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TRANSCRIPT

Dr. Boufford I'm Jo Boufford, Chair of the Public Health Committee. I want to call our committee meeting to order formally welcoming members, participants and guests.

Dr. Boufford Let me go through the public announcements reminding council member, staff and the audience this meeting is subject to Open Meeting Law. It is being broadcast over the internet. These webcasts can be accessed at the Department of Health website for no later than seven days after the meeting and for a minimum of thirty days and then the copy will be retained in the department for four months. We suggest that because there is synchronized captioning, it is important that people do not talk over each other. The first time you speak, please state your name and briefly identify yourself as a council member or department staff. Please note that the microphones are hot mics picking up every sound. Please try to avoid rustling of papers. Those of you that are online, be sure you're mute unless you're speaking. As for a member of our audience, there are forms outside this room to fill out before you enter the meeting to align with the Joint Commission on Public Ethics Executive Law and they will be posted on the Department of Health website. We hope you will fill that form out before you leave if you haven't so far. Thank you for everybody for their cooperation in these areas.

Dr. Boufford Let me open our meeting by saying that this meeting of the Public Health Committee is sort of, in a sense, the last in this calendar year, at least, of a series of meetings we've been having since June of this year, of the Public Health Committee, along with our colleagues in the Planning Committee, as well as the Ad Hoc Committee to advise on the prevention agenda. The goal of those meetings has really been catching up, if you will, with the activities of the prevention agenda. Certainly, sort of during COVID and after COVID. Similarly, getting feedback from partners to shape the next iteration of the prevention agenda. We have had updates and information about the prevention agenda, sort of submissions from our local health departments, and we're delighted that they continue to submit the data requested, even with the pressures are experiencing under COVID. We've heard about the state health improvement plans from other states in order to potentially to inform our redesign and rethink of the next iteration of the prevention agenda. We also are in a series of meetings both on this committee and in the Ad Hoc Committee, heard from our partner agencies, especially the Office of Mental Health, Oasis, NYSOFA and the Department of State and other local health departments and hospitals who have all been really participants in key partners in the prevention agenda to date to get their feedback about the positives and negatives, their recommendations for change. All of those are part of our record. We've also discussed some related initiatives. We were briefed on the Master Plan for Aging by Adam Herbst a couple of meetings ago. We're going to hear again about the work of that group with a special focus on prevention today. We've also discussed the issue of community benefit, which is linked to the sort of community health needs assessments and plans that are required by the hospitals on a regular basis and similarly by the local health department. That's all in our information pot, if you will. Today our agenda consists of hearing really the latest iteration, latest revision. Everyone cautions me to say we're going to hear a lot of good detail, but it's still a draft I'll say that for folks of the latest New York State Health Assessment. If you will recall, this

was the document on which the current priority areas of the prevention agenda were based, which was identifying those health problems that were preventable causes of greatest morbidity and mortality in the state of New York but were preventable. we're eager to hear that information in terms of informing potential modifications of the priorities or reinforcements of those from Christopher Davis. we're going to get an updated presentation of their Prevention Agenda Dashboard. This is I think all of our partners indicated that this was a very valuable sort of feature, if you will of the prevention agenda. They had been using it actively. I know our colleagues in the department information group, Stephanie Mack is going to report on updates there and give us the information about what their thinking is on next steps. Finally, Andrew Lebwohl, who is the now most recently determined to be the Deputy. He's currently Director of the Center for a Master Plan on Aging and sort of Director of the master plan activity within the Office of Aging and Long-Term Care. He's going to be reporting on the sort of prevention elements of the Master Plan on Aging. I think I've mentioned in the past at this meeting that I Co-Chair a subcommittee of that master plan on Prevention and Wellbeing, Health and Wellbeing with Dr. Linda Fried from Columbia. I thought it was a really important time for him to talk about how they're thinking about prevention so that it can inform our work here on the prevention agenda in the next phase. I think Dr. Bauer is representing the state at the meeting and so is not with us today. We'll proceed without her usual welcome and greetings, but I'm sure she would be welcome in greeting you if she were here. Let me turn to our first presentation, which is on the latest New York State Health Assessment, Christopher Davis, Population Health Data Manager and the Office of Science for the State Health Department is going to be presenting that work. We wanted to give you plenty of time for him to go through it and time for you to ask questions. I think still a fairly long presentation, Christopher, if I recall earlier. I think I'm sure you will invite colleagues if they have a question about something they don't understand or want to ask a question during it to sort of raise your hand. We'll interrupt you maybe, but not so much just to ask your questions at the time.

Dr. Boufford Over to you, Christopher.

Mr. Davis Thank you.

Mr. Davis Let me just go ahead and try to share my screen here. Just confirming that you can see the slides here?

Mr. Davis Great.

Mr. Davis Well, good morning, everyone. Again, I'm Chris Davis, Population Health Data Manager in the Office of Science. A pleasure to be here with you this morning. As you're likely aware, conducting a health assessment of the population as part of our planning cycle every five to six years and helps inform our next state health improvement plan as well as fulfills necessary criteria for the department to maintain its accreditation or Public Health Accreditation Board. This presentation is just one piece of the overall State Health Assessment, but of course it is the more data heavy description of the general health status and some population demographics of New Yorkers. There are other sections, of course, which will be conducted as well. Within the presentation we largely have a series of screenshots from a variety of health topic areas taken from our many different data dashboards that we maintain here in the Office of Science. Now, this was a team effort and collaborative effort between the Office of Science and Office of Public Health Practice. We started by kind of casting the net pretty wide for topic areas and then worked together to organize those topic areas as well as the selected indicators for this presentation. It's

important to note that what is shown in the presentation is really just a representative sample and selection of the many health outcomes, health behaviors, risk factors and demographics that we do track across the number of dashboards that we have. It would be easier if we can hold questions to the end, but if something is absolutely unclear, then please go ahead and stop me and ask something for clarification. We do have plenty of time for discussion over the three-hour meeting block that we have here. I will also point out that we did move a number of the slides from the original draft to the end as supplemental slides to help shorten the length of this overall talk. I will say that this presentation is now about 30% shorter than the 2018 assessment but is still quite data heavy.

Mr. Davis With that said, let's go ahead and start with what our team thought were the overall findings of this round of the State Health Assessment. First, America's Health Rankings saw New York improving until the 2012 report as new focuses on social determinants of health and the built environment lowered New York's rank from 11th in 2019 to 23rd as of 2022 as the higher mortality, and that was, of course, due to COVID-19. We'll get more into that through the talk. COVID-19 and the opioid crisis were major issues that contributed to declining life expectancy. Chronic disease continues to be a major burden, including cancers and asthma. We're making good progress in some maternal and infant health indicators, including teen pregnancy and breastfeeding. More work needs to be done to address disparities. We are on the path to end AIDS, but we have challenges in reducing STIs. Just the second page here of summary findings. Testing homes for lead and radon continue to be a key prevention agenda outcome that we track. We have seen declines in homes tested for lead hazards. Obesity, smoking and physical activity continue to be public health risk factors that are impacting New Yorkers. The New York State population is aging and is also becoming more diverse. There are significant disparities in many outcomes and social determinants of health across racial and ethnic categories, education and income levels. Access to health care has improved, but many New Yorkers still have access issues. Social associations, disconnected youths and single parent households are very complex issues that are potentially contributing to poor mental and physical health. Let's talk a little bit about the America's Health Rankings. For over three decades, America's Health Rankings has provided an analysis of national health on a state-by-state basis by evaluating a comprehensive set of health, environmental and socioeconomic data to determine national health benchmarks and state rankings. Now, as you can see here in the figure, New York State has improved its rank drastically. We were ranked 11th in the nation, up from 40th in 1990 and up from 26 in 2008, which was the starting point of our first prevention agenda cycle. Now, due to some modifications in the calculation and the algorithm which America's Health Rankings uses, the 2022 ranking was down to 23rd for New York State. You'll also notice a gap from 2019 to 2022 due to the pandemic. America's Health Rankings did not conduct state rankings in 2020 or 2021. That explains that gap. Now, with that said, the first thing we as public health practitioners ask is, well, what happened to cause this drop in a couple of years from 11th down to 23? There are some minor methodological changes that America's Health Rankings does make. There were major changes implemented from 2020 through 2022. They were the most sizable changes that were made since 2016. The rankings are now much more heavily focused on the social determinants of health. New York State's Ranking was also hurt by increases in premature deaths. It's important to note that the data used for the rankings in the 2022 report was mostly from 2020 and 2021. With COVID-19, we saw a huge increase in premature deaths and that also brought down our rank in addition to a much heavier reliance on some of the social determinants of health. I do have a separate summary that I looked at that does have all of the changes that were made. If anyone's interested in that later we can talk about that further.

Mr. Davis Let me just show you what the summary of the state rankings looks like.

Mr. Davis I'm not sure how well this is actually projecting, but this is the New York page from the annual report.

Dr. Boufford We can't really see any of the detail, I don't think.

Mr. Davis That's okay. I mean, it's really what's on the left. I just wanted to show you kind of the overall look.

Dr. Boufford For those of you that hadn't picked up on it, it's in the slides set that's been copied out at your place, I think.

Dr. Boufford Go ahead.

Mr. Davis No problem.

Mr. Davis The graphics show strengths and challenges of many different public health areas that they track. There's physical environment. There's clinical care. There are behaviors. There are health outcomes. As I mentioned before, one of the main findings to highlight shown on the left that should be projecting well is there was a 31% increase in premature deaths from 2019 to 2020, mostly as a result of the COVID-19 pandemic, but also impacted by the opioid crisis that we're facing. Some notable strengths, however, relative to the nation, with a low prevalence of frequent mental distress, a low prevalence of multiple chronic conditions and a low uninsurance rate. In addition to premature deaths, obesity is also called out. We also have and these are new measures high income inequality, high Black to white residential segregation and a high percentage of households that are experiencing severe housing problems. Again, these are based on the most recent data that we have. At least in terms of premature deaths, we expect that we will improve on premature deaths as the COVID-19 pandemic has wound down. Other measures are going to be challenges for New York State, which will continue to hurt our ranking, such as the age of our infrastructure, the income inequality issues, other economic hardships, residential segregation. Those are really broad-based macro issues that are difficult for just public health alone to tackle. With premature deaths being cited as a weakness for New York, we thought we would start our assessment by looking into health outcomes and life expectancy and premature death related information. This graphic here shows the life expectancy at the beginning of each age interval. Each of the colored bars correspond to a different year 2014, 2016, 2018 and 2020. It then shows, on average, how long someone in a certain age category is expected to live. Really, the main point of this graphic is to show that life expectancy had been increasing up until 2020, which was the first drop that we had seen in many years. In fact, life expectancy dropped in all age categories in 2020 for an average loss of 2.84 years. Again, this declines due largely to COVID-19, but also from the opioid crisis as well. We saw the highest absolute drops in people in their 20's and 30's, but the largest relative decline in people over age 65 and life expectancy actually dropped by over 10%.

Ms. Soto Excuse me.

Mr. Davis Go ahead.

Ms. Soto Because we can't really make out that chart of life expectancy in your report further on is their breakdown by race and ethnic life expectancy or is this just in general New York State?

Mr. Davis On our Leading Cause of Death Dashboard there are some interactive tools where you can pull up and get down into some of the causes of death and life expectancy by race and ethnicity. We do have that. This is just the overall composite for all of New York State. The point that we're trying to show here with leading causes of death. We've had heart disease. We have cancer. They've been pretty much number one and number two. If you look from 2012 at the bottom up through 2020 you'll start to notice this tan box of unintentional injury creep up from the fifth leading cause to the third leading cause in 2019. That bucket contains deaths related to opioids. It wasn't until 2020 where COVID-19 came in to become the second leading cause of death. Now, interestingly, although unintentional injuries shifted to the fourth leading cause, the rate was actually the highest that it has been in the last ten years of 40.7 per 10,000. That's where our opioid deaths are included. We saw premature deaths were hurting our ranking for America's Health Rankings. We saw that COVID was the second leading cause of death in 2020. This graphic shows the waves of deaths associated with the pandemic. Of course, the first spike all the way on the left was the initial wave with the alpha and beta strains. The next wave was the Delta variant in late 2020 and into 2021. That's also when we started rolling out the vaccination campaign, which is important to note. We then saw another wave in late 2021 into 2022 with the Omicron variant. Since then, COVID deaths, thankfully, have come down through a combination of vaccination, natural immunity and perhaps less virulent new strains. COVID is still taking the lives of New Yorkers, with nearly 4,000 New Yorkers losing their lives to COVID in 2023. With that said, we do expect our premature death rate to improve with less overall deaths due to COVID. As we showed in the Leading Causes of Death graphic, and we as public health professionals know, the opioid crisis continues to rage on. It's taking lives prematurely. In 2021, the number of opioid deaths was over 4,200 or 21.5 deaths per 100,000 population. We did see naloxone being used more and more. There were over 19,000 naloxone administrations in 2021. This is a lifesaving drug to prevent opioid overdose. Still, there was over 12,000 emergency department visits from opioid overdoses. Why does the burden continue? Well, there's many reasons, but the opioid burden could be in part explained by the high number of opioid prescriptions that are written. There were over 200,000 opioid prescriptions of 90 MME or more. That's morphine milligram equivalent. It's really a strength measure that will prescribe for at least one day or more. There were over 340,000 opioid prescriptions that lasted for a week or more among people who had never been given opioids. It's also worth mentioning that to treat patients with opioid use disorder there were 415 prescriptions per 100,000 population in 2021. These are metrics that we follow pretty closely in our opioid program. This table here shows several different mortality and health outcome indicators. They are three-year averages of total mortality, premature death, years of potential life lost and potentially preventable hospitalization among adults. We can see here that it's stratified by race and ethnicity. Throughout this presentation, where available we do try to present the indicators by race and ethnicity or other sociodemographic indicators where it's available on our dashboards.

Mr. Davis Looking at this particular figure, what jumps out here are the Black non-Hispanic data points. This group has faced some of the worst outcomes for these indicators as well as others in the presentation. We do see that non-Hispanic, Asian, Pacific Islanders and white non-Hispanics fared pretty well in most of the indicators, except for premature deaths, which were actually the best in white non-Hispanics. Just to give you an idea of some of the racial and ethnic disparities that we see in some mortality indicators.

Mr. Davis We started to show some of the differences by race and ethnicity. We're going to present more by socio demographics. We wanted to give you an idea of some of the indicators that we looked at without going into major, major detail, but did have disparities between racial and ethnic groups. That takes us to this figure, which we've shown in previous State Health Assessments. It's called the Index of Disparity. This is a methodological approach that basically calculates the differences between race and ethnicity groups and the state averages. At the most basic level the longer the bar here, the higher the percentage. That means there's more disparities or more differences between the racial and ethnic subgroups that we're looking at. Now, what the index doesn't tell you from looking at this figure alone is which of the groups are doing better or worse. It gives you a jumping off point to start to look at something more deeply to see what's going on between the different groups. We see here that the most disparate outcomes were new HIV case rates, asthma, emergency department visits for those under age 18, gonorrhea case rate, teen pregnancy rate. Where there was a little bit less disparity, but still some important outcomes that we follow, motor vehicle mortality, stroke mortality, congestive heart failure. The next few slides are just a series of tables that present several different indicators again by race and ethnicity. They are grouped by major topic area. Here we are looking at the birth related indicators. We see the percentage of low-birth-weight births to Black non-Hispanics is nearly twice that of white non-Hispanics. Black non-Hispanics also had the highest percentage of premature births. This may be in part due to the fact that only 65.8% of Black non-Hispanic births received early prenatal care. Teen pregnancy, of course, was flagged as one of the highest disparities in the previous slide. You can see here that Black non-Hispanics have a teen pregnancy rate that is over five times that of white non-Hispanics and over eight times that of Asian and Pacific Islanders. The teen pregnancy rate is also elevated among Hispanics. Another one to point out here is infant mortality. Again, among non-Hispanic Blacks it's almost twice as high as that compared to all the other racial and ethnic subgroups. In similar fashion by racial and ethnic groups we're looking here at injury related indicators. Three-year averages of seven different injuries here, injury outcomes. We see that Asian and Pacific Islander non-Hispanics have a rate about half that of all other groups for motor vehicle mortalities and also has three times less unintentional injury mortality per 100,000 compared to the other racial and ethnic subgroups. Now, while Black non-Hispanics often have some of the worst health outcomes when we stratify by race and ethnicity, there are some disparities for white non-Hispanics. For example, fall hospitalizations among white non-Hispanics over 65. It's about twice that of all the other groups. In addition, white non-Hispanics also have twice the rate of suicide compared to other racial and ethnic subgroups. Here we present some respiratory disease indicators, asthma. Again, a major burden for Black, non-Hispanic and Hispanics compared to white non-Hispanics and Asian Pacific Islanders. Black non-Hispanics have asthma hospitalization rate that's five times that compared to white non-Hispanics. While Hispanics also have asthma hospitalization rates that are four times that of white non-Hispanics. We also see similar trends for asthma hospitalizations in those under 18. We see that white non-Hispanics have the highest chronic lower respiratory disease mortality per 100,000. The disparities exist. Depending on which indicator you're looking at it could be different racial groups that are most impacted. For some cancer indicators, a few key differences are noteworthy. White non-Hispanics have the highest incidence of lung cancer. It's actually twice that relative to Hispanics. Colorectal cancer incidence is pretty similar among the racial and ethnic subgroups. Black non-Hispanic females have the highest breast cancer mortality, highest late-stage breast cancer incidence, highest cervix uterine cancer mortality and highest cervical cancer incidence relative to the other groups.

Mr. Davis This is a bit of a busier slide here. This is just a table, a screenshot of a table taking from our annual HIV/AIDS report. What's being shown here really is just the newly diagnosed HIV cases in 2021 by sex at birth, age, race and ethnicity and risk categories. There's also some heavier detail here about HIV A or HIV B strains. I really just want to focus your attention here to some of the disparities. We're seeing males four and a half times more total diagnoses than females. We see most of the cases being diagnosed in people in their 20's. We see massive racial and ethnic disparities still ongoing, non-Hispanic Blacks and Hispanics. Although we know the risk categories for contracting HIV really haven't changed, it does pop out here when we look to see that over half of cases were in MSM risk category and still injection drug use remains an issue as well. Now, what's interesting is that although we've done a tremendous job in reducing new HIV incidence and new HIV cases, we're actually seeing problems in sexually transmitted infections. From 2010 to 2019/2020, we've pretty much seen an increase across the board in the rate of chlamydia, gonorrhea and early syphilis case rate. In fact, early syphilis is about three times higher than it was in 2010. We've seen doubling in the gonorrhea case rate in 2020 versus 2010. We do have this information, of course, broken down by race and ethnicity and other sections of our dashboards and different reports. We just wanted to show you here the composite case rate, because this is what is tracked on the Prevention Agenda Dashboard.

Mr. Davis Changing gears a little bit. This slide shows severe maternal morbidity per 10,000 hospital deliveries. It's stratified by urban/rural residents, race and ethnicity, median zip code income, maternal age and health insurance status. We see higher rates for maternal morbidity, nearly 120 per 10,000 for deliveries in large metro areas, which is significantly higher than the 80 per 10,000 seen in other areas. The highest maternal morbidity was seen in Black non-Hispanic deliveries, nearly 200 per 10,000, while white non-Hispanics experienced the lowest at less than 80 per 10,000. Disparities were also noted by income quartile with a clear trend in higher rates of maternal morbidity as income declines. Younger mothers also experienced higher morbidities. One interesting point here on this slide is that the uninsured category actually had the lowest maternal morbidity relative to those on Medicaid or other public insurance. One of the things that we feel is very important to highlight and to track, and I think it will definitely be something that's a focus in the next prevention agenda is firearm assault and firearm violence. We just have a simple slide showing firearm assault related hospitalizations the rate per 10,000 for the state as a whole. We initially had set the prevention agenda objective of 0.38 per 10,000. Thankfully, we have met that objective. That's also good news that the rate has declined steadily over the last few years of data that we have. There remains work to be done to reduce firearm related violence in New York State. Another topic area that we thought was important to include was actually Alzheimer's. This infographic that you're seeing here shows some key information related to Alzheimer's statistics. It's a condition that leads to many poor health outcomes and comes at great economic cost to New York. The number of people with Alzheimer's in 2020 was 410,000 New Yorkers. That's projected to increase 12% to 460,000 by 2025. In 2019, there were over 3,700 deaths from Alzheimer's. From an economic cost standpoint, over $35,000 per capita Medicare spending is on people with dementia. The total Medicare costs for caring for people with Alzheimer's in 2020 exceeded $5.4 billion, with a 15.6% projected increase in costs by 2025. Finally, there needs to be an estimated 39% increase in the workforce to meet the demand related to Alzheimer's by 2030. We took a look in the first part of this presentation at a number of selected health outcome indicators. Now, we'd like to shift gears a little bit to look more into health behaviors and health risk factors. This is another index of disparity for some select health behaviors and risk factors. Again, comparing differences in racial and ethnic subgroups to the state averages as a whole. Once again, a smaller percentage or shorter

bar means there's less disparity in a behavioral risk factor. A higher percentage means there's more disparity, more differences between the racial and ethnic subgroups here. Some of the largest disparities are found in opioid burden, current smoking in high school students, high school students who are physically active and vaping among high school students. On the lower end, we don't see many differences in fruits and vegetable consumption, having health insurance or having hypertension and currently taking medicine. One interesting point on this slide, though, is that while 5% for current smoking in adults there's not much disparity there. If we look at smoking among those making less than $25,000 a year in income, we do see high disparities in the racial and ethnic subgroups. We're going to look a little bit deeper at some of the selected health factor data like; smoking, obesity, physical activity, binge drinking and marijuana use. Some of the bread-and-butter public health risk factors.

Mr. Davis A bit of a dizzy slide here, but I do have some animations to help focus our attention. I just want to point out that these dashboards and we're going to see more of this in a little bit. We have tons of information that are able to be pulled up, lots of stratification, really, really a wealth and powerhouse of information. We're looking at smoking in adults. Overall, 12% of New York State adults are smoking cigarettes. More males smoke cigarettes than females. Those aged 35 to 44 years have the highest prevalence of smoking. Smoking is most prevalent in white non-Hispanics. One interesting trend that we have found is that there's a correlation with education level. As education level increases, the prevalence of smoking decreases or vice versa lower education higher rates of smoking. We also see that related to income. The greater the income, the lower the prevalence of smoking. Also, in keeping with the importance of mental health and well-being, we see that those who report having frequent mental distress in the last thirty days are significantly more likely to be smoking than those not reporting frequent mental distress in the last thirty days. In fact, the prevalence is about twice as high.

Mr. Davis This figure looks at the percentage of high school students who are physically active. It's stratified by gender, race and ethnicity and grade. Now, you may be wondering why there so few stratifications on this slide versus the last slide are?. The reason is that it's depends on the data source that we have and the data that is available. Where available on our dashboards we stratify as much as we possibly can. For this particular outcome, there is only three stratification categories. The prevention agenda has a goal of 24.4% of high school students being physically active. We are lagging that pretty badly at 19.2% overall. We note that the confidence interval also does not cross the prevention agenda objective. We see that males are almost twice as physically active as females. In terms of race and ethnicity, white non-Hispanics are the most physically active. Asian non-Hispanics the least physically active, although there's a little bit of overlap in the confidence intervals there. Here's another indicator which has a number of different strata. This is binge drinking. We see that males are much more likely to binge drink than females. We see an interesting finding actually here in education and household income. Unlike smoking, which saw less smoking as college as education level went up. As education level goes up, we see more binge drinking versus lower education. That was a bit of a surprising finding. Of course, the same trend we have here with income. The higher the income, the more likely to binge drink. Vaping. Vaping is still kind of an up-and-coming issue. We've known about it for a few years. It's seemingly becoming a really new problem. As a father of teenagers, I know firsthand that there are kids vaping and pressures to vape and things like that. We wanted to include some information on the vaping here. The prevalence of vaping among high school students in 2020 was 22.5%. One out of five students vaping. That's a problem. We do see that females are more likely to vape than males. There are some racial and ethnic differences here. Black non-

Hispanics actually reporting the lowest prevalence of vaping, although we do note some overlap of the confidence intervals here. Maybe it's of course related to just getting older. We see that as the grade level increases, the prevalence of vaping increases as well. Some regional differences here are noteworthy. The rest of state outside of New York City much higher prevalence of vaping than New York City. That is a similar trend that we see in cigarette smoking, but it's much more pronounced here for vaping.

Mr. Davis Just a slide here on marijuana use. This is looking at marijuana use in high school students in New York State and the United States from 1991 to 2021. There has been a steady decline of marijuana use since 2013, with 21.4% of high school students reporting marijuana use in 2013. It's down to 14.2% in 2021. We wanted to include this data as marijuana has been legalized in New York state and obviously it's not legal for high school students to purchase marijuana. We were actually surprised by the findings here to see the declines. It's something that's also being matched nationally as well. We've covered some major health outcome areas. We've covered some health risk factors and behaviors. Now, we want to just briefly show two slides on the progress we've made on the prevention agenda to date. We also do have a number of more detailed slides on the progress of the prevention agenda in the supplemental slides.

Mr. Davis Here you've seen versions of this before. We won't spend too much time. As of October 23rd, 29% of the indicators that we set for the prevention agenda have been met. That's represented by this green slice of pie here on the chart. These other three major-colored sections are the unmet indicators. 70% of our targets have been unmet. Within those eighteen indicators have improved. Thirty-two have not statistically changed. Nineteen have actually gotten worse. Just one layer of stratification here to get a little bit deeper is just looking at the number of indicators that were met or among those that were unmet if they changed, worsened or didn't change by the priority areas. We see that half of our communicable disease indicators were met and nearly half of us promote healthy and safe environment indicators were met.

Mr. Davis Is there a question?

Dr. Boufford No, not from here.

Mr. Davis I thought I heard a hot mic. Sorry about that.

Mr. Davis The thing that jumps out to me looking at this figure is really what's going on in the prevent chronic diseases. We have only four indicators being met, thirteen, which have been unchanged, four, which have worsened, three that have gotten better. There's a lot more work to be done. We also have work to do in us promote healthy women, infants and children, as you can see by the bars here, as well as us promote mental health and well-being. We've covered health outcomes. We've covered some health risk behaviors. We kind of showed you the prevention agenda progress. We put it in the middle of the presentation because the prevention agenda is really health outcomes focused and a bit of behavioral focus.

Mr. Davis We're going to start to think about the population and some of the more holistic overview topic areas as a potential framework for the next round of the prevention agenda as a potential. I stress potential. We will look at a few indicators here based on the population demographics, some social determinants of health, some health-related social needs in New York State. We wanted to dedicate the assessment to more of this type of data as the field is kind of moving there, as we saw that with America's Health Rankings

that are putting a lot more weight on some of these more social health related data factors. The five sections just shown on this slide; economic stability, health care access, neighborhood, social community context. These are possible holistic groupings that some of the committees have been discussing to potentially group the next prevention agenda by. Just a few measures on economic stability to talk about. This table, again, stratified by racial and ethnic subgroups, shows some income and poverty related metrics. We see non-Hispanic whites and Asian Pacific Islanders having the highest median gross annual incomes in the state, whereas Black non-Hispanics have the lowest. Looking at percentage of families below the poverty line, non-Hispanic Hispanic Blacks have the highest at 17.6%, whites at the lowest at 5.7%. Just all the way over in that far right total column for the third indicator here. We have 18% of children in New York State that are living below the poverty line. That number really jumped out at me. Yes, we do see stark differences in the racial and ethnic subcategories here, with nearly 30% of Black non-Hispanic children and over 25% of Hispanic children living below the poverty line. It's more than double what we're seeing in white non-Hispanics. Kind of following that trend with the unemployed it's probably linked to, of course, to both poverty and household income. The unemployment rate is also about twice as high in Black, non-Hispanic and Hispanics versus white non-Hispanics.

Mr. Davis Food security. That's something that we've tried to take a look at here. What you're seeing on this busy slide is a screenshot from our Prevention Agenda Dashboard. We're looking at kind of our most economically vulnerable sub population here. This is adults with an annual household income of less than $25,000 who say they have perceived food security. The prevention agenda target is 61.4%. We're not even close to meeting that at 48.1% of New Yorkers making less than $25,000, perceiving they have food security. Comparing by race and ethnicity, the white non-Hispanic group does seem to indicate at the highest prevalence that they are food secure. We do note wide confidence intervals between the groups. Not surprisingly, the lower education level has a lower perceived food security here. Non-high school graduates at 37.1% feeling food secure. I think the most important finding on this particular graphic is disability status. Those reporting they have a disability are significantly less likely to receive food security, just 40% versus 55% of those saying they do not have a disability. Just to look at another vulnerable population within an already vulnerable population by income.

Mr. Davis Just some quick things here on access to care and quality. I'll just say we've done a great job increasing the number of New Yorkers with health insurance. I think most of us know we've been around a 6% is uninsurance rate for New Yorkers for a few years now. We do have data on that. I'm not going to show that to you because it's pretty well known. Another thing that we know is we need more providers. We have to have more providers. We do have data on that. There's some in the supplemental slides if you'd like to look more. We need more primary care providers. We need more dentists. We especially need more mental health providers in New York State, especially as the population is expected to grow. One thing that we thought was interesting was from the Behavioral Risk Factor Surveillance Survey. New Yorkers were asked if they had avoided seeking health care because they couldn't afford it in the last year. We took that outcome, and we stratified it here in four different charts by race and ethnicity, by education that was obtained, by gender and by household income. What jumps off the page with race, ethnicity? We did limit the Y axis to 30% just to show these differences a bit more. The Hispanic group. Over 15% of Hispanics saying that they actively avoided getting health care because they couldn't afford it. Almost twice as high as every other group. As we see with high school and with income, the lower the income, the lower the education, the more likely someone is to say, I couldn't go get health care because I couldn't afford it. This is a

major issue. I think it's an important graphic that really just kind of jumps off the page at us. No differences were really noted by male and female, however. Just another measure of access and quality here. One of the things we monitor on the prevention agenda is the percentage of twenty-four- to thirty-five-month-old children that have their full 4313314 vaccination series. If you don't know what that is, that's basically the combined seven vaccine series for diphtheria, tetanus, pertussis, polio, measles, Hep B, varicella and pneumococcal conjugate vaccine. Anyway, the prevention agenda objective is 70.5%. We're kind of badly behind that at 63.8% overall. We do see a little bit of regional differences with twenty-four- to thirty-five-month-olds in New York City at only 62% versus 65% in rest of state. I imagine that vaccination will be another key focus area in the next round of the prevention that at least for consideration, seeing that we lagged our target here so far.

Mr. Davis Another bit of a busy slide here again, but this is a screenshot taken from another dashboard. This is our Maternal and Child Health Dashboard. It's a key access indicator in my opinion. This is the percentage of births with early prenatal care. We know that early prenatal care is associated with better birth outcomes. We have a target of 79.2%. We did meet that overall, at 80.6% for the state. We do see some differences when we start to stratify. One clear trend is in the first grouping, maternal age. As the age of the mother increases, we do see a clear trend higher of actually having early prenatal care. The younger the mother, the less likely to have early prenatal care. By race and ethnicity, we see white non-Hispanics have the highest percentage of births with early prenatal care at 85% versus the mid-60s for some of the other groups. A trend with education. The higher the level of education, the more likely we have early prenatal care that could be whether it's an income related issue or actually having health insurance. Of course, mentioning health insurance, we see here that those who are uninsured, only 40% of births with early prenatal care, about half that of those with insurance.

Mr. Davis Some dental data. We wanted to include something on this because we know we need more dentists in the area. We do have a dental health program here at the department. What jumps out here, we're looking at children and adolescents aged 1 to 17 who have had a preventative dental care visit in the last year. The overall objective here shown at the bottom is 81.5%. We're close at 77.2%, but still trailing that objective. Children aged 1 to 5 only 51% have had a preventative visit in the last year. That number kind of jumps off the page when we look at age. The other trend here would be the highest education of the adult in the household. The higher the level of education, the more likely the child has had a preventative dental visit in the last year.

Mr. Davis Now, we'd like to talk a little bit about some of the neighborhood and built environment. This is another core holistic area. Just a little bit of information on air quality, fluoridation of water and some housing safety data. This first slide here is from DEC and CEH. What it's showing is the number of days each year where the air quality index was unhealthy. Generally speaking, there's only a few days a year where the air quality is at unhealthy levels. In 2023, we did have an unusual spike. As we may remember, the Canadian wildfires in those days where it was all hazy and red outside. We did see a spike there. Why do we want to monitor air quality? I think the biggest reason being that sensitive groups when the air quality is unhealthy. It can lead to emergency department visits for asthma attacks and other things like that. On our dashboards, we often have the ability for you to pull up statewide maps and look at county level outcomes. Here we're just looking at the percentage of residents that are served by community water systems that have optimally fluoridated water in the state has as of 2021. New York State total is 71.2%. There are several counties in the low single digits for optimally fluoridated water. Those

are represented here by dark blue. Now, the challenge for public health to improve these numbers is that we need to work with municipalities, local governments and water supply to talk about the benefits of fluoridation and to get participation within that. The other side of this, though, is that a lot of residents, particularly in more rural areas, may be on well water and not actually served by community water systems.

Mr. Davis This slide just shows the number of homes that are inspected for lead and other health hazards. We have set a target of 23,000 homes to be inspected annually for lead and other health hazards. We have not met that objective. We saw a peak in 2019 of over 20,000 homes inspected, but a notable drops off in 2020 to 8,600. That is probably due to some of the impacts of COVID-19 and remaining indoors. That's me editorializing that that is what we're seeing. We expect that number to increase with later data years. However, the number of radon tests performed per year looking at the three-year average has steadily increased. We've surpassed our target of 50,000 radon tests per year in New York State. In fact, we've almost doubled it, including the years impacted by the pandemic. Why might that be? A lot of times radon tests are required as part of real estate transactions. When you buy or sell a home it's often included in one of the home inspection tests. The real estate business was actually pretty booming in 2020 to 2022. That's probably one of the reasons we're seeing this increase. It is important to note that this is not the number of homes tested. It's the number of tests performed. It's possible in here you're seeing the same home a couple of times just to point out.

Mr. Davis Some social and community context. We'll show you just a little bit about who's in our population, a little bit of data from the county health rankings, such as social associations and a little bit of neighborhood safety here. Here is our population. This is showing the distribution by age and gender comparing 2006 to 2021. I tried very hard to come up with a way to overlay these to try to animate and show you the shift. I was unable to do that successfully. However, you may be able to see that the age has shifted higher. In 2006, we saw wide bars here in the ages 40 to 44 and 45 to 49 group. That age has shifted higher to the 50 to 55, 55 to 59 and 60 to 64 age grouping. We also notice that children under 10, we have less children under 10 now in 2021 than we did in 2006. The median age has increased from 37.4 in 2006 to 39.2 in 2021.

Mr. Davis Just a breakdown by race and ethnicity here. We have seen over time the population by race and Hispanic origin be more diverse. In 2021, white non-Hispanics made up about half of the state, 55%, Black non-Hispanics at 14%. Hispanics were the second most populous at 19%. Asian, non-Hispanic at 8%. American Indian and Alaska natives now making up less than 1% of the population overall.

Mr. Davis The next three slides are taken from the New York State County Health Rankings. We wanted to include a few figures that measured connectedness, connectedness to society as social isolation is a risk for poorer health outcomes and poorer mental health. This figure statewide map from county health rankings basically ranking the counties from best to worst based on the percentage of youth aged 16 to 19 that are disconnected. Well, what does disconnect mean? It means those in that age category that are no longer in school but are also not working. Overall, we see the percentage of disconnected youth in that age group at 6% with a range of 3%, the lowest in Allegheny to the highest at 23% in Greene County.

Mr. Davis In keeping with the theme of social connectedness, social cohesiveness, this figure, again from the County Health Rankings, it's map of social associations per 10,000. What are social associations? These are the different kind of associations in a community,

whether it's civic, social, sports, religious, professional, political. It's basically account of how many potential possible membership organizations there are that one could be a part of. Overall, we see 8.1 per 10,000 for the state. Surprisingly, Bronx had the lowest at 2.8 per 10,000. In Chappaqua, with the highest at 17.0 per 10,000 population. The percentage of children living in single parent households. Overall, New York State had 26% of children, percentage of children in single parent households. The lowest was in Schuyler at 11%. The highest percentage of children in single parent households was in the Bronx at 50%.

Mr. Davis Just some safety data here. Violent crime was one of the indicators that we track. This is from our Community Health Indicators Reports Dashboard. While it may not be entirely clear on this figure from the trend violent crime has actually trended lower over the last decade, which is good news. As of 2020, New York State as a whole reported 361.8 violent crimes per 100,000. That's down about 10% from 397.3 in 2011. Regionally, we see some differences, of course with New York City experiencing more violent crime per capita versus rest of state, which is shown in the orange.

Mr. Davis Depression. Major depressive episodes. The percentage of adults reporting a major depressive episode during the past year. We have a target of 6.2%. The point estimates have yet to meet the target, though the confidence intervals do overlap. We may have hit the target here. The point of this slide is to really show that we've been pretty stable around this 6.3, 6.6% of adults in New York State having a major depressive episode during the past year.

Mr. Davis Just on the last few slides that I have for you for data just some indicators with on education, access and quality. This table here showing two educational indicators and a language access indicator by race and ethnicity. We see a much higher percentage of Black non-Hispanics and Hispanics dropping out of high school relative to the state total of 7.3% and also much higher than both white, non-Hispanic and Asian Pacific Islanders. Perhaps, of course, linked to dropping out of high school. Getting a bachelor's degree. We see a higher percentage of the population with a bachelor's degree in the white, non-Hispanic and Asian Pacific Islander bucket relative to Black, non-Hispanic and Hispanics. Just a language access measure here. The percentage of the population who speak English less than very well. It's the highest among the Asian Pacific Islander population at 41.3%, but also still high among Hispanics at 32.9% relative to the state total of 6.7%. Just early access to education. The earlier a child is enrolled in school seems to be associated with better life course outcomes. We're looking here at the percentage of children aged 3 to 4 who are enrolled in schools among that population. These are five-year averages between New York State and New York City. We're doing a little bit better in New York City compared to the state as a whole. It's about 61/62%. We've held pretty firm over the last eight years of measuring periods or last five, five-year periods here shown on the screen. The point is, we have about 40% of children in this age group that are not enrolled in school early.

Mr. Davis I know that was a lot of information and we went kind of all over the place and went through a lot of different topics. It's a slide set that serves as a very general overview of major topic areas. We have a ton of more data available on all of our different dashboards. We're going to have a presentation from Stephanie Mack on our Prevention Agenda dashboard in just a few moments. I just want to thank you all for listening. Hopefully, it wasn't too dry. I want to thank the Office of Public Health Practice. I want to thank the Office of Science and all of the staff members who contributed to this presentation. We were meeting biweekly on this presentation, refining it, tearing it down,

moving things around to try to improve it. Just thank you very much and we'll open it up to any questions that you might have and some discussion.

Dr. Boufford Thanks very much, Christopher. This is terrific. I think your pacing was excellent.

Dr. Boufford You mentioned the next steps, because I know we are after the first of the year in talking with the Office of Public Health Practice, the idea we'll be having a Public Health Committee meeting in early February, followed by an Ad Hoc Committee in late February, which hopefully will be sort of giving feedback. You mentioned some holistic options, some other options for the states considering for the next version of the prevention agenda. I wonder if you could just talk about who's involved in those conversations, because a number of the areas that you mentioned are, as you said, really outside the purview of the Department of Health of the state health department. We have traditional and close partnerships with mental health, Oasis, NYSOFA and I think to some degree, the Department of State on the economic issues. We had hoped to do more there, but we weren't able to do it. How are you engaging with other agencies that would arguably need to be in partnership to address some of the broader determinants of health that you've identified or how you're thinking about it at least?

Mr. Davis I started to partake in some of the meetings with some of the other agencies. I hate to do this, but I would like to defer this question to Shane Roberts if I can. I'm sure you knew I was about to ask you on that, Shane, to talk more about it. I mean, in terms of the State Health Assessment, you know, the next step for us will be continuing to refine this presentation and also building a broader write up that will be posted on the website. We're also starting to talk about some of the other sections that off public health practice and also science may be involved in. These include summarizing our state assets, summarizing the stakeholder feedback that we're receiving through all of these meetings and some other sections there. But in terms of engaging some of the other agencies and what we're thinking about in terms of organizing the prevention agenda that I would like to ask Mr. Roberts.

Mr. Roberts Thanks, Chris.

Mr. Roberts Thank you, Dr. Boufford, for the question.

Mr. Roberts We've had ongoing communication with the agencies that you listed, so OMH, Oasis, NYSOFA and the Department of State. We've continued to meet outside of the Ad Hoc Committee meetings with them and the engagement of refining our two proposals down and making sure that the priority areas, regardless of what structure we use, a representative of what the needs are identified either through their work and also our own here in the department. I can give you a just a brief timeline of what we've got going on now is we met with OMH to get their substantive feedback on the proposals. Last month we met with NYSOFA last week. We're still negotiating with Oasis to get one final meeting with them and Department of State, we still need to just get that scheduled. The goal is that by the end of January that all of those meetings will have occurred, and we'll have the feedback implemented into the proposal. As you had mentioned, we do have a Public Health Committee meeting which is going to be scheduled, I believe, on February 7th, in which case we would like to do a final proposal to the committee to get your feedback on the two different formats that we have. And then from that, at that point, after we get your input, I'll make a decision to move forward to the Ad Hoc Committee with one or the other as our final presentation. And then from there, we're continuing to work with

our colleagues across the other departments to really build out the evidence-based interventions that will be offered up to the counties and the local health departments and the hospitals, counties and their local partners in implementing this plan going forward. I believe that Ad Hoc Committee meeting is on February 22nd. We have those two meetings scheduled currently.

Dr. Boufford Thanks.

Dr. Boufford Let me open up for questions from colleagues.

Dr. Boufford Ms. Soto has a question.

Ms. Soto Along the lines of Dr. Boufford's comments or question, amongst the agencies and departments that the Department of Health is working with, does that incorporate the Department of Education? Because I'm focusing in on the health care providers and what initiatives, what opportunities, what action is taken to increase the individuals going into health care.

Mr. Roberts We have engaged the Department of Education through the Ad Hoc Committee and attempting to get representation there. That's an ongoing process. We're still working to get some representation from education under the committee. I think that's an important point. I think before that we move forward with the proposals; we will be certain to get their input into those priorities as well.

Dr. Boufford Your question reminds me that we've identified for the Public Health Committee we're going to be looking at the public health workforce. We had our initial presentation last time, but I think it may be time to have a briefing on the health care delivery workforce issues, because I know there has been a parallel activity there and we have not heard about it. I'll mention that to Jeff in terms of a future PHHPC meeting.

Dr. Boufford Dr. Torres.

Dr. Torres Good morning. Christopher, I really appreciated the report here. It made me reflect on the past two days. On Sunday, Sunday morning, Jane Pauley had a whole segment on suicide in the United States and the seriousness of this. They were saying that it was about 132 individuals taking their lives in the United States on a daily basis. Last night, I attended the town hall meeting with Mayor Adams in Harlem, East Harlem. There were groups of individuals that were standing and talking about many of the things that are listed here, especially with the schools and the potential cuts and how that will have an implication negative in access to health care, especially for the children with oral health prevention, access to other medical services in a community. They were also talking about them witnessing drug use, abuse, things that are happening in their community with people walking around with needles in their necks and so forth, and how traumatizing that is for the children in the neighborhood and the impact that it has and the incentive to actually go to school and feel like they're getting something out of their local school. How some parents are keeping their children away from the school ON certain days because of the danger that looms before them. I think that there are all these other pieces that really highlight or feed into the number or the statistic or the reference that we must do a little bit more in-depth analysis on just to give it color.

Dr. Boufford Christopher, you had mentioned that there are some interactive features. I don't know if you want to elaborate a bit on that for those that are really our data geeks in

the crowd who really want to go in and take a look in more depth. Is that now available or are we going to hear about that next time in the next presentation?

Mr. Davis I think you may hear a little bit about that from Stephanie in just a few moments. Yes, on the different dashboards that we have, we've moved from kind of a static web interface to a tableau housed dashboard. You can kind of point and click and filter and play with lots of different things that you might want to look at, whether it's by priority area, by county. If you go to that Leading Causes of Death Dashboard, you can filter the leading causes by gender and race ethnicity. It really just depends on which dashboard you are looking at. For the most part, those are up and ready to go.

Dr. Boufford I look forward to hearing more about the next round.

Dr. Boufford Mr. Lawrence.

Mr. Davis I just wanted to follow up on the point of the suicide and what's going on with the schools. Another area that I think is very related is the cyberbullying. This is a real problem with kids making fun of each other on the social media. It's hard for parents to follow it. It's percolated into the schools. It's kind of like a real 21st century of what we used to see on the playground back in the day. It's a new challenge for public health and mental health. I think it's all kind of combining and coming out is what we're seeing in the data with frequent mental distress, the major depressive episodes for adults. We do have some data on our dashboards looking at mental health in youth and the suicide among youth as well. It's a real problem.

Dr. Torres I just wanted to add a very quick point because I'm sensitive to the subject matter of mental health. I think that we have to be very careful on the messaging because I think people that are looking at assault, murder and these types of crimes and dubbing them as a mental health issue also has a negative impact on the stigma and people feeling comfortable enough also to share because they're going to be perceived in a not so healthy manner.

Dr. Boufford I wanted to ask an extension of your question. In the conversations with other agencies, I wonder are in terms of more in-depth data on the sort of mental health. You raised cyberbullying, other social media influences, other things that OMH may be collecting. Is all of that sort of publicly available? Will it come out in a little bit more depth in your collaboration with some of these other agencies to get into some of the perhaps more root cause data they may have because they're focusing in on mental health or addiction services rather than a whole panoply of activities. Christopher, that's a question to you actually.

Mr. Davis I will have to look more into that in terms of what they're offering for the Office of Mental Health, in terms of the data that they're tracking on those. I will have to take a look. I'm sorry. I don't have an answer on that right now.

Dr. Boufford No, I think one of the hopes with the partnerships and we heard that really loud and clear and the Ad Hoc meetings from our agency partners, mental health and NYSOFA and Oasis seem to be working pretty closely together and sharing data. I know that your new science office is fantastic in the health department, and you're sort of getting your footing. I think our hope would be that in terms of the information that might be available for some of the modeling in February there would be a cross-fertilization of a little more of a deeper dive into those areas by working with those departments. You mentioned

the meetings. I think understanding what they're collecting and how it may affect decision making about priorities and interventions will be really important going forward.

Dr. Boufford Mr. Lawrence.

Mr. Lawrence Thank you, Dr. Boufford.

Mr. Lawrence This has been an incredible presentation. I was attempting to hang in there and go through all of the data. I kept asking myself, wouldn't it be wonderful to be able to at some point ask, chat, GPT what does this all mean? How could you design a prevention agenda for us? I'm just wondering whether at some point you're looking to use artificial intelligence to really put all of this data into some kind of a database and be able to have that kind of an interactive exchange with a machine that might be able to look at things. Because the other thing that I was looking at is, well, what are we not seeing that's really in front of us when we look at all of the data and look at some of the correlations and some things you met. We know that education impacts on a whole host of things. Is it education? Is it income? Be able to sort of tease all of that out and look at what are some of the factors that are driving population health across the state?

Mr. Davis That's a fascinating suggestion, actually. To my knowledge, we're not really doing much with AI yet. I do feel that the more that it's becoming used in everyday life and in business that it's going to make its way here to government as well at some point. We haven't done anything in that regard yet. No machine learning or anything like that. We've done things like statistical modeling and things like that. But to be able to plug all that information in and kind of ask in AI, "what are some potential interventions that they could query for us?" I never in my wildest dreams that I imagine I'd be having a conversation like that. I think it's definitely a possibility for public health over the next decade. AI can be a benefit. So far, though, that's not something that we're doing here in the Office of Science.

Ms. Soto It's funny because I had the same concern that you just raised, which is this is a lot of information. What does it mean? Are we missing something? What is this telling us? How are we supposed to sort of make sense out of this and create an agenda moving forward? I had exactly an opposite response, which was we should be taking these data to communities and sitting down with community organizations and saying here's what we found. Does this make sense to you? Does this resonate with your reality? Does this reflect the priorities that you feel in terms of the concerns of your community, the values of your community? Have we missed something in your community that we haven't picked up because we just didn't know to ask the question? I mean, my interest is how are we verifying what these data are telling us and sort of crystallizing that this is a meaningful representation of the experience of various communities across the state of New York so that as we build a prevention agenda moving forward we know that we are actually reflecting the felt concerns of the various communities.

Dr. Boufford Just to comment briefly. I mean, part of one of the challenges, I think a part of bringing in. There is an infrastructure that has historically been part of the prevention agenda; local health departments, area offices on aging, OMH and Oasis, local engagement. I think one of the questions, one of the reality testing issues. It's a really important question for us to carry forward in the next conversation Historically, there's been a menu of avoidable morbidity, mortality, priority areas in the prevention agenda, but each community picks two from the list of five essentially and can also define the specific objectives that they think are more relevant to their community. Everybody's supposed to address disparities. The disparities issue, we know, has been a weakness in the past.

Functioning at the local level we haven't had too much TA or otherwise. We're hoping now with the department having a new Deputy Commissioner dealing with health equity and human rights that there's a technical capacity to support that. It's a really important question to remember when we begin looking at the options as which ones lend themselves perhaps to local reality testing and local engagement more than others. I think it's something to keep very much in front of ourselves.

Dr. Boufford Ms. Soto was first and then Mr. Lawrence and then I'm going to have to close us out, so we have time for our next presentation. Our guest is arriving, we think, around 12:30. We want to get everybody in.

Ms. Soto Regarding getting a sense of the community, the Minority Health Council that I used to Chair, we did about eight, nine years ago listening tour. We went to Buffalo. We went to Albany. We also went to Syracuse. A report was done. It was very interactive. Various members of the community. We worked with the community to set it up. When we were up in Buffalo the things that that sort of stood out on two things was they provided a man who was a barber was giving haircuts and trimming men's beards as a way to engage people in discussion. There are barber shop and beauty parlor talk around the nation addressing things, everything from prostate cancer to breast cancer. A report is out there. That might be something, a model that could be used in terms of the listening tour. I had a question because it seems there's a lot of in-depth information on your dashboard. My question is, is among the information and groups listed, is there data being collected on the LGBTQ community? I could see in particular with youth, and since you have one of the areas, whether it's binge drinking, disconnected youth, social association. This is a population in particular the youth that are at risk. Also, when you look at the sexually transmitted disease, HIV, again, other factors are indicators that we need to look at in addressing these issues the prevention agenda with this specific group of individuals. Is that information that could be teased out of your dashboard?

Mr. Davis That's a very good point to bring up. I will say that we are a little bit limited by the source of the data in question. So, for example, a lot of our data that we're presenting will come from hospitalization records. For example, emergency departments or inpatient hospitalizations. They don't collect that information at the time of diagnosis. They'll collect age. They'll collect race, ethnicity. They'll collect where they live. They don't ask you at the time of that admission a question like that. Same thing on like birth records, death records. That information is not captured. There is opportunity, as you brought up, I think in the STI realm. I'll have to check with our surveillance team there to see what they're doing. I know that in some of the survey data that they're collecting and some of the case reports they're trying to collect more of that information so that they can collect and stratify some of the outcomes and target interventions to that population. For the broader data sources that we have, if it's survey data it would need to be one of the questions that are asked by one of the national surveys. For example, the Behavioral Risk Factor Surveillance System. I showed a slide on the affordability and avoiding care. In order to stratify like that, they would have to ask that question of the participant. I think right now that's our main limitation to getting more granular data at a level like that.

Dr. Boufford Mr. Lawrence, last question and then we'll move on.

Mr. Lawrence I don't have as a question.

Mr. Lawrence I think surveillance data is really important and that at some point the data has to speak for itself. It has to be collected. I think when you're setting up a tool for that

you want to validate it to make sure that it's accurately capturing the information that you want. On the other side, when you are talking about interventions and outlining things that you want to do to make a difference based on that data, I believe that's the time you want to engage community. I know that the community is not a monolith. That within any neighborhood you're going to find a whole host of different views within the community. That becomes the art of trying to be impactful in neighborhoods. The data has to be validated so that you know that you're looking if it's breast cancer, if it's asthma, if whatever, that you are in fact collecting information that is in fact an indicator that this exists in a neighborhood. The next step is what's the level of engagement that we want to have to rectify or to impact on this indicator?

Dr. Boufford Dr. Soffel.

Dr. Soffel I just want to say, I think that what the community brings is why it is the way it is. Here's the data. We're trying to figure out why it is this way and how to create a strategy moving forward. That's where community input is absolutely essential because they live it and it's part of their experience.

Dr. Boufford We will come back to this in our further conversations when we understand some of the options for the model that are being considered.

Dr. Boufford Thank you so much, Christopher Davis. That was terrific. We appreciate it. We're excited about the resources in the Office of Science that are helping enrich this data and data collection.

Mr. Davis Thank you.

Dr. Boufford Stephanie Mack, welcome to the microphone. Stephanie is the Senior population Health Data Manager for the Public Health Information Group in the department. She's going to give us a sort of update on some of the things that are happening with the dashboard, what their thoughts are, what the future may hold, etc.

Dr. Boufford Stephanie, over to you.

Ms. Mack I'm going to share my screen.

Ms. Mack Thank you to Chris for that great presentation. You did show some great screenshots of the dashboard.

Ms. Mack Just confirming that everyone can see my screen. You should be seeing a website.

Ms. Mack Over here in the Office of Science a lot of updates and improvements have been going on. Our team here has been working diligently to provide updates to all of our dashboards that provide data at the state and the county and the subcounty level where available. I'm going to walk you through the prevention agenda and then highlight a couple of our other dashboards as well. Just to note our dashboard now will have this new landing page. The landing page will look like this with the dashboard title up here in the gray bar. It will have our state dashboard and our county dashboard linked. It will have this left side menu with other important information like the data exports, the technical notes, our handy dandy user guide, and also a one stop shopping for some of our other useful dashboards

and data links. We're trying to house everything in a nice, clean, standardized way to make it easy for you to navigate around.

Ms. Mack We'll start with the Prevention Agenda State Dashboard. Clicking on that link will bring up our new interface. All of this is done, as Chris mentioned. We have our different dashboard buttons, the main state dashboard and the state level sociodemographic information. We have buttons for the county dashboard, the county region comparison, our familiar maps, bar charts and tables and our sub counties. These are our main buttons that we use to navigate around the different areas of the dashboard. What I'll bring up first at a glance is the summary information that we present to you this way now. The prevention agenda has 99 indicators at the state level, and at a glance we can see how many we have met. We have our indicator status bar and showing that we've met 29.3%. 70% are unmet. We also have our indicator performance. We can see how many have improved, worsened or experienced no change from the previous year. All of these acts as filters. Clicking will change the view, change the screen. You'll see that we have those twenty-nine indicators met. You can look within those twenty-nine indicators how many have improved? How many have not changed? How many have worsened from the previous data point? This might be really important because even though we've met the indicator, we may want to know which ones have gone in the wrong direction from the prior year so that we can keep an eye on those indicators. These are good summary information and the way that it filters it. You can also see these by the different priority areas. We can see which indicators we've met and what direction they're going in, in the different priority areas. You can continue filtering as you want to produce different summary visualizations. If you have filtered too much and you feel like you have now made a visualization that's not useful you can go ahead and hit the reset button, and everything will reappear with 99 indicators allowing you back to the original view. We also have the table down below with all of our indicators. All 99 indicators are listed here by their priority area with the indicator information for the most recent year of the data available, that year's estimate, the prevention agenda objective and that indicator status again. Whether or not we've met that indicator goal and how the indicators are performing, whether it's worsened or improved. Some neat things that we did improve on is we wanted to make sure you could get relevant information right away. without having to navigate the page. We have this mouse over where mousing over the indicator status you can see what the prevention agenda objective is, where New York State is and how far away we are from reaching that, as well as the desirable goal. Mousing over the indicated performance. You can also see what the prior year is that we're comparing that indicator to the value for that prior year and that direction. These select bars up at the top at those filters so you can choose different priority areas to focus on. Maybe we want to focus on promote healthy women, infants and children. The table below will readjust to only those indicators in that particular priority area. Also, the visualizations up above will also adjust. You can see that we have twenty-one indicators in this priority area. Here are the ways in which those indicators are performing.

Ms. Mack Clicking on an estimate within the table will take you right away to our trend bar. We might not want to just see how it's performing against last year's indicator or last year's estimate, but we might want to see the trends. Clicking on those and we can see that indicator and the trend line. We can see the years that it hasn't met the objective. There was a point in time where this indicator was meeting the objective.

Ms. Mack You can navigate here through different priority areas and select different indicators from our list of indicators within those priority areas.

Ms. Mack If you want to go back to the main page, we just click back to the main state dashboard and that takes you back to our main page. I know there was a lot of interest in the state level socio demographics. We'll go ahead and take a look at that page. As Chris showed some of these screenshots from our data dashboard here is the demographics for the percentage of deaths that are premature. We can see here this indicator by the different groups available with the breakdowns and the percentages for each of those groups. Hovering over will actually show you the trend as well. You don't even have to navigate away from this page to see the trend line. Hovering over those bars will give you the trend for that group and for that indicator. We also have the table down below for all of the values as well. Again, all of these bars and dropdowns act as navigation. You can change the indicator. You can also look at different data years for that indicator. You can customize to only look at a particular set of groups. Say we only want to look at this indicator by race and ethnicity, gender and income. We can select those groups and get a more customized visualization. We hope that this is nice and easy for people to use to grab to pull into Power Point presentations for that. You can also navigate to the trend view not just by the overview but by clicking on the trend view button as well. Those are main views for the state dashboard for the prevention agenda.

Ms. Mack Every single county in New York State has their own data dashboard page. You select the county up here at the top. It defaults to Albany County as these are in alphabetical order. Say you want to know about Onondaga County. Select Onondaga County. You'll see here Onondaga appears up here in the title. All of these indicators are for Onondaga County. There are seventy indicators we have at the county level. Again, we can see quickly at a glance how many are met and unmet. We can see again filtering here how many are met and unmet that familiar performance. We now also have concern level. This lets us know where that indicator falls in relationship to other counties in the quartile that it is. Those concern levels you can see show up in the dashboard below. You can see each indicator what the estimate is, the prevention agenda objective, whether or not it's met, that performance and what the concern level is. Mousing over these will give you an idea of what the quartile ranges are, where this county is in the quartile range. We also indicate there where the county is in the state just in case someone needs to leave that check and that reminder. Also, when you mouse over the indicator status it not only shows you the county value, but it shows you the New York State value and the region value and where we are in terms of meeting the objective. Again, clicking on the estimate will take you through to the trend for that county. One of the things that we added and updated here was that you can select up to eleven counties and regions and have them reflected back on the data dashboard so that everyone can see their county, their county in relationship to New York State, to rest of state and to other neighboring counties as well. You can select, recreate your view. The view will adjust. You can see where your county is in relationship. You can also click on that so that it highlights out your counties particular trend line so that you don't get lost in all the information that's there. It highlights all the county values on the table. The table also adjust to reflect any of the choices that you have made. Again, we're trying to make data nice and easy and accessible for counties to be able to compare with each other and compare with the state and see where they are in relationship. We also have another way that counties and regions can compare. This table has all of our prevention agenda indicators. It has the ability to select up to four counties in the region. Say you want to see Long Island, Nassau and Suffolk all together in one data table. You can see all of their most recent year of data, the most recent estimate. You can see whether or not it's met or unmet. You can highlight if you want to see what has been met and unmet. This is all of our indicators that we have at the county level. This table you can take and use. A nice summary assessment. We also have some of our favorite views that are useful for presentations and useful for deeper data dives. We have the map and

the county bar chart. The county bar chart shows you the prevention agenda objectives. It shows where the state average is. It also shows by region all of the different counties. You can quickly at a glance see where the counties are in relationship to their region and relation to other counties in their region and in relationship to the state average. Again, we want counties to be able to understand and situate themselves where they are in the state quartile range as easily as possible. Again, each of these views can be navigated by choosing a different priority area, a different indicator within that priority area, a different date a year. You can go back through different data years and get maps and trends for different data years. Lastly, we have our sub county data view. Indicators that we have the availability of data below the county level. For example, asthma emergency department visits. We can see which zip codes are in the high concern area, which zip codes are in that highest quartile, have the highest rates of asthma ED visits. This is extremely useful to our local partners who are providing services. If you're providing services within a county you can at a glance see where some zip codes of concern might be, where we might want to target. In fact, this was recently used by Albany County to try to identify areas that might be of concern when you do have poor air quality days of these areas that already have high rates of ED visits might be areas that need to be targeted for passing out of masks and other prevention efforts. Again, you can change the indicators that are available here and change the county that you're looking at through the dropdown filters. If you want to highlight and zoom in on a particular zip code you can do so by clicking on the map. That will highlight the zip code in the map and also highlighted in the table. That is our major views for the Prevention Agenda Dashboard. Are there any questions in particular about what's available and how to navigate around in the Prevention Agenda Dashboard?

Dr. Boufford We have some questions. I have some. I'll hold off and let Ms. Solo go first.

Ms. Soto Well, an impression and then a question. My impression is, wow, to have all this data at your fingertips. It's also overwhelming. I think it's great if there are local communities or areas that wish to target and see you've already provided some information where they are and the various factors and a prevention agenda. My question is, and you may have mentioned it in the very beginning. My question is how often is this data updated?

Ms. Mack The Prevention Agenda Dashboard is updated generally once a year once we have complete data from all of our different data sources. We're pulling in data from over a dozen major data sources; our data for ED and hospitalization, birth data, mortality data. We are currently right now in that process of getting all of our data requests back for our next update, which will be out for next year of most recent data for each of the indicators will be out early next year.

Dr. Boufford I have a couple of questions, Stephanie. One just asking you., maybe you can drop this if you like. I'm sort of emerged in looking at you when I'm asking that question or maybe you want to keep it up. You mentioned 99 indicators. One of the conversations we've been having about this sort of next iteration is there are too many indicators. We heard that from NYSACHO and from other representatives. I guess just sort of your maybe reflections as you sort of look at the quality of the data that's available, the numbers. What are you thinking about relative to that particular question? I have one other one I want to ask you about on the data sources were just the number, the number of indicators just in general and which ones are easy to find quality data? Which ones should be dropped on that basis? Which ones are missing?

Ms. Mack I think that a lot of these indicators are really program driven. We consult with the program areas and the subject matter expertise that they have in those areas to really understand what is quality data, what's an indicator that we can track, what's an indicator that we can update at least on an annual basis, and what is an indicator that is relatively uniform across the state that we can also display on a county level? There's a number of considerations that we have to take into account to ensure that these indicators are able to be displayed and displayed in a meaningful way for counties as big as Kings County and as small as Franklin or Hamilton County. There's a number of considerations that have to go into place. We've been working hard with Shane to really, really assess some of the feedback that we've gotten and what might be missing, especially social determinants of health and social health needs indicators and really looking into how we can add those in. The prevention agenda does have an area of improving health status and disparities. However, we are definitely focused on expanding where we can there and providing more of those social health needs indicators.

Dr. Boufford Well, you segway nicely into the question, the second question I was going to ask you. I think one of the goals in bringing more social determinants in obviously, as we've discussed already, some of the actions or the interventions are not really, you know, the health department isn't able to execute them. The question is, presuming there are a lot of the data. I'm going to give you an example of. One of the things that came up, has come up during one of the Ad Hoc meetings. This was a couple of years ago. AG and Markets has been an agency that's been really involved. They've been very involved in the prevention agenda over time and are also very involved in the Master Plan on Aging, as you'll hear about shortly. One of the issues, it was identified in some of the county sort of frameworks that you looked at, especially, there's nothing like a map for an elected official to see their county there and see what choices were made and what the issues were. One of our counties indicated this issue of food security being a major issue, along with a local hospital that identified the million-dollar patients who are end stage renal disease patients with obesity and diabetes being enormously contributory. There was a collaborative process which I won't go into. The local health department was very concerned. Was able to tell us where within this particular city folks live, the obesity rates, etc. The hospital had similar data. AG and Markets came in and said, I don't understand why there is food insecurity. We have seven programs providing food banks in that city. They were able to give us that data by county. One of the things that I've been really keen to put on everybody's plate going forward is that all the other agencies, if we're really talking about health and all activities, the other agencies, Energy, AG and Markets, Department of State on Economic Development, Transportation, Housing, all of these agencies. I've been in city government for seven years. It's hard for me to imagine that they don't owe the Governor an annual report by whatever they've been doing in each county every year. Maybe not. I would be surprised if many of them could not do that. I think the question for the next iteration is the capacity or the thinking maybe of how one would access at least county level data from other sister agencies that become really important in addressing some of these broader determinants of health. Just to get your what are you thinking about in that regard?

Ms. Mack We have provided an example here on our Opioid Data Dashboard. So, for example, from Oasis, we have the treatment data available. That's I think one of the things that requires collaboration and cooperation with other agencies and understanding their data and any of the caveats of their data. Where available and where possible, we would present their data as long as those indicators have been vetted. We do have collaboration and cooperation. Just giving you one example where we work closely with Oasis on opioid overdose prevention. Here's where we do incorporate their data.

Dr. Boufford I think that's a great example because obviously, OMH and Oasis and NYSOFA have been sort of core partners of the prevention agenda for a number of years. I think the challenge is going to be when we sort of identify what our new goals may be or what some of the focuses on upstream prevention may be, is it's a question I asked earlier that Shane obviously is holding. Holding the ring on is sort of the degree to which these collaborations move beyond those who have been the core partners and engage those that have the authority over things like healthy and safe environments and housing and transportation and AG and Markets and other issues. It's to me one of the big challenges of the new version of whatever we look at. Denise's question from earlier of how does it relate to a local infrastructure that can really tailor decisions about priority setting and interventions to a local community? I just want to flag those two takeaways from these great discussions and presentations. For me, I'm going to continue to raise them in terms of the other options that we're asked to look at.

Dr. Boufford Dr. Soffel has another question or observation.

Dr. Soffel I do have a question. This is a really wonderful resource. I'm really impressed with how easy it is to use. I'm wondering what the department is doing to make the world aware that this exists and it's a resource that we all can be using, what you're doing to publicize this, whether there's like a training guide how to use this, whether you're doing community presentations that tell people here is an incredible resource for your community and here's what it might be able to help you think about and do as a community. I think it's a great resource. I would love to see it really broadly used.

Ms. Mack Thank you for that feedback. We do try to get the message out in a number of ways. When our data gets updated, we send information out about these updates via our prevention agenda listserv. We also do presentations to our different programmatic and partner areas. For example, we work closely with the New York State as a control program. We have an Asthma Data Dashboard that was presented at the Asthma Partners of New York meeting. We present to the partners. We get that message out to the community that way. The asthma one is a particularly great example because when we show that data at the county level, we have a number of contractors like the American Lung Association, who then do programs and services. They're able to gather different on the ground data that they use in the Asthma Control Program for understanding their population. Our surveillance data works in tandem with what those programs are doing at that local level and can be done. We inform their work. They in turn collect data that helps us with our performance measures and informs our work as well. It's a nice bidirectional process. Indeed, we want to do better and do more to get this information out. We are currently revamping our data index page so that these dashboards are featured in a more eye catching and friendly manner along with a number of other dashboards. We will likely be doing some press releases and press announcements about it as well. We're very proud of the work that's been done here in Office of Science and throughout the Health Department. We want to be a resource. We do want to help people understand these data products. Another thing we are doing is recording demos so that we will have a demo recorded so that people can utilize that. Every dashboard has a nice how to user guide. It's a quick set of slides that just helps you navigate around, understand what the different features are. Every data dashboard has this quick set of user guide slides that make it so that it's friendly and understandable.

Ms. Mack I don't know if you want to chime in on anything else that we're doing to promote this.

Mr. Rosenberg Well, I just came in off of video just to say that we're also within the next day launching a new navigation and page on the department website to get to all these data much faster.

Mr. Rosenberg You have to end screen sharing.

Mr. Rosenberg Thank you.

Mr. Rosenberg One of the perennial issues with our website is that it's impossible to navigate. I see some laughter in the room. It's true. We have a terrible website by many standards. Terrible is the wrong word, but sort of hard to navigate, lots of challenges. We are launching this new page here. This is going to be lives again, as I just said, shortly. It will be accessible off of the health data button on the upper right. It's a landing page that puts together many of our key dashboards that we just saw, prevention agenda, other sort of cross-cutting ones like you saw from Chris's presentation, the Leading Cause of Death Dashboard and so forth and then it goes into topic specific dashboards. The prior page that this was, was this A-to-Z listing that sort of disease area. Some of these links are old. They need new organization. That's the next project. For now, what we're doing is highlighting these dashboards and you can get to them very quickly off of the main DOH web page. There are all the strategies that Steph just said and then plus this redesign of the overarching web page itself is coming. We're trying. Thanks for being with us.

Dr. Soffel We were all chuckling because what we all do, everybody agreed is that we Google what we're looking for rather than trying to navigate the DOH web page, because it really is challenging right now. This would be great.

Mr. Rosenberg When we started this, redesign this page. We had the internal discussion with our communications group. That's what they said. They said, well, everyone just Googles it anyway. It's sort of everyone knows that. That sort of becomes the reason to almost not change it. It's like, well, just easier to Google it. We do think that it's worth redoing the navigation to really make this right.

Dr. Boufford It's so much better to have one stop shopping. I mean, that's what everybody wants. You weren't here to hear all the praise for the first two presentations. I didn't know whether you said you were in another meeting. I didn't know if you heard it.

Mr. Rosenberg No, I was here.

Dr. Boufford I did want to ask you another question, though. We've been talking about interagency engagement. Is there sort of analogs to your unit within your office within health department in other agencies that you that convene together or routinely talk to each other? Is that more self-organizing in that regard because that issues come up before?

Mr. Rosenberg You're saying other equivalent to our group, sort of like other data responsible?

Dr. Boufford AG and Markets and OMH and NYSOFA and other areas that are sort of doing what you're doing. I mean, we know at high level there is sort of agency data but that it's really looking at these areas of deeper analysis.

Mr. Rosenberg It's really topic specific, ad hoc as things come up. Stephanie highlighted the work with Oasis. It's one of our strongest interagency collaborations there on data that we're involved with. As needed, we talk to State Ed or other groups. Standing all the data nerds get together forum. There should be.

Dr. Boufford Maybe that can be promoted in the next round.

Dr. Boufford Thank you very much. This is great to see all the work that's gone into this. I really appreciate it.

Dr. Boufford Shane, I'm going to give you a chance for a comment or two if you have it before I introduce Andrew, who's sitting here by my side waiting to go on.

Mr. Roberts Sure.

Mr. Roberts Thank you, Dr. Boufford, and thank you, Dr. Davidson and Stephanie, for those two recitations. I just wanted to follow up on a couple of comments that the committee has been making. Is that one of the things that we're looking at with the Office of Public Health Practice is with the new prevention agenda cycle, is that we want a stronger implementation presence from the department, from the Office of Public Health Practice this time around. What I mean by that is we have looked at what other states are doing and maintaining some form of an ad hoc version of the Ad Hoc Committee going forward throughout the cycle that's an implementation arm versus just a planning arm and looking at that, doing that potentially at the regional level. One of the things that our regional offices have been doing is helping us draw in CBOs and local partners into the Prevention Agenda, Ad Hoc Committee, but then maybe convening those annually or biannually also throughout the implementation cycle so that we can talk to communities so we can ensure that over the course of six years that if things change the prevention agenda isn't working on something that was relevant six years ago, but maybe not five years later,. Potentially also using our Office of Public Health Practices to do things like technical assistance, either through training on how to use the dashboards, how to attract CBO partners, how do write a CHA, how to write a CHIP and things like that, and really working to bring speakers and relevant experts into those regional committees to help those counties and hospitals really implement their plans throughout the six-year cycle. one thing I will say is that I know at least one of our regional offices has used the Public Health Infrastructure Grant money to develop a prevention agenda, specific position to help aid with implementation within their region. There may have been others that did that as well.

Dr. Boufford That's great.

Dr. Boufford It's really good to hear about the implementation side. I think the other thing to consider there may be a sort of inner agency. I hesitate to say the word. There has been an executive order in 2018 established a Health and All and Healthy Aging Interagency Group that the Commissioner of Health, along with someone from the Governor's Office, was co-chairing. That group has been a bit dormant since COVID. It might be something that could be reactivated with appropriate agencies once the revision is done. One of the things that's really interesting at the state level is many state agencies don't have direct control over decisions made at local level, like local zoning issues that may be important for active transport, use of cars, etc. It's pretty varied. It's an interesting area.

Dr. Boufford Thank you so much, everybody. It's now my pleasure to introduce Andrew Lebwohl who is the... As blessed as of a week or so ago as the formal Director of the Center for the Master Plan for Aging within the Office of Aging and Long-Term Care. We did get a briefing from Adam Herbst, I think a couple of meetings ago on the overall master plan. He can say whatever else he wants to say. We've asked him to specifically focus on the way in which prevention is being addressed in the master plan and opportunities for sort of cross fertilization with our prevention agenda. One of the things to remind everybody is that in the last iteration of the prevention agenda there had been agreement that there would be cross-cutting attention to older adults in each of the goal areas where it was relevant. Obviously, children and women are a little less relevant, but women's health is relevant. I think they ended up with really being able to tackle the issues of adults over 50, which is not really necessarily the group that the Master Plan on Aging is focusing on. They're sort of 50 and older, but really trying to look at that. One of the conversations is how would attention to older adults over 50, 60, 65, 70, where there's pretty good data now about preventive interventions even at more advanced ages have really important impact on unhealthy longevity and activity. That's kind of one of the things we're looking forward to hearing from Andrew about. What you guys are doing or wanting to do on prevention and how to go forward further.

Mr. Lebwohl Thank you all. Happy to be here. Talking about the master plan is my favorite thing to do. It is why I had the opportunity to move into this role as the Director of the Center for the Master Plan for Aging. We'll talk a little bit briefly about the master plan for aging timeline, which has advanced since Adam had the opportunity to present to you.

Mr. Lebwohl We'll go through the timeline briefly on how it's advanced. We'll talk about the subcommittee structure, which has also developed more since Adam had the opportunity to address PHHPC and then we'll talk about prevention agenda priorities and how those are playing out in the course of the master plan. The timeline has advanced like I said. We are working right now on an interim report that's due to the Governor in January. That will reflect recommendations that were generated by the work groups of the master plan in the course of the late Summer into the Fall. Also give some summary on the activities of the master plan process outside of the work group drafting process. It'll refer to our survey, our town halls, other engagement that we're trying to do in order to identify all the constituencies that should have their voices heard in the course of the drafting of the master plan process. I think when Adam presented it was probably May or June. That was the beginning of when we were just standing up the subcommittees and work groups. Since then, the number of work groups has expanded, in part contracted in part as we really identified subjects that really needed their own attention or subjects that overlapped to such an extent that they really needed to combine. Just as a reminder for the timeline of the master plan, the subcommittee and work group drafting process is supposed to wrap up with a final report that's due in July of 2024. Following the release of that report in July it'll kind of be processed by the Master Plan for Aging Council, as it's referred to in the Governor's Executive Order, which is what we internally call the State Agency Council. It's a council of nineteen different state and New York City local agencies across all of government who have been engaged in this process. It's not just a project of the Department of Health or of the State Office for Aging. It is a project of all of New York State government that includes Oasis, OMH, OPWDD, it includes the Department of Transportation, Homes and Community Renewal. We have really tried to engage a broad swath of New York State government because ultimately these subjects are not siloed. That's something that we talked about a lot in the beginning. It's something we constantly talk about in the master plan process because it is constantly a struggle to try to get the kind of cross-fertilization that you need of ideas across areas that are not used to working

with each other and also that are difficult to report on together in tandem. We've started a project to identify the KPI's and other metrics that we want to use to evaluate the success of the master plan over the course of the next decade as we start to implement its initiatives. One of the things that we have identified as a challenge in the course of this project is ways to identify metrics that aren't just identifying whether or not we're being successful at delivering services, but whether or not the delivery of those services is actually resulting in the outcomes that we want. Whether its helping people live better lives, whether it's extending lifespan/health span, whether it's reducing the incidence of chronic disease. We'll look at the structure again, just as a reminder to everyone. This is the structure of the whole thing. I'll specifically point out that sort of third line up, which is the list of the subcommittees that we've established. The subcommittees are long term services and supports, which is really focused on facility-based care. That encompasses hospitals. It encompasses nursing homes. It encompasses assisted living. There's home and community-based services, which is the services that are delivered outside of a brick-and-mortar dedicated setting. There are caregivers, which really breaks down...

Do we have this as seven?

Caregivers is actually really two subcommittees which are formal caregivers and informal caregivers. People who are doing it on a paid basis and people who are doing it on an unpaid basis. There's health and well-being. We've started calling that health and wellness now. I should change the slide. That is the subcommittee that is chaired by Doctors Boufford and Linda Fried, and that encompasses, again, a broad swath of different subjects that all kind of feed into a larger concept of health and well-being, housing, community development in transportation, economic security, which encompasses both sort of the ways that benefits can or cannot support someone's economic security and also looking at the ways that the state can do a better job of helping people secure their own economic security in the long term basis, whether that's a matter of employment training, ageism, protections in the workforce or retirement planning. Safety, security and technology, which encompasses issues of abuse, which includes both physical abuse and can include financial fraud. It includes work group discussing guardianship and how guardianship can be structured across the state. It includes a technology workgroup which is engaging both with issues of access and of design. It's a lot. It's ambitious. I will also note at the bottom, we have these town halls listening sessions that we've been doing across the state to solicit public feedback. We have a public survey that's currently ongoing. I have a slide at the end that will show the link for it, and I can talk more about that. We have a public website. We're developing a newsletter that we would love to roll out over the course of the next couple of months. Ultimately, that will be a way of updating people on the implementation phase of the master plan. We would also like to give insight into how it develops. It's great to be here and to be talking about this today. I can't help but comment on the presentations that came before me today, because data is such a big part of this. That's a good opportunity to bring up the survey again. NYSOFA conducted a survey earlier this year for the development of their five-year plan. That was really interesting. Generated a lot of data on the ways that people perceive their experience of aging across the state, how older adults feel about aging in their communities and in New York State and what their priorities are. We're trying to dig deeper on that now and develop more information about their housing, about how they allocate a fixed income. We want to understand social isolation and try to identify both where we can look at objective metrics that could be a proxy for social isolation and also how that correlate to people's self-perception of social isolation. In the course of that, we're also trying to understand some core prevention concepts. Obviously, social determinants of health are a core prevention concept, but we've also particularly tried to identify how nutrition plays out. That's a major

element of the survey and something that we are really trying to build out across the master plan process now as we see the different ways that prevention really needs to be a part of the conversation broadly. We have a Nutrition Workgroup under the Health and Wellness Subcommittee, but we are now working on ways to build that out across the entire system of the master plan. I'll also name check. Maybe it's time to go on to the slide about the prevention agenda, but also namecheck how we're looking at the ways that communities are built out and the ways that housing plays into prevention. Because having healthy and safe environments is also one of the major prevention agenda elements that we're trying to build out throughout the Master Plan for Aging process. We have a housing workgroup that is engaging with issues of how housing is designed, how building codes can or cannot support a housing stock that is accessible for older adults and people with disabilities. We're also looking heavily at supply and what the state can do to specifically increase the supply of housing oriented towards older adults and people with disabilities, how the state can support the development of more senior affordable housing. That isn't necessarily a supply question. It is prompting some really interesting and important conversations about, among other things, zoning and financing and what the state can do to really address the supply issue, which then also plays into issues of economic security and whether or not people have the resources that they need in order to meet nutrition needs, housing needs, medical needs. What the state can do to support early interventions that will also long term ease those burdens. New York State is the first state pursuing a master plan that has really made public health a core concept of the way that it conceives its Master Plan for Aging. One of the ways that we are trying to really incorporate that is to encourage people to think about the savings that are generated by prevention initiatives and to say that aging initiatives and health care initiatives are not separate. There are people on the aging side who are really doing a fantastic job. I want to specifically appreciate Becky and some comments that she's made recently. I saw an interview with her on PBS just last night talking about the ways that aging services really support Medicaid and the ways that building out these non-Medicaid non-healthcare-oriented services can really help people stay off Medicaid. It's a win for everyone. It's a win for people who don't want to have to impoverished themselves to get on Medicaid to cover their own care. It's a win for state budgets and Medicaid. It's really important that we understand the ways that all of these things connect. That's also one of the things that we are constantly working to do a better job of in the course of the master plan. When we talk about prevention of chronic disease, it has to do with all of these social determinants of health that the master plan is dealing with. We are looking particularly at nutrition, at healthy and safe environments and at vaccination as major elements of preventing chronic disease, whether that's cancer and asthma or whether it's Alzheimer's. There's new research coming out all the time. I know that there's research evolving on Alzheimer's right now that documents the ways that airborne particulates end up correlating with the onset of Alzheimer's. As we understand more of these social determinants of health, we're able to integrate them more into the conversation of how these systems rely on each other and how we can really think about them on a fiscal basis too. We've talked about promoting a healthy and safe environment. Promoting healthy women, infants and children. I'll also namecheck the Kinship Caregiver Workgroup that exists under the Informal Caregivers Subcommittee and the fact that older adults are often caregivers also. We need to consider their role in the evolution of healthy families in the state and not just how we can support them as older adults who are in that position, but also how that contributes long term to the health of the population in New York State by having families that have the support of the older adults in their family and community. I'll also note that we have been thinking more lately about questions of juveniles with disabilities and the ways that a lot of our systems of support for people with disabilities grew up at a time when we didn't expect people to live for as long as they have with the supports that they have and how those

systems need to adapt to reflect the new reality that this is not wood but I would have been asking wood. Thankfully, we have managed to significantly extend the lifespan of people with serious disabilities. We've talked a bit about promoting wellbeing. There is also a Mental Health and Substance Abuse workgroup under the Health and Wellness Subcommittee that in their first recommendation they proposed a kind of diagnostic tool that can be a little more all-inclusive of a wide range of needs. As that continues to evolve, we're seeing the ways that the different workers need to have joint meetings, the ways that they need to talk about their joint goals, how mental health and substance use needs to be in touch with work groups, talking about cognitive health and about guardianship and abuse and about kinship care. All of these conversations are being arranged across the work groups to make sure that people are talking to each other and understanding the ways that these intersect. Prevention of communicable diseases, again, fundamentally assisting with prevention efforts, assisting with diagnostic efforts. A big part of that also is helping people age in place and helping them stay at home, limiting hospital borne illness, limiting the declines in health that come as a result of institutionalization. We have these pillars. We're working on organizing concepts according to kind of ten pillars that we've put together. We're developing one to really make sure that facilitating aging in place has a central place in the way that we think about the master plan. I think that's the end of my substantive slides. I will just throw out there are many ways that we want people to get involved. Being a part of a workgroup that's doing drafting is not the only way to do that. Please come to our town halls and our listening sessions across the state. Please check our website, see the town halls and listening sessions that we have held so far. Look at our preliminary report that we issued over the Summer and make sure that all of the people in your network are filling out our public survey, which is currently scheduled to close on December 31st. That is the specific link. Honestly, if you go to NY.Gov/MPA, there's a link right there on the page that'll take you into the survey. Send it to all your friends, please. We answer every email that comes into that email address also. You can do MPATownHall@Health.NY.Gov. You can also just do MPA@Health.NY.Gov. That Michaels. I'll stop there.

Mr. Lebwohl Dr. Boufford, if you want to say anything.

Dr. Boufford For before we open it for questions, thank you so much. I just wanted to... Andrew alluded to it, but the health and wellness. We're sort of shying away from the word wellbeing because it's, I would say globally contested word, shall we say. We'll try to deal with wellness, but the lens that our subcommittee is using is very much a prevention lens. The working groups he mentioned. There's a working group on Nutrition and Food Security. There's another one on Preventing Medicare and Medicaid Prevention Benefits under Medicare and Medicaid. That's one of the working groups looking at what's there now and what could be there in terms of ideal situations. Cognitive Health Working Group, which is looking at the sort of some of the dementias, but also the sort of early identification and linking to prevention of things that if people as they begin to perhaps lose capacity for vision and capacity for hearing what may be a mistake in his cognitive issues that aren't. that's where the cross-fertilization that Andrew's talking about. Also dealing with more serious dementia, such as Alzheimer's and others. We have another working group on Mental Health and Addiction and what we call the... It's kind of the all-encompassing work group one, which is Promoting and Sustaining Health and Wellness. This is led by Linda Fried who's really looking at the evidence base for preventable public health and health problems and what interventions, where the evidence base is really strong for an intervention. The first one that's been included in the interim report is sort of all of the evidence around the importance of false prevention in older people, for example, which of course has implications for internal built environment, external built environment, etc.

That's part of the cross-fertilization that Andrew's alluding to. We're trying to really focus on the prevention lens. The other thing, just to channel Linda for a moment. She was the Co-Chair of the U.S. National Academy of Medicine's Blueprint, Global Blueprint for Healthy Longevity Study, which came out about six months ago, a year ago. Has fabulous evidence, really showing, as I said earlier. I just want to emphasize that prevention is important for its own sake, that prevention in older we talk about life course, and it can seem a bit overwhelming. Like if you start sort of prenatal care and have to have everything in place. A lot of the evidence is coming clear that beginning at age 40, 50, 60, 70, there are different subgroups of aging where people may become or are at higher risk for becoming sick more than well. There are ways of intervening at each of those stages. That is very much an emphasis of that particular work group.

Dr. Boufford I'm going to open it to questions.

Dr. Boufford Yes, Ms. Soto.

Ms. Soto I have comments and a question. I'm sensitive to this topic because I am in the aging group. I'm glad to hear that part of the screening will be hearing and hopefully vision because a person may be thought of not having the cognitive ability, but is it that they can't hear? They can't really see. Their actions or the way they're reacting is due to some other health issue, not the cognitive ability. My question is this and hearing about all the various subgroups and working groups. Is part of the discussion on how to address and incorporate cultural and linguistic issues, because not everyone views aging or coming from a racial ethnic group, how you wish to function or the way you react to certain situations? I went through a presentation some years ago. I was born in the Bronx, in New York City. I'm used to eating institutional food. I went to school. This person was talking about how some of the Latinos did not. Some of these are assisted living and also nursing homes were not used to beige food. It was like the turkey with the mashed potatoes. This was not something that these individuals were accustomed to or preferred. I never thought about that because, again, I grew up. I ate in public schools. I ate this beige food. I was fortunate to have my mother to live to be 96. She was a little bit a typical Puerto Rican. Mommy ate Greek yogurt, tofu. It's interesting because my sister fussed a bit one time because Mommy wanted to eat organic. I said, Mommy grew up organic. Free range chicken, food without pesticides. My question is, in the discussions and in trying to provide the best services to individuals is discussions or recognition to the different cultural and linguistic ways of people approaching and what are some of their needs? I see that part of the survey has you can get it in a different language but addressing some of the needs of these individuals.

Mr. Lebwohl It's a great question. I will say what I have seen so far has been more focused on where those needs come up in the home and community-based care setting. I can tell you we spent the first part of the Summer having these work group put together a problem statement because we wanted to help kind of focus the work that would be happening over the ensuing year. The better you describe a problem the easier it is to identify the solution. Many of the work groups included the need for state support for culturally competent care as part of what they were trying to do. It is a big focus in several of the work groups. I don't know that there's been much discussion of it in an institutional context yet, but it's a great issue to flag and bring up.

Dr. Boufford I can say our Nutrition and Food Security Group has talked about it a lot relative to sort of existing, as you said, home delivered meals and other programs for older people. I think with the cross-fertilization, we're going to come after the institutional basis

and some of the others to have that conversation. The other thing that's come up culturally, which has been fascinating to me, is this in really focusing on the strengths of older people, is there value is culture carriers in communities linked to the issue of social isolation and social cohesion. It's an area that we're going to be doing a special kind of working group bounded one within our group and then perhaps broadly looking at that question is the degree to which older people bring that strength both for intergenerational engagement, but also knowing the history of communities, knowing where things used to be that might be places people would come to that they've never thought about before. It's a really important area. I'm excited about that. It's been kind of new to me in that regard.

Mr. Lawrence I was feeling a little uncomfortable because I thought Ms. Soto was referring to me in terms of the hearing and the site/vision. My question is that how are you getting any input around faith-based institution? Because I know in the African American community you'll find most of your seniors in church on Sunday, even if they have to call their grand kids to get them there. Also, to Dr. Boufford's point, intergenerational care. I mean, and services and really what are you doing in that area? For our time and in the community that we're grandparents actually taking care of their grandchildren. That's a pretty hefty responsibility. Beyond that, I think also this transfer of knowledge and wisdom and culture is an important element of contribution that seniors can make in school and elsewhere.

Mr. Lebwohl Thank you.

Mr. Lebwohl You're exactly right. It is something that comes up in several places consistently in conversations about how we reach populations who sometimes might be difficult to reach through, difficult through traditional efforts. The reason that I was looking away from you for a second there was because I was pulling up the rosters to see if I had the name of his church. One of the chairs of our Long-Term Services and Supports Subcommittee is actually Pastor George Nicholas, who's the Pastor of a Black church in Buffalo. It was his church where we had actually our first town hall event in Buffalo. We're very aware of the need to turn to faith-based institutions as a way of reaching a lot of communities across the state. It's an ongoing process. It's an ongoing effort. Those voices are part of our process. I think that there's a lot of consciousness overall about the fact that you can't reach every community the same way and that we're going to need to make room for a diversity of efforts for how we're going to get communication out there for letting people know what benefits are out there for them, making sure that we're getting into the community and hearing what they want to see in the master plan and then just more broadly, what they need in general. The culturally competent care piece of it, too. Making sure that people are being introduced to all of our efforts in a way that they're able to receive and that they're getting from trusted partners.

Dr. Boufford Dr. Soffel.

Mr. Lawrence What about the intergenerational component of that? How are you bringing that together in terms of seniors and say high school students, college students. How are you connecting? What are your plans for making those connections?

Mr. Lebwohl That is also a really good element. When you mention that the first thing I thought it was Kinship Caregivers in the way that we're supporting older adults who are in the position of taking care of their families. The truth is, I think that that's something that we really need to develop. I appreciate it as another note for something that we need to spend

some time thinking about for volunteerism opportunities in both directions and the way to have a smoother continuum of communities across the generations.

Dr. Boufford I mean, Andrew's operating at a fairly high level, understandably, and knows a lot about the details that you wouldn't even expect he would. Within our working group, I mean, I mentioned the issue of social engagement and social isolation, the intergenerational issue is very much a part of that. I mean, part of the issue of the detached youth issue that was raised in one of the other data that I think is a really important area. That's something that's come up in that context. I wrote it down. We'll make sure that it gets the emphasis it deserves going forward. Thank you.

Dr. Boufford Dr. Soffel.

Dr. Soffel I'm curious how you are managing the tension between the need for community based long term care services, home and community-based support and services and their cost? Because it seems to me that it may be not a bottomless need for more human community based. We are far from meeting the need for home and community-based services to keep people safely at home. It's an expensive proposition. I know that the Medicaid program is working really hard to try to keep a cap on how many people are using Medicaid to finance their services because there's just not limitless money to pay for it. I'm curious how you are managing that tension between an obvious need for more services and finite resources to pay for them? Sort of the second piece of that, I guess, is the workforce question and how do we figure out how who's going to actually provide all those homes and community-based services at a price that we can afford to pay for them?

Mr. Lebwohl Great questions. Thank God I'm not in the division of budget. Working out the allocation of the state budget is not the job of the master plan. The fact that resources are finite. I should also say that's not to say that the master plan won't include fiscal recommendations for the programs that people are coming up with. The truth is, even if the state were flush with cash right now there's still ultimately finite resources and always more that we want to do. From that perspective, any time that we improve the efficiency of services that we're providing, any time that we introduce preventive services that cost less than the acute services that they're ultimately preventing, that's a win. We don't need to make a decision about how much are we willing to spend on community-based services before we put someone into a nursing home because it's always better to identify services that improve people's health span, that reduce the need for acute care in the long term, and that improve the efficiency of service delivery.

Mr. Lebwohl Your other question was workforce, right?

Dr. Soffel Yes.

Mr. Lebwohl On the question of workforce... I am switching gears now in my head. Everyone talks about it. It's a major cross-cutting issue. We have a Formal Caregiving Subcommittee that is looking into issues of recruitment and retention and scope of practice, so ways that we can do more with our existing workforce, ways that we can attract people into the caregiving professions and ways that we can make sure that they stay there. It's a concern under HCVS. It's a concern under long term services and supports in the facilities that they're looking at. We recently added a workgroup dealing with licensed professionals because the issues are different when you're talking about licensed nurses and MDS and social workers, for example, versus non-licensed personal care aides. There's no silver bullet. There are lots of ideas that people are generating for

how to continue to attract more people into the industry. There are pipeline programs that people are looking at. There are questions of compensation and benefits. There are also these scope of practice questions for how we can make sure that people are doing as much as they possibly can do. There are also conversations looking at some of the regulatory distinctions that don't necessarily have practical meaning in terms of what people are allowed to do, whether they are or aren't funded by Medicaid or Medicare, and whether we need to look at regulations that unnecessarily separate functions that one person could easily provide. It's an effort that has to attack from all fronts. We have to attack supply. We have to attack retention. We have to attack scope of practice. That means how we recruit people. The retention of the compensation and benefits that they get. Also, things like career ladders and mentoring and how we make sure that people aren't just happy with the job that they have but feel like it's a long-term career that they want to invest in and continue to build skills in.

Ms. Soto I was saying that I imagine that part of the challenge is you're going to have pockets of to say that there's not sufficient supply. There may be more individuals in the lower part were more populated. There may be regions in terms of who are we're going to be these providers and assistance?

Mr. Lebwohl On that point also, I mean, that problem exists particularly in a lot of rural counties. Part of that conversation has also been transportation networks and transportation support. Transportation is also part of that workforce question. It's all connected.

Dr. Boufford Dr. Torres..

Dr. Torres If we can just make sure that we have a commitment to really implementing cultural scripts. The comments made by my colleagues here today kind of like sparked this memory of conversations that we've had on the medical platform level where physicians are saying, you're already in your later 50's. In order for you to have improved outcomes and not die right after you retire you have to implement these changes and these recommendations now. I mean, these are the conversations that are being held as we speak. Just even on the topic of food as medicine. How do people in different neighborhoods and different cultural backgrounds really also interpret and understand food as medicine and energy and sustainability and longer lifespan? Only because there's been such an abundance of clinical recs in our community and a combination of food access, the affordability, the food insecurity and all that kind of stuff factored in.

Mr. Lebwohl It's a great point. I want to say, first of all, one of the great things about our town hall and listening session efforts so far is the way that they're also helping us build a network of people engaged with the master plan across the state. Tomorrow we have a town hall happening at the A. Philip Randolph Senior Center. We've been in places in Utica and Binghamton and Rochester and Syracuse. In Buffalo, we did both in the City of Buffalo and then outside Buffalo. I want to say Amherst. We're also building out this network across the state of local community leaders who are getting engaged with the master plan. We have their email addresses to engage them with how things roll out in their communities. We're going to shift to an implementation phase eventually, right? After the master plan is released in January of 2025. That's the point at which there's going to... For anyone who doesn't know, Dr. Torres sits on at least one of our work groups. We expect the work groups to continue to meet not as frequently, but to continue to meet periodically after the release of the Master Plan for Aging, because it has to be a dynamic document that responds to changing demographics, new research, whatever it is, but also

as a form of accountability in the course of the implementation process and to make sure that we're keeping those kinds of things in mind. Today, in December of 2023, I can give you a commitment to culturally competent rollout. Ultimately, it's going to be in 2025 when we have an official Master Plan for Aging. Thank you.

Dr. Boufford I think, the timing also, Andrew mentioned, I guess, the final report from the various subcommittees in the infrastructure going to the Governor are going to you guys to go to the Governor in July after some good bit of public consultation with your other agency partners and others to be issued in January. Obviously, that's kind of the same time cycle for the new iteration of the prevention agenda. Part of it is interlocking people that are serving on both groups. I know other people that are on the PHHPC are involved in in other groups as well but just keeping this dialogue going and seeing how we can cross fertilize both the structures, I think the reach and the structures and the elements and the agendas there together.

Dr. Boufford Mr. Lawrence.

Mr. Lawrence I just wanted to follow up on Dr. Soffel's point, and that is the budget. Because you can have a wonderful plan. How do you engage in that process to ensure that at least some of the priorities are going to be budgeted?

Mr. Lebwohl We will not remake the New York State budgeting process in the Master Plan for aging. As much as I would love to, and I'm sure that a lot of other people would also love to. At the point that we make our recommendations, we can do our best to identify a fiscal for what it really costs. We can make our best argument for how much it saves. Ultimately, another reason that the master plan is going to be an ongoing process that's going to continue to be stakeholders is because we've brought so many people with so many key constituencies into the room at the same time. If we can get everyone to support the same policies at the same time that's part of the process of getting the budget that we need in order to do the things that we need to do to have a functioning system of services and supports for older adults and people with disabilities.

Dr. Boufford As a non-employee of the state to say that, I think, well, what are the really... This has been an issue, a really important issue that's been discussed a lot. I think in the last meeting of the co-chairs of the different subcommittees, Steve Berger, who some of you will know as both iconoclastic and a very wise person who's been involved in state policy. He made the point. I think people really resonated to it. That it's our job to develop the best possible master plan to address healthy aging and health span/lifespan in New York State. It's the political issue, the political politician’s problem to figure out how to pay for it and what will happen and how it's going to be paid for. I think people really found that helpful because it's pretty hard to be... I think we've gotten permission. People have wanted to be innovative, wanted to think about things that aren't happening now, using examples from other states. I think twenty-seven other states are doing the master plan. Part of this issue of the networking is to get support for a sort of advocacy for the kind of budget or the kind of innovations that you want to see happen. It was a conceptual issue. Otherwise, I think everybody's quite conscious, as Andrew said about how much is it going to cost?

Mr. Lawrence Because if you say we can't afford it upfront then all thinking stops, all creativity stops. Strategically, at some point there will be elements of cost in in that that will be attached to the plan. To further the conversation and the discussion people need to have a handle on, well, if we do A it's going to cost between ten and five, whatever, or five

and ten billion. At that point it becomes more strategic in terms of forcing the conversation about priorities and also about funding.

Mr. Lebwohl I agree. It's a really good point. We're going to continue to try to get the messaging right on to talk about the funding. It's part of why we also incorporated the prevention agenda in the course of talking about the fiscals for everything that the better job people can do of really identifying how something results in system wide savings in the long term the easier it is to make the case. You're also right that we are also forcing the conversation to talk about priorities and to talk about where state dollars need to be spent. Thank you.

Dr. Boufford Thanks very much. Really appreciate it. Very illuminating.

Dr. Boufford I think we had one member of the public down here in New York City who heard the really fantastic presentations and decided to decamp.

Dr. Boufford I don't know if there's any public comment. I think you would have to be in this room, right, Colleen? We don't have anyone for that.

Dr. Boufford I just want to remind me I'm going to give Shane a word. Why don't I give you a word, and then I'll just mention the upcoming meeting, Shane If you want to have any kind of last comments on all of this.

Mr. Roberts Sure.

Mr. Roberts Thank you, Dr. Boufford.

Mr. Roberts Just again, thanking our presenters, I think as we are barreling towards a conclusion to this planning process for the prevention agenda for 2025 to 2030, it has really been probably the strength of the planning process that we've been able to collaborate with so many people, both internal to the department and external of our sister state agencies and our local community partners. We do look forward to being able to preview that to the committee. Colleen and correct me if I'm wrong. I think it's February 7th is when we're looking to have that meeting. I don't think it's been officially sent out yet, but I think that's what we were looking at for a date and then the next Ad Hoc again on February 22nd.

Dr. Boufford Very good.

Dr. Boufford Thank you.

Dr. Boufford As we said, the February 7th meeting will be in New York City thinking about from 1:00 to 3:00 in the afternoon because the next day is the PHHPC meeting, I think. And then February 22nd would be the Ad Hoc meeting, which would be in Albany and New York City.

Dr. Boufford Did I say it right this time?

Dr. Boufford Thank you.

Dr. Boufford We'll get that on your calendars right away. I think hopefully after that we'll get a regular. It's been difficult to find a way to program in the Public Health Committee

given the other committees that have their sort of huge numbers of people and public comments and others that have to come in. We're getting there.

Dr. Boufford Any other final comments for the good of the order?

Dr. Boufford Thanks very much.

Dr. Boufford Again, a been a lot to digest for the last three months, four months. I really appreciate everybody's participation, active engagement. I think we'll be well-prepared to receive the draft of the department about how, as Shane says, options they're considering for the next iteration of the prevention agenda get this groups comments and then carry forward to a proposal to get Ad Hoc Committee feedback and then see where we go from there over the next month. Anyway, thanks very much.

Dr. Boufford I will declare our meeting adjourned.

Dr. Boufford Thank you.