings. This is the University of Wisconsin-Madison that comes out every year by county. That's great. That's really helpful. I can place the health factors there, which there are lots of others, economic and otherwise, which is great.

Jo Ivey Boufford Other observations, questions.

Jo Ivey Boufford Ms. Soto or Dr. Lim.

Jo Ivey Boufford A lot to process.

Jo Ivey Boufford Kevin did Ann Monroe make it up there with you or not? I don't see her.

Nilda Soto I want to share that in my thinking. Reflecting back in the 2019, 2024 process. I had another hack, because I used to be the Chair of the Minority Health Council. There were several meetings that I attended. What really impressed me was the multiple levels of looking at health, whether it was transportation, housing. The various individuals, I mean, you saw the listing. Eighty people would come. For me, it was very impressive that it was not just in part, I guess it comes under the social determinants of health, but how in New York State and all of these individuals and their different roles, expertise were engaged in this process.

Jo Ivey Boufford I think the message is you can't make community conditions change unless you have multiple sectors involved. There's no question about that. Let me maybe push a little bit more on the thinking from the council, the equity council. I'm trying to make sure I get all the new names right about addressing sort of within sort of, I guess, health or multisector related intervention at either state level or local level. I mean, we've been thinking about equity and disparities as a crosscut. Everybody has been not happy with the way it's come out. I think the latest thinking had been to move from what had been largely race, ethnicity driven equity measures to include economic development, but then there was COVID, so we didn't move in that direction. Can you talk a little bit about what they're thinking about relative to the factors in the equity question?

Dr. Bauer I certainly don't want to speak for the Health Equity Council. I brought my cheat sheet of key takeaways from the various groups that we've spoken with. For the Health

Equity Council, I have three bullets, which is prioritizing, engaging with and listening to communities, including indigenous nations, collaborating with those outside of public health to improve social determinants of health. I think to your point, Doctor Boufford, that's built into the current prevention agenda. That's something we're all committed to. The question is, how do we kind of make it happen and empower it to drive change over the six-year cycle? The third bullet was learning from other states that have made more progress than New York in terms of the health rankings.

Jo Ivey Boufford Just to talk a little bit, does the council or does the office have a notion of community-based initiatives around community based equity improvement? Do they have a plan for something to go on in that space?

Dr. Bauer I think this is what we're all struggling with, right? I mean, we all agree we need to improve health equity. We all agree we need to advance the address and improve the social determinants of health. Where we've struggled, I think, is how do we translate that into action on the ground? Potentially we have an opportunity. We have the Office of Health Equity and Human Rights that is really giving a lot of thought to this. We have Healthy People 2030 that invested a lot. How do we move forward addressing the social determinants of health? As we think about the next cycle of the prevention agenda, how do we kind of harvest the learnings from those processes that are still ongoing and craft our prevention agenda in a way that clearly articulates and and operationalize that work? That's what we're struggling with, I think.

Johanne Morne Hi, everyone, this is Johanne.

Johanne Morne Can I add a comment?

Jo Ivey Boufford Oh, please. We didn't know if you were still here. I'm delighted to have you with us.

Jo Ivey Boufford Please comment.

Johanne Morne Thank you.

Johanne Morne I think that, you know, as I'm listening to the conversation, which is a really important one, I want to echo on some of the areas that Dr. Bauer has touched on. I think certainly for the Office of Health Equity and Human Rights, a lot of the work that we're doing really is around the partnership, around community and becoming more knowledgeable as it relates broadly to health in other areas as well. What are the community-based actions that are currently underway? What are the greatest needs these community groups have? I think that to echo the challenge, you know, when I talk with people and they say, well, what is one of your priority goals of this office? It's not only about impacting change, but it's about impacting sustainable change, too, which I think is part of what the challenge of this conversation has been. How do we impact change in a way that's meaningful and more so sustainable? We are looking at a few different things. When we think about the frameworks that any type of state health equity plan would have to be informed by as well as inform. Certainly, we look to the prevention agenda. I think it's very significant for us to have conversation related to the 1115 waiver from Medicaid, recognizing some of the challenges that we have there, but understanding that from a fiscal perspective and in looking at the most vulnerable of communities, the 1115 labor should have the most significant impact. And then, of course, the Master Plan for Aging, which has such a broad footprint. It was interesting in a recent conversation that we were

reminded the Master Plan for Aging is not only for seniors, but that the reality is we are all aging. It is a much broader concept than I think many who are doing the direct work are thinking about. Those are main major frameworks that are impacting our thinking as we think about a health equity plan. In addition to that, you know, we commenced a group. This group started as a result of our immediate work that needed to be done to develop the regulations and guidance for the Health Equity Impact Assessment. The group is made up of key equity stakeholders in New York State. I should acknowledge that on a daily basis we're adding names to this group. At some point we'll have to think about subcommittee because the group is getting larger and larger. However, what our intention here is, is to have a routine place in which we can share the work that the department is doing related to equity and advancement, and also to hear what the emerging and continued challenges are that health equity experts across New York State are seeing and are now working on. I just wanted to add that. I think, again, it aligns with the conversation and certainly the points that Dr. Bauer is making. It's almost that conversation of there is a lot of things in motion, but all of the items in motion depend upon one another.

Jo Ivey Boufford I have just one other question.

Jo Ivey Boufford Are you working with other departments relative to their take on the equity question, other departments in the state government?

Johanne Morne I'm sorry, dates get away with me since COVID. Last month we had our initial kick off meeting. The meeting is an interagency task force on health equity and human rights. I believe at the point of kick off, we had about twenty-five state agencies. Part of the initial conversation was understanding that in order for us to achieve equity, everybody at the table has to contribute, right? Because it cannot only fall to the Department of Health. The Department of Health has a component, but from a resource perspective, an expertise perspective and a sustainability and accountability, the other state agencies, really, we need to work in alignment with them. As I said, we had to kick off meeting it. This group has been very well received. Just as an example, just a week or two after the kickoff meeting, Office of Mental Health held a summit in which they were having conversations related to mental health and equity, as well as looking at continued challenges around structural racism. The summit was dynamic. It also gave us the opportunity to think about this task force moving forward and who needs dedicated seats at the table in order to advance their own agendas as it relates to equity? The simple answer is yes.

Jo Ivey Boufford It's exciting. I want just to add one piece of something to think about, because we've done a... I work mostly in urban health at NYU. We were looking at a sort of multi-sectoral look at equity, not health equity, but equity and asking how does transportation sector define equity? How does a housing sector define equity? Rather than coming at it totally with a health or a public health lens. It's really interesting. There are really interesting differences. It might be something to consider down the road. It's really not necessary putting the health word in, but sort of how do they deal with equity questions? Because I was pretty surprised by some of the responses when it's not only public health deciding what's health equity in that other sector versus them saying, this is the way we think about it. It's just something to think about. It's great that you're having those conversations.

Jo Ivey Boufford Ms. Soto.

Nilda Soto Thank you.

Nilda Soto One of the areas in thinking about this for me is access of professionals, because who's going to be providing these services? We've had major shortages in some of the health professions. Nursing has been chronic. COVID didn't help. If we are looking at keeping New York State healthy, they're going to need multiple avenues. It's just not nurses and dentists and so forth and so on. Also amongst the issues is the distribution of these health professionals. They have shortages throughout the state. New York State has lagged something like Doctors Across New York and Nurses Across New York that has a financial incentive for these individuals to work in certain areas within the state. There is a whole group of New York State individuals who have been historically underrepresented in some of these health providing professions. How do we increase those numbers? How do we compensate financially the individuals who may be interested, but the cost of getting trained? Is there a way to help them get training, their credentials? We provide them an opportunity to enter it. There have been some initiatives that you get a subsidy. We will offset the cost of your education. In return, you have to give the state X number of years of service in your particular area. That may be also helpful. I just finished retiring after thirty-three years at Albert Einstein College of Medicine and through the Department of Health, they have instituted diversity scholarships for individuals who have done special programs through the Associated Medical Schools of New York. Right now, the scholarship is $42,000. Now, in return, that individual, once they finished their residency and or their fellowship, because we figured if they have an opportunity to go on and get their fellowship. They have to work in New York State full time in an under serviced community. Initiatives like that, in terms of trying to... Because if we're looking at, okay, we need all these professionals, whether it's midwives, whether it is dentists and so forth and so on. Where are they going to get this help? It's like, you know, someone told me, well, now I got a Medicaid card, but I don't have the access to a doctor. I think it's one of your reports. You're waiting three to four months to have that initial appointment. My whole point is that in looking at improving the access, we need to look at what's the workforce.

Jo Ivey Boufford Is there a group looking at workforce? This has come up over and over. I've not saying specific to part of this agenda. It would be a little bit overwhelming. Has raised this workforce issue. I know there was some earlier.

Dr. Bauer Not on the public health side, but certainly on the primary.

Jo Ivey Boufford Because the workforce issues in public health are not trivial either, obviously. It's an ongoing saga here. I guess we'll have to keep it in mind.

Dr. Bauer I want to raise a slightly different issue, which is and I'm thinking about the meeting we're going to have this afternoon, John, of which is how the Medicaid managed care plans play a role in thinking about preventive health care in New York State. They get paid an enormous amount of money. They are tasked with keeping people healthy. They are responsible for the health care delivery for over seven million New Yorkers. I don't see them being brought into the conversation A or B, being challenged with improving their own outcomes for their own members and doing a better job at saying here's what our prevention agenda looks like, here's what our health equity agenda looks like. Here are the things that we are doing for our members proactively to keep them healthy and to act to respond to the health care crises that we see across the state of New York. I think that it's really easy to disconnect the public health function and the Medicaid function, but they really must be integrated.

Jo Ivey Boufford I think it speaks to Dr. Bauer's notion about the waiver or I guess it was Johanne mentioned. The waiver is very relevant. I don't know if we know any more about it than we did the last time in terms of who is, in fact, going to hold those funds and how are the funds going to be dealt with relative to broader determinants of health, the social determinant networks or whatever.

Dr. Soffel I mean, we've have taken kind of baby steps now. Health plans have to identify one community health need, identify one CBO that they're going to work with to address community health needs, one particular community health need. It's really been very much baby steps, given how large they are, how many people they're responsible for providing funding and care for. It seems to me that it's an opportunity to push a key player. Certainly, part of the thinking in this waiver, you're correct, Dr. Boufford, is that the health plans were not central to the last waiver. They are going to be much more pulled in this go round.

Jo Ivey Boufford Maybe a set of voices we want to hear from. I think we often leave out the insurers and the payers and health plans. We certainly haven't talked to them about this. I know that North Carolina has a very nice semi collegial payment process, which really helps a lot on the public private sector. Those contextual factors are so important, but that doesn't mean the lessons couldn't extend for sure.

Jo Ivey Boufford Any other questions?

Jo Ivey Boufford Dr. Watkins.

Dr. Watkins Yes.

Dr. Watkins Getting back to the prevention agenda, you've made mention that hospitals and local health departments are encouraged to work very closely together. I noticed that both local health departments have chosen as one of their priority areas chronic diseases. In order to work to reduce the list of chronic disease within a community, it is really important that our hospitals are more engaged with our local health departments. Is that are we getting closer to actual a mandate for local health departments and hospitals to work together in order to move towards these to improve outcomes for chronic disease?

Dr. Soffel Thank you, Dr. Watkins.

Dr. Bauer It's interesting. Of course, we have more hospitals than we have local health departments. Most local health departments are working with a hospital, but only 40% of hospitals are working with the local health department, right? We have more hospitals. I would say our local health departments are very engaged with at least one hospital in their jurisdiction to try to work together to drive whatever change. I think one of the questions we're putting on the table is there are lots of things we can do at the point of care around, for example, diabetes management, cancer screening, better management of high blood pressure. That's absolutely critical to avoiding some of those adverse health outcomes. We also know that we can take a few steps back and we can look at that community context and we can work hard to try to make sure that the overweight and obesity doesn't happen from childhood up through adulthood, or that the quality of the foods that are offered in the communities are healthier. Maybe we can avert some of that high blood pressure and so on. We can take a step back even further and ask, how do we help this community thrive? We have we just heard seven million people benefiting from Medicaid across the state. What can we do in terms of economic development? What can we do? Dr. Boufford mentioned equity across other areas besides health. How do we improve

wealth equity? How do we improve income equity? How do we work with the partners that can do that so that we have thriving communities at the outset? I think those are kind of the philosophical questions that we're wrestling with. Is there an opportunity in the next cycle of the prevention agenda to maybe think about those way, way, way upstream factors? How do we mobilize at the community level? How do we mobilize at the state policy level where we can track from a job opportunity to an outdoor greenspace to healthy foods in the community to lower rates of hypertension and less diabetes and really across that spectrum have thriving communities?

Jo Ivey Boufford There's another point you're raising, though, Kevin, which I think depending on really regardless of the model, the paradigm of the model is this question of sort of obligatory community benefit that nonprofit hospitals really owe the state relative to their nonprofit status. I think that that fits with the state, I mean, arguably to some degree with the state health improvement plan. I mean, that we're talking about the crediting body determining the elements. Legally speaking, I mean, there are as many variety across states in the community benefit obligation the way it's handled. For a regulatory state New York is pretty light touch in that regard. There had not even been, I think previously in the previous model, the will, if you will, to say thou shalt rather than we encourage you to collaborate. Perhaps use the use the health department's community health needs assessment as part of as a basis for collaborative planning. I think the statutory possibilities there could be explored. It may not be in that same, approach or the same model. This question of I think there's a lot of interest in the hospital world of looking at hospitals as anchor institutions and looking at hospitals as potentially critical players in addressing broader determinants of health. We have not really brought that. I mean, I think Denise raises the question of health plans. We haven't really brought the hospital role that more expanded hospital role into these conversations either up to now. I think your point is a really important one, is do we have tools or levers that could improve that collaboration at local level? It may be a vehicle for getting some of these things done.

Jo Ivey Boufford Any other?

Nilda Soto Is that a way to engage the hospitals?

Jo Ivey Boufford The previous waiver actually. The new waiver, the previous waiver. It wasn't terribly successful. I think we were had our eye on Section 4, which was the sort of mandate that each hospital would address a prevention agenda priority that presumably they were working on. It didn't move us very far. It didn't move the needle. I think we're kind of starting over at this point with that. It would be nice to have had a legacy to look at, but I think that's back to Johanne's sustainable question. I think that that's been the problem here.

Jo Ivey Boufford Any other questions?

Jo Ivey Boufford Comments?

Jo Ivey Boufford More fodder for the conversation, I think for moving into July. Really, really important points. I think more, the more detail you all have from your analysis would be really helpful. I think we've heard perhaps telling us in a more granular level, if possible, about the models for community engagement. You mentioned two or three. Similarly, the equity question to look at that, that would really be helpful.

Jo Ivey Boufford As a committee, we want to ask for any public comment. I see no public here I don't think.

Jo Ivey Boufford You have anybody sitting in the room with you, Kevin, up in Rochester?

Dr. Watkins I'm all by myself.

Jo Ivey Boufford All by yourself. We're so happy to see you, though.

Jo Ivey Boufford I think we don't have any public comment.

Jo Ivey Boufford With that wrap up, I think the other. I want to come back. Johanne mentioned the Master Plan on Aging. We probably won't get into that conversation with Adam, I guess. I think there are a number of similar issues coming up relative to the equity question, relative to community voice, relative to. Because a lot of the healthy, the age friendly models just are driven by the statements of older people and their caregivers. I mean, you don't even start anything. You don't dare started anything in the global approach to older people without having them involved in the first instance. There may be things emerging there that will be helpful. It's still pretty early days for them.

Jo Ivey Boufford Thank you all very much for coming for active participation. Thank you, Dr. Bauer, for you and your team's help in putting this together. Onward to the Ad Hoc Committee, I think.

Jo Ivey Boufford Shall we stand adjourned for lunch and then Dr. Rugge's group will reconvene at 2:00, right?

Dr. John Rugge Yes.

Jo Ivey Boufford Great.

Jo Ivey Boufford Thank you very much.