NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
PUBLIC HEALTH COMMITTEE
AUGUST 24, 2023 10:15 AM – 1:15PM
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
TRANSCRIPT

Dr. Boufford I'd like to call the Public Health Committee meeting to order. We have some of our terrific participants who are on tight timeframes, so we want to stay on schedule. My name is Jo Boufford. I'm Chair of the Public Health Committee. This is the fourth meeting of our committee, post-COVID. I'll stop saying that next time because we'll be on a regular schedule. Our first meeting, going back to March 1st, 2022, we did try to set an agenda for topics we wanted to take up during the course of that next year now moving well into 2023/2024, which included obviously the prevention agenda with the news cycle beginning. The committee has been focused in the past on maternal mortality, wanting to stay abreast of progress in that area, which we had worked on considerably about four or five years ago. The other topics identified were public health workforce, stepping up on the waiver to the degree it had impact on social determinants and the issue of community benefit. We're trying to sort of tick those off as we move through the various meetings of this committee and also the Ad Hoc committee. On February 8th, we had our first committee update. This was this year reviewing the report, the latest reports on the prevention agenda, and also having some initial questions and discussion from the department about their thinking relative to moving how they're going to be. We're conducting an internal review of the prevention agenda, and it's a process. April 3rd, we had our first Ad Hoc committee meeting. There were over thirty organizations present and along with representatives from the Department and Departments of Mental Health and Oasis and NYSOFA, as well as Department of State. It was a really lively kind of relaunching of that ad hoc process and really orienting everyone to the progress on the prevention agenda since they had met last. June 26th, we met as a committee. We did have a terrific update on maternal mortality from Kirstin Siegenthaler and her team. We had a number of follow up questions that we're going to give her. They were a bit jammed up this time, so we'll have them meeting with us at our next meeting to give us a continuing progress report, not only on the work of the department but also the Governor's commission. We had a really nice presentation on the Equity Impact Assessment. Happily, Johanne Morne who's now been moved into Executive Deputy role, Commissioner role has been with us from the beginning, really looking at the prevention agenda next cycle. We further discussed the department's progress on it and had a nice internal review of a look at the other state health improvement plans. The prevention agenda is essentially New York State's health improvement plan. We're able to look at what some other states are doing, begin to develop some themes, and we'll have more on that in future meetings as the staff really look through hundreds of pages and came up with some really nice top notes, but we'll have more to explore. July 13th, we had our Ad Hoc committee meeting, and we have two more of those scheduled before the end of the year. I just want to say, because some have asked me, we're trying to develop a regular schedule for the Public Health Committee. Unfortunately, Committee Day is pretty much occupied by our colleagues on the Establishment Committee. It's really unpredictable. I don't think any of us would want to be meeting after them on a particular day. We're going to be working on figuring out as we would have had to do sort of days other than on Committee Day and we'll notify you as soon as we are able to do that. The next Ad Hoc Committee meeting will be September 21st, I think it is.

Dr. Boufford Is that the date?

Dr. Boufford In New York City. Colleen's going to make it work, even though we have some concerns about the IT systems and other things, but hopefully that'll happen. Today's agenda is we're going to sort of reprise where we're going to go. There's sort of two parts to it. One is sort of continuing our work on oversight of the prevention agenda, which is our primary responsibility, but we're also introducing a return to what we had been, which is we always pick a topic, one other topic of significance every year to work on. Maternal mortality was one of those. I think we can be quite proud of the work that's done, has been done there and what it triggered, which is our hope to use this kind of public platform to bring attention to key issues. It has been proposed that we take up the issue of public health workforce as our issue, which we know is incredibly complicated and incredibly important. We'll have a discussion on that later for your discussion and decision on how to take it forward. We also have a presentation from our colleagues at NYSACHO from Molly Fleming, I think, who's from NYSACHO and we're delighted always to have Sarah Ravenhall with us as back up and for questions. They'll be really talking about their assessment of the prevention agenda from the local health department point of view as we did at the Ad Hoc meeting, really having the same kind of reflections from mental health and Oasis and NYSOFA. I think I'm going to come back to that a little bit later on so as not to delay the process. We'll start obviously hearing from Adam, Adam Herbst, who's the Deputy Commissioner running the Master Plan for Ageing, which is kind of working in parallel in a very kind of similar time frame. There is a committee focusing on prevention and wellbeing out of that Master Plan and Adam will talk about that and how it might link to our work on older people and then finally we'll have a presentation by Shane on some options for the next round of creating that prevention agenda and then we'll hear about the workforce issues. I think if Adam is ready, let me just... I'm sorry. I was going to delay but let me just take two more minutes. I had skipped over my notes on the Ad Hoc committee. I wanted to mention a couple of things that happened that I think contextualize this discussion. One was we had a really terrific panel of OMH, Oasis, and NYSOFA who have been our core partners in the prevention agenda from the beginning. I think it's really important to remember that we have goal four is around mental health and wellbeing, which has sort of been developed in conjunction with the Office on Mental Health and Oasis. We also added a crosscut attention to older adults, older persons in the last prevention agenda on each of the relevant priority areas. We've had them involved with us from the beginning, and I think the takeaways for me from their presentations were one, is they had felt that the work on the prevention agenda had really helped each of their agencies increase their focus on prevention, obviously doing it in their own ways, but many of them had actually developed prevention units in their departments and were really much more attending to it. A second take away, I think was really dramatic increase in their cross-agency collaboration. Each of them obviously working together, more collaborating more at the state level around the prevention agenda in around cross-fertilization across their agencies and also at the local level with their area offices on aging, the local mental health and Oasis field infrastructure and working with local health directors as well. Obviously, that varies from county to county, but it was a really important emphasis of the value of that from their point of view. They also talked about really beginning to do some important data sharing around the integration of health status, mental health status, the issues of addiction and others, which are huge problems in New York. I think we talked a little bit about, as I mentioned, the other health plans which was reviewed. I think the other issue that came up, which we have not really addressed because we were trying to stop at the doorway to the clinical enterprise is the issue of access to care. It came up sort of repeatedly. Suggestions made that that might be added to a dashboard or a tracking activity, looking at the access to these various kinds of care.

Dr. Boufford With that, I think we're ready to now hear from a collaborative effort that the Health Department is leading with NYSOFA, and welcome Adam Herbst. Let me ask Ursula to comment, please.

Dr. Bauer Thanks.

Dr. Bauer Good morning, everyone, and welcome. Really great to have you here and thank Dr. Boufford for your leadership. Looking forward to Adam and Molly and Sarah to our presentations today and driving forward our prevention agenda work and the topical areas that the committee is interested in. Welcome, everyone, and thank you.

Dr. Boufford All right, Adam, over to you.

Dr. Boufford We can't hear you.

Dr. Boufford There you go.

Dr. Boufford Now you're okay.

Mr. Herbst Can you hear me okay?

Dr. Boufford Now we can.

Mr. Herbst Good morning. I was just saying thank you. I appreciate the opportunity to speak. I think there is, like you said, Dr. Boufford, a lot of crossovers in the work in the Master Plan for Aging with the prevention agenda. I look forward to going through that with you this morning. We do have a slide deck. I believe someone will be pulling that up momentarily. While we do that, I'll just do some high level. New York's Master Plan for Aging is reflective of the aging and changing New York. New York's over 60 population is projected to diversify and grow faster than any other age group in the state. We see demographically, by 2030, we will see double the number of New Yorkers who will be considered older adults, making up one quarter of our state's population. Our state's first Master Plan for Aging that the Department of Health and the State Office of Aging are helping to co-lead, together with twenty state agencies participating and the private sector affirms the priority of the health and well-being of older New Yorkers and people with disabilities. It is a blueprint for state government, local government and the private sector to prepare our state for the coming demographic changes and continue New York's leadership in aging, disability and equity.

Mr. Herbst Are we able to pull off the presentation? If not, I can just simply talk whatever we prefer.

Dr. Boufford We have a printed version of your presentation, so if you'd like to refer to it, it's fine.

Mr. Herbst Thank you.

Mr. Herbst If we can start then with the first slide.

Mr. Herbst Governor Hochul signed Executive Order Number 23 on November 4th, 2022, establishing the process to build New York's first Master Plan for Aging. The purpose of the master plan, as I said, was to create a plan that includes a series of strategies and

interconnected policy service proposals to be implemented at the state and local levels through legislation, regulation and private public partnerships. The plan is intended to be comprehensive and a living document to build a framework to support New Yorkers as we age. It's intended to be a public health document in many respects, and we'll talk about that today as a coordinated effort that will provide a response on the necessary scale. We've been given the opportunity to detail strategies and partnerships across the state that are critical to promote healthy and equitable aging for all New Yorkers. Let me just be clear. Aging New Yorkers does not just mean New Yorkers over the age of 60. We are all aging New Yorkers, regardless of our age. That is why the Master Plan for Aging transcends so many different sectors and populations of our state. We can influence the lives of aging New Yorkers, which all of us are, by ensuring that we're able to live fulfilling lives in good health with dignity and the opportunity to age in place for as long as possible.

Mr. Herbst Thank you for whoever brought that up. I appreciate that.

Mr. Herbst If you can go to the next slide, we can just see some of the demographics that I mentioned before.

Mr. Herbst New York needs a Master Plan for Aging now. I mentioned quickly, by the year 2030, we're going to see the population being a quarter of the state over the age of 60. Most New Yorkers that 70% are over the age of 65 will need some type of long-term care setting, according to our data. At any given moment in time 80% of New Yorkers over the age of 65 are not in a long-term care setting. That's why we care about more than just medical care as part of the Master Plan for Aging. That's why we're having so much overlap with the conversation you'll have today. Medical care is just a big part of the master plan, but not the only part. We will talk about housing, transportation, technology, caregiving, financial supports and many, many other areas that we'll talk about in this conversation this morning. Aside from the obvious demographic reasons for the master plan, the other reasons that we need a plan are because we have a culturally diverse state, Upstate, Downstate, in different communities, and the longevity of our population will continue to change. That is why we have a very diverse state that will live longer and will contribute to our state in new ways, untold ways continue to make our state a vibrant place. As we see our state aging, we'll also share in the challenges across the decades with more people staying in the workplace, more of our neighbors living alone, and too many of us enjoying less economic security than in past decades.

Mr. Herbst If we can get to the next slide, please.

Mr. Herbst Thank you.

Mr. Herbst I mentioned quickly, just, you know, we take great pride in being an age friendly state in New York. In 2017, New York was the first state in the nation to be recognized as an age friendly state by the World Health Organization, a global network of age friendly cities and AARP's network of age friendly states. New York is the first age friendly state in the nation because of our prevention agenda, because we have a diversity and magnitude of outdoor spaces and buildings and transportation. We have housing opportunities that other states do not have. We have quite a bit of social participation. We really think in New York we respect social isolation more than other states do. This is something that we're going to develop and build out more as part of a Master Plan for Aging. Our work and civic engagement and our communication and community services help lend itself to helping New York become the first age friendly state in the nation. The Master Plan for Aging will build off our state successes and healthy aging, emphasizing

aging in place and improving the lived experiences for all ages. We're going to foster the policies you see on this slide here and the service that meet the needs of aging and disabled New Yorkers. We have a bold agenda. Our agenda for the master plan will include factors that impact transportation and housing, like I mentioned, and funding like Medicaid and Medicare, and offering meaningful choice for those who want to remain in place and age in their community where they live. We see rising use of health care services of people who age, and obviously those create challenges downstream with workforce and caregivers, both informal and family caregivers. We want to ensure that we are at the heart of looking at social isolation as people age. With that, the foundation, the landscape for our work is integrating many of the age friendly community health systems and the ideas that you see on this screen here. We look at fair pay, working conditions. We are taking a person center planning approach. I mentioned before, we're taking a public/private approach to have partnership to support aging in place.

Mr. Herbst If we can go to the next slide, please.

Mr. Herbst We are laying the foundation for change. I mentioned this already. You know, the structure of our master plan will really ensure that we're integrating the age friendly community health systems and having a seamless system of care across different settings. Again, it's important for us to use this bold agenda to ensure we're meeting the Governor's request for a successful first master plan for aging.

Mr. Herbst Next slide, please.

Mr. Herbst You'll see that I wanted to organize the organizational structure of how we built out an ambitious group of diversity and opinions. The organizational structure was predicated on the Executive Order that established two oversight bodies that are charged with the development of the master plan, a state agency council that's made up of the twenty state agencies and the two offices within the Governor's office and the New York City Department of Aging on the one side. On the other side, we have a stakeholder advisory committee that consists of thirty representatives from the private sector who have expertise in the aging and disability communities. The New York State Department of Health and the State Office for Aging are responsible for coordinating the development of the master plan. What we've done is we developed eight subcommittees to help ensure that we are looking at the breadth and scope of aging in long term care. That's why you see these different subcommittees and I can read them out to you; the long-term care services and supports, the home and community based services, informal caregivers, formal caregivers, health and wellness, housing and community development and transportation, safety, security and technology, and of course, economic security. We have developed within each of these various eight subcommittees three to six workgroups to address the discrete issues that make up the broader topic area. The work groups do most of the detailed work of engaging with specific problems and developing the solutions that are then vetted with the respective subcommittee members. We're also planning public engagement in the form of town halls, listening sessions and surveys. Upcoming listening sessions actually are being held today in Syracuse. We'll do some in Buffalo and Amherst. We've done town halls already in New York City and Albany and in Plattsburgh. We're planning future town halls in Buffalo, in Long Island and again in New York City and across the state. We're also launching surveys. Our first survey launched in March for provider organizations. We received almost 1,000 responses. Our public survey that will launch at the end of August will help us recommend additional strategies and policies to develop the master plan. As previously mentioned, we have eight subcommittees. We believe that

each subcommittee has been critical to ensuring that we have an age friendly approach and that we are really looking at the diversity and scope of our work here.

Mr. Herbst Next slide, please.

Mr. Herbst I just went through the subcommittees. You can go to the next slide.

Mr. Herbst The pillars that support the master plan, again, these are the areas that reflect our subcommittees. These are the foundation to the work that we are all doing. The preliminary report that many of you are familiar with, we delivered to the Governor two weeks ago. It's still with the Governor right now and hopefully will be released to the public in the coming weeks, offers these foundational pillars to support our work in the subcommittee's development of the recommendations for each of these pillars. Each pillar you see here is critical to the development of the different areas of the master plan. We've been very aggressive ensuring that we meet all of the different areas within these different pillars to promote aging and disability, systemic change and opportunity in our state.

Mr. Herbst If we can go to the next slide, please.

Mr. Herbst This is our timeline. We've already met some milestones. I mentioned we delivered our preliminary report to the Governor two weeks ago, and we're continuing our public engagement. In early 2024, hopefully in January 2024, we'll have a draft final advisory report that will once again go to the Governor. We hope one year later, towards the end of 2024, early 2025, we'll have the ability to adopt our first New York State Master Plan for Aging. Really, again, I want to be very clear that this is a living document. It's intended to be relevant for years to come. Although we will deliver a final report, as you see here, we will continue to measure our success of the master plan against a series of key indicators on an annual basis and with the Department of Health, with our partners at the State Office of Aging and all the other state agencies who are involved will work together to share an annual report with updates and improvements to the strategies and recommendations that we at the state need to pursue. That's why public and private engagement are critical to help us continue to guide us, and we encourage you to stay involved as this is a final call to action with accountability for all of us. This is just a journey that is only the beginning for hopefully many years to ensure that the master plan stays relevant.

Mr. Herbst Next slide, please.

Mr. Herbst Most importantly, and I'm almost done. How can you help us? How can you help us develop a successful Master Plan for Aging? I mentioned that we are having a public survey. We're doing quite a bit of public outreach with town halls and listening sessions. We're engaging with every community across the state. We're doing so in various ways. We want to hear from everybody so that we are as inclusive as possible. Really equity is an absolute critical aspect to the Master Plan for Aging. I encourage you to come to some of our town halls and our listening sessions, which we've been advertising both on the master plan website and also, it's been on social media and continue to email us. We receive emails all the time. We have a team dedicated to responding to our emails to help ensure that we really are listening and engaging to be as age friendly as possible. I believe together we can build the age friendly New York that every one of us deserves. That's why New York's Master Plan will hopefully get us there. Thank you for the time today. I look forward to answering any questions and working with you over the course of the next couple of years.

Dr. Boufford Thank you, Adam.

Dr. Boufford I wanted to to add a little bit to get you to maybe elaborate a little bit on the issues that are potentially quite complimentary and integrated with the work of the prevention agenda going forward. There is a committee on health and wellness, which you mentioned. I wanted to indicate to folks that I'm co-Chairing that committee with Dr. Linda Fried from Colombia, and there are five working groups under that committee. One is cognitive health, which is dealing with Alzheimer's and other dementias. The second is mental health and substance use disorders. The third is nutrition and food insecurity. The fourth is Medicare and Medicaid and other preventive benefits that should be available to older persons. The fifth, the final one is sort of broader prevention, general prevention and promotion of health and mental health and wellbeing, using especially a community approach. We're heavily using a prevention approach. Dr. Fried's team has identified the fact that the master plan so far in New York State is the only one that has a significant public health and preventive element and aspect. I know that was featured at least in the preliminary draft that went to the Governor. Adam has been incredibly generous and really supporting that approach. It's challenging as you might imagine, but it's really alive and well. I want to ask you maybe to elaborate a little bit on that, how you see that from the point of view of sort of managing this complicated initiative.

Mr. Herbst Complicated is the key word there. I appreciate that. I think that that is something that we have been highlighting that really makes New York's Master Plan stand out from other states with the federal government and other local jurisdictions are doing. What we're considering is that age friendly approach, that public health perspective. That's why the policies and recommendations that will hopefully cross over with this group. It's important for us to stay focused on partnering and hearing the issues that we want to do together. Dr. Fried has been generous with her time and her data in collaborating with us in offering some of the issues that we should focus on that will make New York that much more unique with respect to access and quality composition of ideas like home and community-based services, ideas like caregivers. Again, we were unique in New York to split caregivers in our work into formal and informal caregiving in our subcommittees that focuses on both training and support and compensation for the formal and informal family unpaid caregivers to define both is something that we have been very careful in ensuring as we look at our state's economy, our community based organizations, our not for profits, our faith based organizations, aging service organizations, and again, health care and long term care settings. These ideas are helping us focus on issues that are quite unique and again, I think will benefit us as we get to the final recommendations in our report to the Governor next year. Health and wellness and the corresponding work groups focus on areas including mental and behavioral health, which again, although was focused in some other states like California and others, we are going deeper. We're looking at substance use disorder. We're looking at other dimensions and nutrition and general wellness, including, you know, like you said, Dr. Boufford, Medicare, annual wellness benefits, chronic disease, self-management and other evidence-based interventions to sustain and improve health and quality of life for aging and older New Yorkers. I also want to highlight the housing subcommittee is critical to this as well. In New York, housing is so important to wellness. The corresponding workgroups are focusing on, on quite a bit of the housing challenges that we have in our state and the environment that impacts health and well-being as we age and the disability spectrum and addressing the interrelated issue of housing and transportation in both urban and rural communities. That's why we are very excited about getting this breadth of different ideas that again overlaps with this group

today. We're eager to get your input as you help co-lead this subcommittee with Dr. Fried and really helping to move the needle here.

Dr. Boufford Thanks.

Dr. Boufford Questions from the committee members.

Ms. Monroe I have one.

Dr. Boufford Yes, Ms. Monroe.

Ms. Monroe Good morning, Adam. It's Ann Monroe. I am part of the work groups that are working. It's really a good experience with my colleagues. We're going to be moving things up the ladder, if you would, to the higher levels. I'd like you to think about and the Public Health Committee, I think, is also involved in something like that. I think there needs to be an overarching campaign against ageism. We have a serious problem with dollars being devoted to older people. There's a phrase that I've heard over and over that money for children is an investment and money for older people is an expense. I think if we're really going to be successful, I think a campaign to kind of fight ageism, maybe even ableism, but certainly ageism needs to come at a higher level rather than in little pieces that come up through the groups. I'm wondering if there's an opportunity for the two groups to cooperate on something that might be a real public awareness campaign or attitude change, change the narrative around how people look at funding for older people, how they look at what they contribute to the community, and really work to change that attitude. Because without that, I'm worried that all of this will fall into the budget process and all of that. We won't really have taken the major step of changing people's attitudes towards aging in the public health arena. I guess it's not a question. Do you have any thoughts on that? Do you see something like that being additive at the higher levels of the MPA so that it has broad application across the state and the Public Health Committee and department could be part of that?

Mr. Herbst Thanks, Ann. I really appreciate that. We have discussed this as part of our strategy. Let me first respond that the Governor in the last two state of the states has mentioned this in her address. We want to ensure that ageism is tackled. The Governor has been very clear about that in the last two years. That has trickled into our work in the master plan. When I talk about the unique opportunities, you know, we see the diversity of New York and we see that there needs to be a framework that really responds on the necessary scale that details strategies and partnerships to battle ageism. It's not something that we can do at the state level alone. This is where we need the partnership of many people in the private sector and the local governments to promote different approaches to battle ageism, which we see playing out in different ways across state and different communities. We can have, you know, quite a bit of a conversation about the different communities and ageism, and it's being magnified and was magnified, I believe, during COVID, which disproportionately impacted aging New Yorkers. I think that that only, you know, created more urgency for us to look in magnifying the idea of ageism. I appreciate the flag. It's something that the Governor has spoken about and we continue, again, to put that as part of our strategy in the master plan.

Dr. Boufford Thanks, Adam.

Dr. Boufford Dr. Soffel.

Dr. Soffel Thank you.

Dr. Soffel Good morning. Denise Soffel, committee and council member. I am struggling to understand what it is. Maybe I'll have a sort of a block. Could you talk a little bit about the level of specificity that we are going to see in the master plan? Will it have a particular articulated legislative agenda? Will we see items in the Governor's budget this year or next year that specifically say this is being driven by the Master Plan on Aging? Will you be looking at regulation that could be revisited and revised specifically, or is it more broad brush we're marching in a direction?

Mr. Herbst Thanks for that question.

Mr. Herbst Well, first of all, we're not finished with our report to the Governor. Our recommendations at this point are going to be somewhat tenuous with respect to this coming budget cycle. That being said, there is a lot of thought in partnering some of the ideas that we hope to put together for the master plan into the experience of this year state of the state and budget cycle. There will be regulation recommendations. There will be legislative recommendations. All of that is critical. It's also important for me to highlight, again, the groundswell of consumer advocate and public support, which is going to be critical to making this a comprehensive plan. It can't just be at the state level where the Governor, the arm of the Governor or the executive branch can solve the work that we want to do here. We're calling for the development of the master plan to get everyone involved. That, again, is the consumer and the advocates and the public that have been really informing us and coming together as experts, subject matter experts to help us develop a roadmap which will impact, I think, industry in many ways. Part of our town halls and our conversations are with different sectors. We're going to be meeting with the health system sectors. We'll be meeting with the payers. We'll be meeting with transportation companies and technology companies. We hope that the master plan creates a comprehensive road map for New York that will impact more than just our state's budget cycle, our state legislative and regulation. That also includes local and the national working together. New York has a lot going on with respect to some work in the federal level, and that will hopefully be developed as part of the master plan as well. That will, I hope, answers your question to help us improve where New York is to address the work that we hope to accomplish in building a better system of care and more inclusive communities for tomorrow.

Dr. Boufford Other questions.

Dr. Boufford Great.

Dr. Boufford Thank you so much, Adam, for coming in. We'll have you back later maybe towards the end of the year to hear how that end report is going. Thanks very much.

Mr. Herbst Thank you.

Dr. Boufford I'll add to Denise's question. I can tell you from being on one of the subcommittees, the guidance to write up your recommendations includes all of the above that you mentioned. It's a really important point and a good question.

Dr. Boufford I think we're ready to hear from our frontline troops here from the local health departments. This is, again, a continuation of the panels that we've been hosting to get

feedback on the prevention agenda as it has worked with different agencies and now with local health departments. We appreciate your coming and turn it over to Molly Fleming.

Ms. Fleming Thank you for sharing my slides.

Ms. Fleming Thank you, Doctor Boufford and Dr. Torres and the Public Health Committee for inviting us to speak today. I am Molly Fleming. I'm a Senior Program Manager at the New York State Association of County Health Officials, also known as NYSACHO. We are the Membership Association for all fifty-eight local health departments in New York State. You do have a printed version of these slides. I just want to note a few of the slides have been taken out of the presentation I'll be doing today, but they just have some additional information you can look at.

Ms. Fleming Back in July, NYSACHO worked with the Office of Public Health Practice to develop this survey, which was distributed to local department leaders and their staff leading the CHA locally in order to vendor better understand local health department perspectives on the 2019 to 2024 prevention agenda cycle and to understand their priorities and feedback moving forward into the next cycle. Since local health departments are one of the primary stakeholders involved in the utilization of the prevention agenda, we are hoping some of these suggestions will be incorporated by the Public Health and Health Planning Council and Public Health Committee as the next iteration of the prevention agenda cycle is being developed.

Ms. Fleming Next slide.

Ms. Fleming For some background, community health assessments are a core public health service, meaning local health departments are required in statute to complete a community health assessment, which a community health improvement plan is wrapped into, and then submit it to the New York State Department of Health in order to be eligible for state aid funding.

Ms. Fleming Next slide.

Ms. Fleming Now, to get into the makeup of our respondents. Overall, we had a really good respondent response rate with 53 out of 58 local health departments, or about 91% responding to the survey. There was a good response rate across regions with 100% of counties from Western New York, Mid-Hudson, Long Island and Central New York responding to the survey. Every other region had at least over 80% of counties represented. You can see on the right graph; the overall respondents were pretty split evenly by region.

Ms. Fleming Next slide.

Ms. Fleming Looking at the makeup of respondents by population served, we had a good response rate across county population sizes as well. 100% of extra-large and large counties completed the survey. Over 80 and 90% of small and medium counties respectively completed the survey. When you look at the right graph showing the overall makeup of respondents by county size, you can see that small counties, even though they have the lowest response rate, they made up the majority of respondents simply because there are more small counties in New York State.

Ms. Fleming Next slide.

Ms. Fleming Finally, looking at respondents by service level. Local departments can either be a full or partial service. Full service, health departments offer environmental health services, whereas impartial service health departments, environmental health services are provided by the State District Office.

Ms. Fleming On the left, we can see that we again had a good response rate from both full and partial service health departments across the state, though there are more full-service health departments in New York State and so they made up the majority of responses.

Ms. Fleming Next slide.

Ms. Fleming Now, to get into some of the local department feedback on the previous prevention agenda cycle or the one that's still ongoing from 2019 to 2024.

Ms. Fleming Next slide.

Ms. Fleming Looking at successes in the 2019 to 2024 prevention agenda cycle, the most reported successes from local health departments were engaging community members and raising public awareness around priority areas. With over 80% of respondents indicating that they had successes in those areas. That was closely followed by engaging new or strengthening existing partnerships with over 79% of respondents having successes there. Only one health department indicated that they had none of these successes during the 2019 to 2024 prevention agenda cycle. Open ended responses. A major theme that emerged was that the pandemic had created more opportunities for local health departments to work with their community partners and stakeholders, with many local health departments highlighting that they were able to strengthen preexisting relationships with partners or expand the partners they worked with during the pandemic.

Ms. Fleming Next slide.

Ms. Fleming Regarding challenges experienced during the 2019 to 2024 prevention agenda cycle. By far, the most commonly reported challenge was pandemic response with over 90% of respondents saying that the pandemic had some impact on their prevention agenda work. Other frequently reported challenges were lack of resources and funding and the negative impact of the pandemic on outcomes. Open ended responses. Staffing, both for local health departments and their community partners was commonly cited as a challenge. In particular, high turnover in partner organizations made continued engagement difficult for local departments, and other challenges associated with partner organizations included managing competing priorities, engaging partners virtually, and a lack of understanding of what the prevention agenda is.

Ms. Fleming Next slide.

Ms. Fleming We also asked local departments about what partners they engaged during the 2019 to 2024 prevention agenda cycle. Overall, the top five engaged were community-based organizations, hospitals, local departments of mental health, mental health and substance misuse and prevention and treatment programs and K-12 schools. While hospitals were reported as one of the top partners engaged, it should be noted that in open ended comments some local health departments did indicate that there is a lack of partnership between hospitals in their jurisdictions. This is a regional trend. Less than 50%

of local health departments reported working with their federally qualified health centers, academia, employers, media, advocacy groups or transportation. Those were the least engaged to the partners we asked about.

Ms. Fleming Next slide.

Ms. Fleming The survey also asked respondents to rate their experience in the following areas listed in the slide on a scale of poor, fair, good, very good and excellent. This graph here shows in each of those areas we asked about the percent of respondents who ranked as each of those levels. The most favorably ranked experience overall was collaborating with diverse community partners, with the highest percentage of respondents who ranked it as either excellent or very good at 48%. Knowing about evidence based and best practice interventions was also favorably ranked, with 46% of respondents ranking it as either excellent or very good. Interestingly, though, adapting evidence based and practice interventions in our community was less favorably ranked, with 48% of respondents ranking it as poor or only fair, showing a need for more trainings on adopting evidence-based interventions to fit the needs of specific communities and populations. Overall, the least favorably ranked experience was achieving improved outcomes in one or more priority area, which had the highest percentage of local departments ranking as poor at 20%. This was likely due to the impacts of the pandemic. Collaborating with policymakers from different sectors, having consistent staff support and connecting with outside subject matter experts also had a high percentage of respondents who only ranked them as either poor or fair.

Ms. Fleming Next slide, please.

Ms. Fleming I also wanted to look at this data a slightly different way, so I gave each ranking a numeric value. I gave poor was one, fair was two, good was three, very good was four, and excellent was five. Using those values, I calculated an average numeric value for each experience to better enable comparison. Overall, collaborating with diverse community-based partners was the most highly ranked, with an average ranking of 3.42 out of 5. The lowest ranked experience was achieving improved outcomes in one or more priority areas at an average of 2.37 out of 5.

Ms. Fleming Next slide.

Ms. Fleming We want to talk about some of the local health department recommendations moving forward into the next prevention agenda cycle.

Ms. Fleming Next slide.

Ms. Fleming In the survey we asked out of the priorities identified in the 2019 to 2024 prevention agenda cycle, which are continued priorities for local health departments in their communities? For all respondents, the most commonly indicated continued priorities were prevent chronic disease at 87% of respondents and promote wellbeing and prevent mental and substance use disorders at 91% of respondents.

Ms. Fleming Next slide.

Ms. Fleming I also wanted to look and see if there were any difference in priority areas by regions. Overall, though, prevent chronic disease and prevent mental and substance use disorders continue to be top priorities across regions. I did want to highlight a few regional

differences that came up. The Capital region followed that pattern, but they also highly ranked prevent communicable diseases. the Mid-Hudson region, prevent chronic disease and prevent mental and substance use disorder were again top priorities, but they also highly ranked promote healthy women, infants and children and prevent communicable diseases, with 85% of respondents saying that those were continued priorities in the Mid-Hudson region. In the Mohawk Valley they had the same two priorities or top priorities. Prevent chronic disease was ranked much higher at 100% of respondents in the Mohawk Valley, saying that that was a continued priority, whereas prevent mental and substance use disorders then went down to 60%.

Ms. Fleming Next slide.

Ms. Fleming Open ended responses. We asked what other priorities local departments have that they would like to see incorporated into the next prevention agenda cycle? Health equity was the most frequently mentioned topic through our open-ended responses with social determinants of health, access to care, health across the lifespan, particularly healthy aging, primary and early prevention and parent education being frequently mentioned key terms, climate change and environmental health were also frequently mentioned as priorities local departments want to see incorporated with tickborne and other vector borne diseases. Wastewater management, extreme heat, wildfire smoke and floods mentioned as priorities. Violence prevention, particularly gun violence was also mentioned by several health departments as something they'd like to see more emphasis on. A lot of the health departments in their open-ended responses really emphasize the need for continued focus on mental health and substance use disorder with a view particularly mentioning suicide prevention as a priority in their county.

Ms. Fleming Next slide.

Ms. Fleming In the survey, we also asked about how progress in prevention agenda priority area should be measured. Twenty local departments or about 40% of respondents said that progress in priority areas should be measured through the same measures and indicators for each local department. Thirty or about 60% said that measures should be individual and set by each local health department. There was no clear majority with this question. In open ended responses comments seemed to support a hybrid approach where the New York State Department of Health would provide a set of indicators for local departments that they could then select from and tailor to their specific community needs and target populations. Several comments also noted the need for better data sharing systems and for local health departments to have access to current data in order to track progress in priority areas. Regarding the ideal number of priorities to focus on, thirty-one local departments or about 60% said that one to two priorities would be best.

Ms. Fleming Next slide.

Ms. Fleming Many of the open-ended comments also mention the need for a longer CHA cycle, with the CHA being completed prior to selections so that communities can understand data that was gathered before local health departments then select their priorities. On the slide, we have a proposed schedule of changes that some of our Downstate counties put together. In this proposed schedule, the CHA would be completed at the end of year one, with a chip coming at the end of year two. A mid-cycle update for the CHA would be completed in year four to align with IRS hospital requirements, but then they wouldn't have to do a completely new CHA every three years. It would be in a six-year cycle. It's important to note that this change would require a regulatory change.

Ms. Fleming Next slide.

Ms. Fleming One suggestion that was frequently mentioned in discussions for updating the prevention agenda was to align it with the National Healthy People 2030 objectives. We also asked in our survey questions to assess interest in using Healthy People 2030 as a model. Overall, 51% of respondents said yes, that they agree with aligning the 2025 to 2030 prevention agenda priority areas with Healthy People 2030 objectives, and the other half of responses were either no or unsure and that they needed more information. We asked about which of the Healthy People 2030 priority areas are priorities in local health departments communities. Overall, the top five were addiction, drug and alcohol use, health care access and quality, mental health and mental disorders and overweight and obesity. These top priorities really follow similar themes that we've seen throughout the survey and in open ended comments that local departments want to see a greater focus on substance use disorders, mental health and wellbeing, chronic disease and primary prevention. If the committee is interested in moving this direction, we do have additional data we collected on Healthy People 2030 objectives to share.

Ms. Fleming Next slide.

Ms. Fleming Overall, working with community partners was both a strength and a challenge for local departments. While the pandemic created more opportunities for collaboration with their community partners and stakeholders, virtual meetings and staff turnover in other organizations really impacted local health department's ability to engage partners. Moving forward, prevent chronic disease and prevent mental and substance use disorders were the top continuing priorities for local health departments throughout the state and local health departments also wanted to see a greater focus on social determinants of health, climate change and gun violence in prevention agenda priority areas moving forward. Other feedback focused on the need for increased collaboration between local departments and other county and state agencies with suggestions to incentivize or require collaboration on the prevention agenda. Many comments also said that a longer cycle is needed, and that the CHA should be submitted before to allow for additional community and stakeholder feedback. A lot of comments mentioned data with the need for improved data sharing across agencies and local health departments having access to current real time data being important. Several comments also mentioned a need for more guidance from the State Department of Health, particularly related to statewide initiatives related to priority areas in the prevention agenda, and how to adapt evidence-based interventions to specific communities and populations. Thank you everyone for listening, and I'm now going to turn it over to NYSACHO's Executive Director, Sarah Ravenhall for some closing thoughts.

Ms. Ravenhall Thank you so much, Molly. That was incredible work. NYSACHO's lucky to have you and your data expertise. Thank you again to Dr. Boufford, Dr. Torres, everybody on the committee and our partners at the New York State Department of Health, Dr. Bauer, Dr. Roberts, everyone.

Ms. Ravenhall Just a few kinds of highlights here. What I'm taking away from Molly's presentation and the data that we've collected from our members. The prevention agenda really is a historic framework. It's been valuable in bringing stakeholders together, and that's what local health departments do. They know who in their community has access to community members. They bring them together. They coalesce around a certain priority. They work toward a common goal. There is no doubt that the prevention agenda has been

useful in that sense. While we're grateful for the meaningful partnerships that have been established in part due to the prevention agenda, our members are definitely open to meaningful change around the prevention agenda and what the next iteration might look like. I think there's the framework of the prevention agenda. It's how we use it and how we make local impact. I think some of the how we use it is where we'd like to see some change. First moving the prevention agenda cycle from no more frequently than every two years, which is what is verbalized in in state statute to every six years as indicated on Molly's slide would redirect time and valuable resources that we spend developing the plan into actually implementing the plan and hopefully moving the needle on some of these priorities. We want to continue working with hospitals, however. That's really important. Our members have said that time and time again. We don't want to lose ground with our hospital partners. We want to continue that effort. Our members also feel that the prevention agenda and in my previous role, I worked at National Suffolk Hospital Council, where I helped to lead the community health needs assessment process in Nassau and Suffolk County. I've seen a few different cycles like the last two cycles of the prevention agenda from start. I've seen that through. What our members are saying is over that time they really haven't seen much of a change in those priority areas. That's something. It takes time to move the needle on these things. While we're not seeing the outcomes that we want to see with the prevention agenda, I think there is space there to recognize that a longer cycle time would be valuable. I also want to just challenge us to think collectively about funding and resources. I know this is something that we've talked about in the past, but particularly for local health departments, right? We often in public health see that funding is disease specific, right, in the way that it can be used. There are restrictions. That's not always state restrictions. It's federal restrictions. It's how these contracts and grants go. Because of this, the funding drives the true health priorities that we're addressing. It limits the local ability of public health professionals to really do what's best for their community and address the true community need. With flexibility and funding and local discretion being permissible, that's really where we're going to make a local impact. That's super important when we're thinking about the next prevention agenda cycle and where we can make a difference. We are so glad local health departments are so glad to be a part of this monumental effort. We thank you for your time.

Ms. Ravenhall Questions for the fabulous Molly.

Dr. Boufford Thanks very much, Molly and Sarah.

Dr. Boufford Are there committee questions? I, as usual, have a bunch.

Dr. Boufford Mr. Kraut.

Mr. Kraut You talk about the priorities don't really change, right? These are the problems that have been around, have been around. We're coming at them with all different angles. When you take a look at the response from the local departments of health they've improved in engagement. There's closer working. Certainly, COVID was an accelerant or a lubricant to do that. Resources are always an issue. If local departments of health had more money, what would they do with it? What would be one, two, three priorities to spend? Would it be data? Would it be engagement? Would it be boots on the ground interventions directly by the department rather than through partners? Just out of curiosity.

Ms. Ravenhall That's a great question and one I have an answer for. It's going to depend on the needs of the community. The first thing they're going to do is higher up that staff to do the actual boots to the ground prevention efforts. They're going to go into homes.

They're going to work with families who have living in older housing stock. They are going to help them, educate them on how to keep their kids safe from lead poisoning prevention. They are going to go out into the community. They're going to do maternal home visits if they feel that that's a need in their community. Make sure new moms and babies are supported in early childhood. They are going to go out and do education. Tobacco cessation programs. Some of them have STI clinics, they have family planning clinics. They're going to provide naloxone training. They're really out in the community and working with community members to do that work. I really, truly feel that if we invest more in prevention up front, we're going to see decreased hospital admissions and readmissions down the road, and we're going to have more success in keeping people healthy and safe.

Mr. Kraut You take that, and I appreciate the answer because it's direct. You can work on water supply and really do think. You're in more of a retail part of health care. It's one on one new moms and stuff like that. If you think about it, you look at the local departments and their budgets. There's some that come from the state. You're at the mercy of local county budgeting. If this money doesn't really come through the state, because... I'm not going to pick... No two counties are alike in their capability. Put New York City you off to the side because it's somewhat of an anomaly in a good way. It's a standard. The issue here is when and I don't know who can answer this and Dr. Bauer, you may be involved. When we're thinking about the waiver that's coming out a lot of this is focused on community-based organizations and the like. Does the waiver anticipate funding flowing directly to the local departments of health, which I don't believe it does. I'm asking a question I already know the answer to. The issue here is, is how do we incent that a little as you create the RFPs that are going to do this? Because there is a value there. Let's face it, they're the first line of defense in a public health emergency. We found how fragile that varied by county. You don't have to respond. It's just an editorial comment I'm making.

Ms. Ravenhall That was well said. We certainly plan to get involved in the 1115 waiver. We're thinking about it now and we're going to insert ourselves. Having conversations with the Department of Medicaid is definitely important. We have a role. Some of the 1115 waiver priorities are what we do right? Emergency preparedness, health equity. We're right there. I know Dr. Bauer probably agrees.

Mr. Kraut You know, of the data that you showed. It was encouraging to see the degree of a high level of engagement with community-based organizations, health providers, hospitals and the spectrum of providers. That's good. We haven't seen data like that in a long time.

Ms. Ravenhall One other thing, Mr. Kraut. You know, local health departments also work with their other local government entities, like their local governmental units, the local mental offices of health, local offices of aging, social services. So, you know, that same network is happening locally within the county government.

Dr. Boufford Ms. Monroe.

Ms. Monroe Thank you.

Ms. Monroe (Phone ringing)

Ms. Monroe I'm sorry.

Ms. Ravenhall It's okay.

Ms. Monroe It's spam.

Ms. Monroe Did I understand you that you'd like to move from a two year cycle to a six year cycle?

Ms. Ravenhall Do you want to go back to that slide with the calendar? It's so helpful.

Ms. Monroe It's a little hard to see it.

Ms. Ravenhall There you go.

Ms. Monroe Well, let me follow up on that, because one of the things that I... The key to all of this in my mind is the impact on the problem. What we saw when you assign numbers to that, that that's the lowest scoring one is actual impact. I agree that if it's a longer time period, we might see that number come up. I'm also concerned that from an accountability perspective, there have to be milestones built in so that it's not a matter of just looking in six years from now, only to hear, oh, we didn't have enough time for impact. If we extend the cycle, if the department extends the cycle, I think there have to be points along the way where progress is looked at or lack of progress is dealt with from an accountability perspective. I'd be worried about a six-year cycle with no outcomes or measurement until the sixth year.

Ms. Fleming In this proposed cycle, local health departments would still do their yearly updates to their chip and there would be a mid-cycle CHA update. It just wouldn't be the full revamp of their CHA. They would still have to work with their hospitals to do an update on their health priorities and what kind of progress they've made in that area.

Dr. Boufford Dr. Bauer.

Dr. Bauer Just to clarify, the indicators would still be reported annually, and they'd be updating over the six years. They just wouldn't have to stop, create a whole new plan.

Dr. Bauer Thank you.

Dr. Boufford Ann's questions really important because part of, you know, there is a connection between the resources available to do the work and the other issues you identify, which is technical assistance on adapting evidence-based interventions to local situations, etc. I think it's all part of the same issue. We have had presentations and I think Shane did one of the earlier was at a statewide level looking at the metrics and which ones were going in the right direction or the wrong direction. When you take it down to the level where it makes a difference, which is at the community level, you've identified where the assistance is needed and especially the degree to which funding has been so historically earmarked around a particular population or a particular disease entity. It's very difficult to have that kind of flexibility and adaptability to do that. I wanted to mention, Dr. Bauer, maybe you have mentioned this in other meetings, but the $135 million that did come through the Biden, I think, infrastructure, I think it was I can't remember which... I never remember which national initiative it was part of, I think was infrastructure, which, as you mentioned, had been directed, I think you said largely at workforce and capacity building, but also there was an earmark of a percentage of it to local health departments. Could you just talk about that briefly, so we know at least that element of the resources, the availability on the issues we're talking about?

Dr. Bauer Thank you.

Dr. Bauer That public health infrastructure grant. It's a five year, $137 million roughly grant in three components. The first is workforce, the second is foundational capabilities, and the third is data modernization. The funding is roughly $126 or $127 million for workforce over the five years, four and a half million or so for foundational capabilities and $2.8 million for data modernization. The $127,000,000 is lump sum funding. That's the entire amount for five years. The other two are annual amounts, the four and a half and the $2.8 million. With that $126,000,000 or so for the five years for workforce, that's really entirely focused on rebuilding the public health workforce with the metrics being hiring people. 40% of those $126,000,000 or so is required to go out to the local health departments. We have put those contracts in place since our budget was approved. Local health departments are in the process of finalizing their budgets and spending those dollars in ways to recruit new workforce and to retain current workforce. There are different kinds of initiatives in terms of tuition reimbursement. If someone wants to go and get their Master of Public Health, a current staff person, training, additional kinds of training and conference travel attendance. This is a surprise from CDC. Even retention bonuses and workforce bonuses to help sustain that existing workforce and a big push toward hiring and bringing more, more bodies into the public health enterprise.

Dr. Boufford The other question I had because this is the who comes to the to the table at the local level is always really, really important and talking about the issue of resources. The business community wasn't listed, and I wondered if you could talk about that a little bit. I know some counties have had some success there, but it has tended to be the least well-developed of the partners at the table. Obviously, there are local resources in local businesses because they have an investment in their communities actually. Could you talk about that at all? Did that come up? Or if it didn't, it's okay because it means it's an area we haven't really focused on. I just was curious.

Ms. Fleming Yeah, I'm looking back at that slide the partners engaged slide and we didn't specifically ask about businesses. We did ask about community members. Thirty something of our respondents said that they had worked with community members.

Dr. Boufford Yeah, I was just thinking about the resource possibilities there.

Ms. Ravenhall I actually think now after COVID, post-COVID, there is a huge opportunity because the businesses saw the impact of public health on the economy. If now's the time, we need to get out to the businesses and make sure that they're involved to the next local iteration. I do know that some coalitions that work on the prevention agenda together, specifically Long Island, did have the business community involved. They've done a good job there. I do think it takes a lot of work to engage business partners there.

Dr. Boufford We haven't had that much success at state level either historically. We invited the Business Council, but we haven't had them come. That's another challenge in terms of that issue. I just want to sort of reflect on the other resource issues. You mentioned some of them. I mean, obviously other state agencies, Mental Health, Oasis, Aging, have community-based networks of representative services and obviously budget expenditures. I think the more of those links can take place going forward, you know, linked to what Adam Herbst was saying. I know that's coming up a lot in the Master Plan on Aging is that and AG and markets is a very wide representation of agencies in the master plan exercise. It's been interesting in that regard to learn what they can do. This is

all for older people, of course it's specific, but and then the degree to which they work together. I guess the last thing I wanted to raise, because we've talked a lot about the question of, well, environment was very low choice. That's one of the climate changes. One of the areas you identified is we need to get more involved in and how would you think about doing that at the local level, getting more engagement in the sort of environment, climate area from their local health department point of view?

Ms. Fleming We actually know nature has a climate change grant that we have been doing some work in bringing technical assistance to local departments. One of our program managers last Summer did a really good series of webinars on what local departments can do in various areas of climate change. I think climate change, you know, local departments have to set up cooling centers when there's heat emergencies. They have to respond to emergencies like flooding, like the wildfire smoke that this Summer we have seen a lot as they've had to deal with this and inform their communities and provide them with resources and ways to avoid negative health impacts of those issues. Those are all related to climate change. I think moving forward, it's going to continue to be a larger and larger issue and something that local departments have to address in their communities. I think it also goes into the health, the wanting a greater focus on health equity because climate change impacts the most vulnerable are the most at risk from the impacts.

Dr. Boufford Thanks.

Dr. Boufford Other questions.

Dr. Boufford Dr. Yang.

Dr. Boufford I'm conscious of time, but we'll give about three or four more minutes.

Dr. Yang Just very quickly bouncing off yours. I mean, the local boards of health, particularly on the regulatory side for environmental is so strong and has such incredible potential to make community level differences towards environmental protection and prevention. That would be lovely to see some boards really moving towards that, not just an emergency response or climate response, but being proactive, locally understanding all the economic and development issues that need to be considered. If you can do that locally, that is the nexus for actually making a difference. I think that's fabulous.

Dr. Boufford Interesting.

Dr. Boufford Dr. Bauer.

Dr. Bauer Just a quick question. You noted that local health departments supported or asked for a greater focus on social determinants of health, climate change and gun violence. Is that because they're already working in those areas, and they already have resources to kind of drive those forward and putting the prevention agenda framework around that would kind of accelerate that progress? Is that because they're hoping that they would receive some resources and they'd really need those resources in order to make progress in those areas?

Ms. Fleming I think there are areas where they can do some work. A lot of public health is obviously related to social determinants of health and preventing health issues. They work in environmental health, which is related to climate change, but I think these are issues

that they'd like to see greater focus in funding on so they can do even more and really focus on these issues in their communities.

Ms. Ravenhall I think that's spot on. I would also say that they could be working with community partners or other agencies in their local government who do have funding, but I am not aware of any funding where local health departments can take this lump sum funding and put it towards environmental changes. The fact that they're saying like, hey, we need to address climate adaptation means that there is a need for funding in some communities to do this work. I think vector borne illness and tick-borne illness is a really good example of climate change response and what local health departments need to do. They do have Article 6, but that doesn't cover all of it and there are challenges with the tax cap outside of New York City. think that this is an indicator that there is a need for flexibility in funding, in addition and additional funding to deal with some of these issues in that they have interest in doing that.

Dr. Boufford I think we were lucky to have the Department of State. Representatives have been part of this group in terms of the Regional Economic Development Councils as well as the Environmental Justice Initiative, which they're leading. We're going to be hearing from them in the next Ad Hoc committee. I think it's kind of the resources not in that you can tap and get involved in the processes. I think you're working on it really hard and it's really an immediate source. We have to look at some of these others around business. We're going to come to community benefit at a future meeting because part of the notion of working together between hospitals and others is hospitals increasingly sort of aligning their own community benefit investments with these kinds of local health priorities that are part of these partnerships.

Dr. Boufford Any last comments?

Dr. Boufford I'm going to turn it over to Shane, who will do as he needs to do in the next forty-five minutes or so in two sessions. You could just slide between the two if you like. Just tell us what you've made the transition and we'll start talking.

Mr. Roberts I'm going to bring up my slides really quick.

Mr. Roberts Thank you.

Mr. Roberts Again, Shane Roberts with the Office of Public Health Practice. I work under Dr. Bauer. Dr. Boufford had approached us, the Office of Public Health, with the need to identify another priority topic for the prevention agenda.

Mr. Roberts That was the next topic after this one.

Mr. Roberts Sure.

Mr. Roberts The office took it to the leadership. We did discuss some ideas for the priority topic. The Office of Public Health was asked to consider priority topics that the committee might take up with a focus on identifying critical health issues and problems, that the state requires inter-agency work with DOH to work with. Dr. Boufford had given us the charge of really looking at problems that would require us to work with other state agencies and professional associations, businesses, academia, etc. That discussion yielded a number of different topics. The main topic areas were the public health workforce, climate change, public trust in health institutions and science, and then tobacco

use prevention. Further discussion with the office built a consensus around public health workforce as one of the most critical issues faced by the public health institutions across New York State. It's a topic where the committee's ability to elevate and bring attention to issues can really provide benefit. Several factors make the department well-positioned to support the work in its focus area. One is the public health infrastructure grant that Dr. Bauer had just talked about. We're currently also in the process of standing up a workforce division who I hope will be able to present at a future meeting. We've had the success of the Public Health Corps Program, which is currently in the Office of Public Health Practice, and has had, I believe, over 500 successful placements of fellows across the state. We have workforce investment in local health departments through that grant, which Sarah and Dr. Bauer just mentioned. The public health infrastructure grant, the departments received $133 million and a five-year grant from the CDC. It has three components. We have a workforce, which is to recruit, retain, support and train the public health workforce. Foundational capabilities, which is to strengthen systems and processes. Data modernization, which is to deploy scalable, flexible and sustainable technologies. The public health workforce is both a timely and critical issue, both nationally here in New York State. There's been a continued gradual reduction in full time staff and vacancies across the local health departments in New York State. We believe that the topic is worthy of the committee's consideration and that we would benefit greatly from your ability to bring attention and focus to the issue. Implementation of the public health infrastructure grant and the new workforce division and our local partners will also benefit from the committee's focus and guidance on the topic. This is our proposed topic to you all. We're happy to answer questions.

Dr. Boufford Let me just add that I think when we were discussing these. There has been a very recent public health workforce enumeration coming out of the Albany SUNY Department. I think NYSACHO was involved in that with Sylvia and others. We have pretty recent data, at least to know where we stand and where some of the shortages are. Similarly, while there is a gubernatorial effort and budget and investment in health care delivery workforce, there hasn't really been a complementary effort in the public health side. I think I asked and was answered very positively that would be coordinated with the work that's going on, on the health care delivery side so that it would not be cross fertilizing. We'll have a chance to hear about that as well. I just wanted to see if some of the others seemed a little bit harder to reach. In terms of the staff support within the department itself, which obviously is the key for us as a committee. It was a little bit easier to... Not that it won't be a complex problem, but it was a little bit easier to take it forward.

Dr. Boufford Is that okay? Does the committee agree with that generally? Any concerns?

Dr. Boufford I think you have your next priority problem. Next time for the committee we'll look at sort of laying out from your new leadership and others to get started on it.

Mr. Roberts Thank you.

Mr. Roberts I apologize that these were reversed.

Dr. Boufford That's okay.

Mr. Roberts We did want to give a brief update on where we're at with the prevention agenda planning for the 2025 to 2030 cycle. It is a brief update, but we're happy to discuss it in more detail. Since our last meeting, we've had, or I should say since the last meeting of the Ad Hoc committee. We have sort of collected all of the stakeholder feedback that

we've received from the various groups. We've been reviewing them with our internal work groups. We have a steering committee internal to DOH. We also have several workgroups which are working on developing a framework and evaluation plan and then ensuring that there is a structure for the committee to respond to at our next meeting, which I do have listed as October here, but I think that we were able to secure the September date. It will be September 21st. Part of what we've done is to develop a roadmap for having those proposals ready for the September meeting. In addition to that, you know, the Prevention Agenda team met with the Office of Health Insurance Program and their physicians. We did discuss the alignment between the prevention agenda and the quality strategy, which has many similar priorities to the existing prevention agenda now, and also has some of the categories that we are looking to potentially expand into, including access to care. Additionally, we were able to meet with our Regional Coordinator for Healthy People. We had a regional meeting for Healthy People 2030. Our region includes the state of New York and also the U.S. territories. we were able to have a large, long discussion regarding the planning process across our different regions. some of the strategies that could be used in terms of community engagement and also in developing health sector-based priorities. Additionally, we were also able to meet with North Carolina Department of Health Staff to discuss planning, community engagement and plan implementation and utilizing results-based accountability as a framework for developing priorities. North Carolina has been a plan that we've taken some interested in because of some of the innovations that they've used with their community council and also the results-based accountability model that they use for prioritization, which it moves away from smart goals by taking sort of the timely piece off of it as population size problems don't really have timely fixes. That is where we've been at. Where we're at now with the work groups is that we recognize that we have two sort of framework models that we're considering. We have a holistic framework which is a broader reorganization of the priorities, focus areas and goals in alignment with Healthy People 2030 and social determinants of health. It attempts to reflect the changing lens of how public health is viewed and approached post-COVID with an understanding of the importance of racial justice, social and economic factors on health, but it also proposes to streamline the existing focus areas, goals and indicators into something that might be more focused and allow for us to make more progress and maybe in fewer areas versus trying to make progress across the 99 indicators that we currently have. We are also considering an integrated framework. That maintains existing priority structure with integration of the social determinants of health and health factors under the current five headings. It attempts to retain the common language of past iterations of the prevention agenda, which aligns focus areas and goals with the social economic factors impacting health. In this instance, we would take the existing priorities and we would try to weave the social determinants of health and health factors into it where we could see them making sense. This framework would also propose to streamline existing focus areas, goals and indicators. These two models we are hoping to have drafts of in advance of the 9/21 meeting. We do have to have the steering committee internally review and approve these. We also will need leadership at the Department of Health to add their input as well. They will be just frameworks. Once we have the frameworks in front of the Ad Hoc committee, we're really hoping that they will provide us with more guidance on which priorities they would like us to include also the focus areas and the indicators, which we will provide for them in advance to respond to.

Dr. Boufford Thank you.

Dr. Boufford Open for questions, comments.

Dr. Yang I was fascinated by sort of the alignment between the prevention agenda folks. Are we talking about metrics, funding or reimbursement rates like driving? What are we talking about?

Mr. Roberts It was just a very preliminary discussion. They have a quality strategy which they're working on. They have broad priority areas as well. I believe that it's based and now they have alignment with the existing priorities, the prevention agenda. Those priorities are largely the same with a few exceptions. They are in the process of starting up their planning process as well. Our meeting was just basically an initial conversation about what direction we might be heading in with the prevention agenda now as they look to also begin their planning process. It is the broad, just the broad priorities so far that we've discussed.

Dr. Boufford Could you make those available to us? Because I'm not familiar with them. Other people may be.

Dr. Yang I think when it gets down to reimbursement rates---

Dr. Boufford Absolutely.

Dr. Yang Great.

Dr. Yang Thanks.

Dr. Boufford I wanted to ask on either model, just could you talk a little bit about because we talked about the sort of engagement of we've heard from OMH, Oasis and NYSOFA. How are you thinking about linking up presumably engaging other agencies, which you would have to do under either model? How would that work? Adam talked about his interagency council. We've had a sort of interagency group, but it hasn't really been activated since COVID actually, though, does exist under a previous Executive Order by the Governor.

Mr. Roberts Absolutely. I think what we want to do is we would like to have the priority areas for both models established as examples to review with them as a group. We would like to have a separate meeting with OMH, with Oasis, with NYSOFA, and then probably a group of state agencies together. We would like to have something for them to respond to. What we have found is with the prevention agenda, because it is such a large and encompassing plan, it is hard. It is hard for a group to create something from scratch. It is much easier to get engagement when we have something for them to respond to. We have been in communication with our partners since the Ad Hoc committee and we are planning on having additional meetings. And then also through the committee itself, we would like to have breakout sessions within the Ad Hoc committee and have more hands-on interaction with the writing of the plan versus, you know, I think we've come to the end of the phase of the stakeholder engagement and now it's time to start engaging the committee and the actual writing of the plan itself.

Dr. Boufford I want to also mention, just ask a question about the data, because obviously the objectives that are sort of driving the dashboard, which I think our colleagues have said was helped. That was a sort of new innovation and also sort of presenting the department really took the lead in putting together evidence based initiatives from all the basic sort of reports out of CDC and others, national and otherwise, and the objectives themselves, although that be reported, I think there would be a piece of work, I assume,

under either model for updating the objectives, perhaps trimming them down, modifying them, etc., or, you know, other especially around the disparities issues. We have enough horsepower here. I know you have a couple of folks, but the Office of Science would also be involved with their data people since this would be a department wide activity.

Mr. Roberts Absolutely. The Office of Science holds a meeting every Friday regarding the the state health assessment, which we attend. Part of that is also working on those indicators that would be what we are referring to as headline indicators for the ship. In addition to just the indicators we are also looking at the focus areas, the goals. We are looking at where it is that we can actually measure the things that we're looking to change as well. Zahara and Samaan have done a lot of work in identifying sources for indicators and for indicators that we have easy access to either internally here at the state or from other resources. Dr. Rosenberg and Dr. Wynn, their group has been active within all of our work groups, also making sure that we can support anything that the committee comes up with in terms of focus areas.

Dr. Boufford Other comments, questions.

Dr. Boufford We're on time for public comments. This is is a formal meeting of the Public Health Committee. I don't know. Dr. Bauer, did you want to make any comments around Shane's great presentation and then we can move to public comment.

Dr. Bauer Just to say, you know, this is very much a work in progress and very iterative. We're looking forward to sharing the ideas with the Ad Hoc committee. It is important as, as Shane noted, to get to the point of of writing the plan. We do need that engagement in September in particular to to figure out which direction we're headed.

Dr. Bauer Thanks, everyone.

Dr. Boufford I think also the agenda of this committee will become clear as that goes forward and we take up the workforce work as well. Anyway, thank you.

Dr. Boufford Let me invite any members of the public that would like to comment, make comments on what you've heard or other public health issues. Knowing what you've heard, I think now they're probably just won't go there.

Dr. Boufford We were asked to give everybody a bit of a break before the Establishment committee begins. I think we're going to be on schedule to do that.

Dr. Boufford Let me thank the members of the Public Health Committee and others who are here from the council for their work. I know everybody has been very committed to this over the last difficult and challenging time the last two or three years. We're very excited about the forward motion. Thank you, Dr. Bauer and your team and all of those who came to speak today.

Dr. Boufford I'll declare the meeting adjourned.