NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
JOINT PUBLIC HEALTH COMMITTEE AND HEALTH PLANNING COMMITTEE MEETING
TRANSCRIPT
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Dr. Boufford I'm going to start. Is that all right with you?

DOH Albany Go ahead, Dr. Boufford.

Dr. Boufford Okay, great.

Dr. Boufford Laura's our facilitator. Will convene the meeting and she'll help us later as we proceed. First of all, welcome to everyone. We're delighted to see so many people from the council with us from this is a meeting, joint meeting of the Public Health Committee and the Health Planning Committee. We have met together many times in the past and wanted to sort of kick off what we hope is a new, I will never say post-COVID, but at least post obsession with COVID era so that we're continuing to do COVID and preparing for future challenges, but also moving back to our attention to a broader, sort of the broader health systems agenda. We're very delighted to be back. I want to specifically thank Ms. Santilli and Priti Irani and their team for helping pull this meeting together. And especially I wish I was there in person but not able to do so today, but really to thank the public health team under Dr. Bauer's leadership and the local health department leadership who have done such heroic work in the face of the last two years of just sort of really previously unexperienced crisis and come through really, really well. We really appreciate all the work you've done and are delighted to move forward with you in COVID plus, I guess, in this next phase. I also want to say that we're delighted with that Commissioner bassett was able to meet at their last full meeting a week or so ago, and I'm very delighted to welcome Dr. Ursula Bauer, who's taken over as the Deputy Commissioner for Public Health. She'll speak to us in a few moments, but it's great to have you on board. I think I want to go back and give a little bit of background to this meeting. First of all, the Public Health and Health Planning Committee, as the council will know organized a set of discussions really at a sort of webinar forum in July of 2020. The council was very supportive of a white paper that came out of that, expressing our concern for sort of moving in the direction of a fully integrated health system that not only was led by hospitals who have been doing such a fantastic job over the last couple of years, but also included organized primary care, primary care providers and local health departments as part of an integrated approach., we tried to highlight opportunities that could have been taken more aggressively during the initial COVID response and the follow up and identifying areas that we felt could benefit from an integrated approach as the health system is reframed, arguably under a new waiver request, which we'll hear about later. The idea was really this council has been, I think, a voice for sort of integrated health system, not only in relation to local health departments, primary care and hospitals, but also really seeking a strategy for long term care for some years, hoping that we could really integrate all the pieces. I think what we're at least harrowing and what we wanted to hopefully at the end of this meeting know more about is how those different pieces are moving and how they might be pulled together. This joint meeting is a while the focus is relatively more on public health updates. It's really designed to kind of cover critical issues facing the state that this council has been

concerned with or that we believe should be on the agenda of the council going forward in more detail as sort of in the coming months. We're going to be getting an update on the prevention agenda, as you saw from 2020 and from 2021. We want to revisit the status of the health across all policies group. This is the group across agencies that was created as a result of previous Governor's Executive Order in 2018, calling on all agencies to look at the health effects of their programs, planning and policy purchasing, as well as the effects on the age friendliness of New York State, New York State being the first age friendly state. We also wanted to talk about public health workforce. There's been a recent action topping up salaries for the health care delivery workforce, but what are some thoughts about what's going on in the public health space. We'll hear about a particular program, but we also want to explore sort of the last status report on public health workforce in the state was a number of years ago. I think I was on that task force. I can't remember the year. It's been at least 6 or 7 or 8 years, if not longer. What the possibilities are in that regard. The Public Health Committee has also been very concerned on maternal mortality, which continues to be a challenge for the state. We developed a white paper. This committee developed a white paper 5 years ago, resulting in working with the State Department to lay out some of the issues that we thought were important in terms of prevention and of maternal mortality and addressing the dramatic disparities with African-American women. This then was issued. It turned into a Governor's commission, and the former Commissioner of Health held a series of meetings, and those reports have been coming out annually. We'll hear from the staff group today and the council, the Council Public Health Committee at its last meeting wanted to keep this on our agenda so we can track progress. We'll hear about community benefit, which is another area we looked at and want to look at more intensively in the coming months as a potential opportunity for resources for our community health agenda. And then we'll have our last presenter, Brett Friedman, who met with us earlier on the overall wave where we've asked him to come and give us an update since the feds have responded, but especially focusing on the elements of the waiver that are particularly related to primary care and public health, especially the heroes and the social determinants networks. So, that's our plan. That's why the meeting is elongated, but it's highly varied. I think we'll find it really interesting. And again, I want to thank John and our colleague Ann Monroe,we should have like the three musketeers, I guess sometimes maybe some weeks musketeer, some weeks mouse. Sort of trying to keep the public health and the primary care agenda moving and we appreciate the support of the council in doing so and Jeff Kraut support as Chair of the council. I'll stop my remarks there and I think turn it over to John for his welcome.

Dr. Rugge I can only start by thanking Dr. Boufford and staff for all the progress we're making in advancing the cause of public health despite COVID, or wait, maybe because of COVID, we understand all the better how important public health services are and how much we need them. The Health Planning Committee, we have a ways to go. So much to do. Can only hope that our new leadership in Albany understands that in general and certainly health planning our resource that we have lots of expertise, varied experience, cover the geography and also a shared commitment to public service. We're available and hopefully will be used again. It was already brought up at least a bit of progress and made together with our report the Fall of 2020 facing the future and improving the future of health care in response to COVID. 10 months ago, Jeff Kraut suggested a series of retreats, some three retreat days and was going to put together a list of 14 possible topics to choose among. Plenty of activity to do. Previous years, Health Planning Committee has taken a one topic or another. Care comes to mind. Over the course of most of the year, really considered the potentials and ways to guide the future, taking care to assure lots of public input. Hopefully this is the beginning of a new start, and we'll have all the more to discuss. I want to especially thank Brett Friedman today for being available to talk about

how value based care can help us get there by way of improving the integration of health services, certainly expanding primary care and also addressing social determinants. We have a lot to talk about and a lot of people to thank and a lot to look forward to, I hope.

Dr. Rugge Thank you.

Dr. Boufford Thanks, John.

Dr. Boufford Dr. Bauer, welcome to our public health and Health Planning Committee. We look forward to seeing you many times in the future.

Dr. Bauer Thanks so much, Dr. Boufford and Dr. Rugge. It's great to be here. I met the council in December. That was my first meeting and am delighted to be here with the Public Health Committee and the Health Planning Committee. Really looking forward to an exciting agenda today. Certainly, so many public health priorities as has been mentioned, kind of took a backseat to the COVID response. And as we continue to see this stunning decline in Omicron cases and hospitalizations, it's more than time to bring those to the fore, assess the issues that have arisen, intensified, gotten worse, been exposed, been exacerbated by COVID over the last two years and take the public health bull by the horns as it were and start raising these issues to our immediate attention. It's exciting to have these two committees together and really look at how public health and health care, the health services can work together in a more holistic way and for the benefit of population health. I know that's one of the aspects of the New York State Department of Health that was of great interest to Dr. Bassett as she came on board with both public health and health care delivery under one roof as it were. We really have a lot of opportunity to build and strengthen those collaborations. Just thank you to everyone who put together the agenda. Thank you to Laura, to our local health department colleagues who are here with us today, thanks to Dr. Boufford and Dr, Rugge for convening us and really looking forward to an exciting day.

Dr. Bauer Thanks.

Dr. Boufford Thank you very much.

Dr. Boufford Is Michael your Deputy?

Dr. Bauer Yes, he's in the room.

Dr. Boufford Michael, you want to test the sound system in the room for us.

Dr. Boufford Thank you.

Mr. Kharfen Is there an echo now?

Dr. Boufford No, it's good.

Mr. Kharfen Excellent. Good morning. I'm very grateful to be here. Thank you. Dr. Boufford, Dr. Rugge and particularly Dr. Bauer. I joined the Health Department about three and a half months ago, but I'm not a stranger to New York in that I used to work years ago. Dr. Boufford, when you were back in New York City, when I worked for David Dinkins, who was mayor of New York City, then in the 90's and in between, I was at the Washington, DC Department of Health for 15 years directing the HIV, Hepatitis, STD and TB programs, and

also served at the US Department of Health and Human Services. It's certainly a combination of experiences to be here and advance the public health planning and public health agenda for the state.

Mr. Kharfen Thanks.

Dr. Boufford Thank you and welcome.

Dr. Boufford It's now my pleasure. We'll go through after the welcomes to everyone to introduce Laura Santilli who is Director of the Office of Public Health Practice in the department. She's had a major leadership role during COVID and was sort of certainly otherwise engaged dramatically. But as I said to her on the phone two or three weeks ago when we first started talking about this meeting, I feel like she's back, so that means we're going to get a lot of action and be able to bring that public health committee together and move ahead on our agenda. Laura and Priti Irani are going to bring us up to date on the prevention agenda. Welcome, Laura.

Ms. Santilli Great.

Ms. Santilli Thank you very much.

Ms. Santilli I feel like I need my Terminator suit. I'm back. Is that the movie? Do I have the right one? We'll say so. Thank you all very much. Dr. Boufford, nice to see you. It'll be good to give you a hug in person one of these days. But in the meantime, thank goodness for Zoom. I need my little cup that says because of Zoom meetings, but I'm not supposed to tell you what's in the cup, but right now I have coffee. That's good. Dr. Boufford had asked us to just reset to make sure everybody was.

Ms. Santilli Priti, I want to make sure you're sharing the slides as well.

Ms. Santilli Yeah.

Ms. Santilli I want to make sure everybody just really has that reset of where we were so that we don't forget about the prevention agenda. Priti and I are going to tag team a little bit. I'm going to start with just a brief reset to remind everybody and for those that are new, maybe it will be something new that we haven't seen before. I'm going to do a quick five minute review of the prevention agenda and then I'll turn it to Priti. She's going to share a little bit about the plans that were submitted and what that looks like and then a little bit of a preview of the updates that just recently came in, in December. That's our goal for this point in the agenda.

Ms. Santilli Next slide.

Ms. Santilli Is it not advancing?

Ms. Santilli Hang on one second. Figuring out the technology.

Ms. Santilli There we go.

Ms. Santilli Yeah, that's perfect.

Ms. Santilli Just a reminder our prevention agenda is the New York State's health improvement plan, sort of our strategic plan, not just for the department.

Ms. Santilli If everybody could check your mute button. Somebody came off.

Mr. La Rue I'm sorry to interrupt you.

Ms. Santilli Yes.

Scott La Rue Is there slides up that we're supposed to be seeing?

Ms. Santilli There is. Is it not sharing?

Dr. Rugge We see it.

Mr. Kraut Scott, you may have to go to speaker view on your thing. You're going to have to take it off the gallery and put the speaker view and you'll see the slides.

Mr. La Rue Thank you.

Ms. Santilli Oh, Zoom.

Ms. Santilli It's Okay.

Ms. Santilli Just the reminder that that's our strategic plan. What I also have to tell our DOH colleagues is this is not DOH's strategic plan. It is New York State's strategic plan for health improvement. It goes external to our community based organizations, our local health departments, our health care providers, everybody that's in this public health space.

Ms. Santilli Next slide.

Ms. Santilli All of our partners here have been part of the planning process led by the ad hoc committee that is part of this council.

Ms. Santilli Next slide.

Ms. Santilli To give you a sense of the cross-cutting principles. W're really thinking about not just from a topical subject matter expert type area, but really what it looks like in a broader sense. You heard Dr. Boufford talk about health across all policies. How do we really make sure that health is in everything that we do? It doesn't matter if it's a transportation project. It doesn't matter if it's a housing project. We want to make sure health is something that is a very strong consideration in all of those policies across all of those sectors. And then that Age Friendly New York really looking at supporting our older adult population in everything that we do. Both of those travel together with those other underpinning cross-cutting principles of promoting health equity enabling well-being.

Ms. Santilli Next slide.

Ms. Santilli There are five main priority areas. You guys are probably familiar with this. These are not going to change, right? These continue to be the major priority areas they were before COVID. They were during COVID, and they will be after COVID. Chronic diseases, healthy and safe environment, women, infants and children, promoting well-

being and preventing mental and substance use disorders and preventing communicable diseases.

Ms. Santilli Next slide.

Ms. Santilli Two main timeline pieces that I wanted to just make sure I set up before I then turn it to Priti, is that the work plans that were due into the department came in. They were due 12/312019. Priti is going to be able to share a little bit about what those work plans look like, what they said they were going to do. And then the updates, according to the timeline, were due just this past December. Again, she'll give us a sneak peek. I don't need to tell you what happened in between those two timelines. It was the biggest disruptor we've ever had to public health and the successes that we were able to say, as Dr. Rugge said, not despite COVID, but with COVID. How do we frame our thinking in responding to public health after coming through the worst public health crisis that we've seen in our lifetimes?

Ms. Santilli With that, I'll turn it to Priti.

Ms. Santilli Thank you.

Ms. Irani Hello. Good morning. I have been looking at the 2021 updates, and we actually looked at the 2019 to 2021 of comprehensive plans that were submitted in December of 2019. My first part of the presentation will talk about the plans that were submitted in December of 2019. To give you a quick reminder, we asked for an executive summary. We asked them to work collaboratively to work on the community health needs assessment that had demographics, assets, the gaps, they had to identify, at least when I said they it's local health departments and nonprofit hospitals who submit the plans to us had to identify at least two common priorities, and at least one priority had to address a disparity or equity issue. We asked about dissemination, continued engagement. They could submit plans combined, like local health departments and hospitals, one county plan or a hospital system which crossed across counties could submit a plan, or individually organizations could submit a plan, and they were submitted, most of them in December 31st, 2019. You can see from that Venn diagram of this site, 45 combined plans were submitted from 46 local health departments and 68 hospitals. That was kind of a sign of collaboration that also made it easier for many of them.

Dr. Boufford Can I say our hope was to move the Venn diagram, so there are two circles that are superimposed. That's been a process over the last several years.

Ms. Irani I'll kind of briefly tell you what we learned from the 2019 plans that they are working on. They want to work on equity and they expressed an intent because the plans are prospective, so what's going to happen forward. They identified socioeconomic status, race, ethnicity, health care access, geography, disabilities, age and gender as equity issues. Urban counties were more likely to identify race ethnicity. Rural, suburban, more likely to identify socioeconomic status. Most plans were not clear on how to measure the impact on equity, but they do want to work on equity. When we said priority, it's a little broader term. It would also allow two focus areas as two different priorities, so that's one thing to remember. The other thing is it has to be a consensus between the local health department and hospitals and community that they're working towards on those issues towards their goals, common goals. And even though they identify priorities, we are aware that they work on a lot of other issues than what they identify. These are consensus issues that they report to us and they have to evaluate. It's a little more kind of in-depth and

broader in terms of who's involved, and the work plans are prospective. You can see all the state aid payments that go out to the local health department and you can see they work on community health assessments, environmental health communicable diseases is a big chunk of it, the light green, yet very few of them identified it as a consensus priority across. That's important to remember. If you look at what they identified as common priorities across the state. Prevent chronic diseases, almost every county identified it as a common priority that everybody's working on and the next most cited or identified priority was to promote well-being and prevent mental and substance use disorder. That's 57. Prevent chronic diseases. 53. Promote well-being and prevent mental and substance use disorders. All the priorities had some counties that identified it as a priority, all the prevention agenda priorities. The smallest you see is prevent communicable diseases. But as you see in state aid, they are working on it even though it's not identified as a common priority. The other part we had time to look at this time was if they identified a goal, were they really only working on a goal and they're not in silos, so you can see chronic disease. There were 84 goals that we looked at, which actually crossed over to other goals within the chronic disease. They may have been working on self care management, but they're also working on food access or they were working on well-being. You see those little strands that priorities are not in silo. Even though they're required to identify one priority or one goal, they often crossover across goals. That's really what this chart shows. Strengths identified after looking at the 2019 was community health needs assessment. They know their community. They know that the equity issues are. They know what the priorities are. They are collaborating. People are sitting at the table. They describe disparate populations. They submitted a complete information in the work plan, which is amazing because in the past we still get incomplete information. They know what best practices there and that's what they identified. Challenges is tracking progress with intermediate measures. That's the more proximal measures before they go to the long term measures. Articulating how equity and social determinants of health are being addressed. They want to address. They know what they are. When they do an intervention, they're not sure whether it's being addressed. Evaluation is an issue. Collaborating with marginalized communities to strengthen self-determination, leadership and ownership. They are working across organizations. At least in terms of the report, we wanted to see more articulation in how they're working with marginalized communities. I looked at the 2021 updates that were submitted last December. This is a kind of a chart to kind of give you the framework. We look at the work plans and we are assessing the work plans. On the left is just the general process. The arrows shows assets. We work on what we have, our capacity and skills. We develop processes. We identify evidence based practices. We look to see whether it's going the way we want to and that eventually, we hope will lead to outcomes and impacts and towards a prevention agenda for being the healthiest state. On the right, you see a large part of what we do in terms of assets and processes description. It's what we do. It's what we can see and what we can very easily report. A big part where people are challenged and need more support is with the analysis. We are doing a lot of work. What does that mean? How is it working in our community? As Laura said, we have these cross-cutting principles of health across all policies promoting equity, enable wellbeing, healthy aging. That's really a foundation on what we are working on. We are working on the 10 essential public health services that was actually revised in 2020 because of the pandemic. It was first developed in 1996, but during the pandemic, equity came to such a forefront they put equity in front of the essential public health services at the center and tweaked all the essential services to kind of recognize equity is important. Then we work on policies, infrastructure capacity programs. We put in our effort. People participate in different ways. We hope we'll get increased physical activity or increased resources and improved livelihood and that eventually, we hope, will make New York the healthiest state. That's what we want to see. That's our vision. That's like the background. This is what we

learned from the 2021 update. I kind of again put the process on the left hand side and the right hand side description. In this particular chart, I want you to look at the blue line, which is prevent chronic diseases only because that's thickest and it's easier to see. You can see PCD prevent chronic diseases as you go from the bottom to the top. First, we have received updates from 80 percent of local health departments and hospitals. 20 percent are still in the process of submitting the update. This is 80 percent of those that were submitted. They identify the priorities and goals in the work plan in December of 2019. You can see that that kind of column there, which is prevent chronic diseases. You can see it kind of decreases a little bit, but it's still pretty thick in terms of best practices selected for chronic diseases. And then as you go to the next one and you see what's happening, you see the great pipeline there that's disrupted by COVID. They couldn't really do much. A lot of their work involved meeting with people, getting people to some place. Conversations, dialog that really stopped whether they were working the schools, whether they're working in community. They just couldn't go up because people were just not at the table. But then there was a small pipeline that did go forward that blue one. Those tended to be to a large part like the clinical kind of interventions like screening was common. They did for the care management that they turn to Zoom too, but it was harder. It's always been hard to get those multi sessions, so they had to adapt. A little bit happened. And then you can see the third, how do we know that they were disrupted in terms of its relook at the input output measures. What did they say? What meetings did they have? How many people came? What they learned? When we go next and we look at as a result of the meeting, what happened in the intermediate measures? Did people come away? Did you see some changes? You can see that the strain becomes much thinner across all. This actually has been an issue even before COVID. People are really struggling with kind of evaluating intermediate changes. That's really what it is, is we are very good at best practices. We know what the equity is. We are working very hard. We need more help with evaluation. In terms of when we looked at strengths, it's similar to what what was seen in 2019, all five priorities were selected. People are collaborating. The patterns of selected priorities are the same. Collaboration, infrastructure training are catalyst. Measuring impact remains a challenge, so that's not changed. Variations 80 percent submitted updates. Previous levels to get 100 percent submission because it's not cumbersome. A significant disruption from COVID. Even the ones that I showed there is probably an underestimate. People wanted to show they were doing something, so they were really trying to put something down. Clinical interventions had fewer disruptions, but they also were significantly disrupted. Though everybody worked on COVID, only a handful added a COVID-19 goal. Next steps, so you can see in terms of comprehensive planning, the update and the new prevention agenda cycle. Last December, we had the update. This December, we expect to have the comprehensive plan and then we have again two years of updates. The new prevention agenda cycle will be released December of 2021. That's the 2025/2030, and then we continue again. That's it. Thank you very much.

Dr. Boufford Thanks, Priti.

Dr. Boufford Very, very helpful.

Dr. Boufford I just want to make a couple of comments for the committee before we move into just any questions you have before we move on to the panel. One is it's really important to remind ourselves that the State Office of Mental Health and Oasis have been sort of core partners from the beginning of this effort and goal four really has emerged from Sullivan's group and from the department, OMH and oasis together. We really look very closely with them. In the last year or two, really right before COVID, I think the Department for the Aging was very involved. These are sort of really core agencies and as

Priti said, our challenge. Again, we've really not had unfortunately, the resources. We've been doing some technical assistance through webinars before the COVID epidemic. I think as she mentioned the local health departments, many of them have expressed a desire for more sort of technical support and technical assistance in the measurement area and evaluating the results of their work and also in addressing health disparities in health equity. These are areas that we want to attend to going forward. I want to kind of congratulate. I mean, this is just an example I think of in the face of this sort of unprecedented crisis, the local health departments have continued to do their work and it's very, very admirable. The only other point I want to make. You see these. This is a process which is driven by New York State regulatory requirements. In terms of the community benefit requirements hospitals are required to do a community health assessment and develop a community service plan similar to local health department. This is an effort to bring together these, if you will, regulatory requirements and have them coordinated at county level. I want to emphasize that because I think when we get to the discussion of the waiver, especially the heroes and social determinants sections of the waiver, the waiver really needs to realize and I think potentially build on this infrastructure that's been set up at county level at this point. Prevention agenda isn't really mentioned at all in the current waiver conversations. We've had conversations about this and Brett Friedman's very open to it, but I think we want to think about that challenge.

Dr. Boufford Let me open for questions for Laura and Priti specifically around the agenda.

Dr. Rugge Just one question. Are there consequences for the 20 percent of organizations that did not submit a plan or an update?

Ms. Irani We know that everybody's been challenged, so we will encourage them and send a few reminders. We've never really penalized anybody. We just become really troublesome and keep reminding them and then they get fed up and they send it to us.

Dr. Boufford I think it's an interesting question especially around hospitals. Like most hospitals eventually have been submitting plans. One of the questions we've had in doing this work over the last 5, 6, 7 years is the degree to which the state might be more proactive in terms of requiring a kind of bit more coordination, more overlap between the local health departments and hospitals, and also aligning with the prevention agenda. It's an important question for the future anyway.

Dr. Boufford Ann Monroe.

Ms. Monroe Yes, thank you for a really helpful presentation. Both Laura and Priti talked about the challenges of evaluation. You mentioned that local health departments need that, and it struck me that from the conversations that the state also needs to really think about that. What progress have we made practically in terms of assessment of the evaluation of improvement or prevention efforts? Where does that stand?

Ms. Irani Well, when we knew. We've known for a long time that evaluation has been a challenge. Assessment has been definitely a big improvement. Part of it is because DOH has been increasingly giving out open data presenting in different ways. It's much more accessible. The assessment part is actually pretty good from the local level. But evaluation, we tried to do webinars. The hospital associations also tried to work with us and program staff to do webinars. We offered some consultation. It didn't significantly impact the evaluation process. Where evaluation does happen, is when incorporated in the design of what they're doing. We have to really focus on kind of incorporating the design. If

somebody doesn't put an intent to evaluate in their work plan, it's very likely not going to be done. One of the thoughts was going forward, we need to do more one-on-one kind of mentoring coaching. I actually set up a Share Point site to do that. Secondly, also, it's a mindset. The few folks who do it want to know how they're doing and seem to do the evaluation, because they really want to know the efforts are helpful or not. Well, some are so overwhelmed with the concept of evaluation. We kind of have to make it less. I don't know. Just kind of make them feel it's not so hard. It should not be hard, but also encourage figured out ways, examples of how we can put in a design. For example, screening. Their disparity is low income women or low income people. Only one county actually shared what percentage of low income population came in for screening. The others just gave overall screening. That information is there and and maybe highlight the county that did this and get them to explain, how come they did it and others will follow. Kind of also showing this positive, you know, some counties are doing it and this is how they're doing it.

Dr. Boufford Jeff Kraut has a question.

Mr. Kraut It goes back to some of the data we're using to really understand and visualize this. Probably the most. Look, so much of this is ambulatory based. Have you been able to access the all payer database to understand patient journeys that may result in disparities? I would assume that is the richest source that we possess. If, in fact we do possess it. Have you ever been able to access that database to look at disparities?

Dr. Boufford I just want to remind everyone that the prevention agenda is coming up to the door of the clinical space where we're really trying to deal with, if you will, pre hospital, pre care elements that could be changed in the community.

Dr. Boufford Over to Priti in terms of the data.

Mr. Kraut I'm really looking at we have so much data after you cross the threshold of the emergency room in the hospital. What we've lacked is visibility on everything that occurs before that.

Dr. Boufford Yeah, that's right. I hope the hospitals could bring some of what you're saying into their conversations at county level.

Dr. Boufford Priti.

Ms. Irani Yes, I was going to just say exactly what you said, Dr. Boufford. Is that our population is before they get sick, right? The data is useful in the assessment and some of them use it. Very often folks that work in the prevention agenda were before they get to the hospital. It's more population based, general, community based. The screening and the clinical parts, that's why you get better evaluation because it's in the medical record. That's why they use it. The problem is when they work on policies and they're working with general community. They're kind of not sure what to do. It's not so much the issue of what data is in the hospital records. It's what we don't have in the hospital records. How do we get that information?

Mr. Kraut Do you have access to your payer database?

Dr. Boufford Through the hospital partner.

Mr. Kraut No, no, I mean, the department owns the data.

Ms. Yes, staff do.

Mr. Kraut Staff do.It is available and it's being used?

Ms. Irani Yes.

Mr. Kraut Because we spent 60 million dollars, we haven't really seen that data out and made available to the people who have boots on the ground. I'm not sure the local departments have access to that, but maybe that's something we can follow up at a later date.

Dr. Boufford It's a good idea.

Dr. Boufford My favorite example of the kind of collaboration that can happen with the prevention agenda comes exactly in the line of what you're talking about. Jeff, I remember I think it was in Syracuse, the leading teaching hospital there had identified there what they call their million dollar patients, where their end stage renal disease patients on dialysis and really develop partnerships with the Cornell Extension Service and the Maxwell School and the local health department to really identify areas where there were food deserts in the city that needed to be dealt with. Interviewing finding their patients were actually, ironically, those suffering from obesity and diabetes were in food deserts. Addressing the problem by bringing in with hospitals financial support, actually. Bringing in 7, I think, local sort of food banks, if you will, looking like shopping centers, little stores into the community and tracking that progress. This partnership can bring these things together, but we want to encourage it more.

Dr. Boufford Scott.

Dr. Boufford Maybe two more questions. I don't want to shortchange our colleagues on the panel.

Scott La Rue Just a quick one. I wonder whether you think that the plans that were submitted properly address or include the significant aging of the population and how fast the population is aging.

Ms. Irani Well, some of them identify aging as an issue, but it's part of all the plans, but they don't specifically evaluate for the aging components and prevent chronic diseases. It is a significant component, but they don't break down by age. The part where we usually see a specific focus on aging is falls prevention. It is there throughout because aging is such a cross-cutting issue. Like I said, when you try to get particular segments of the population again, it comes down to evaluation. In the assessment, they see it. What are they doing about it after they work on it? That's something we have to work on.

Dr. Boufford I'm glad you asked that question because there was a big debate and discussion involving organizations like AARP, long term care providers and others before the latest revision of the prevention agenda about three years ago. We decided rather than having an aging goal, we would integrate concerns for aging and each of the objectives areas. You'll see that when you look at the granular under each goal, but Priti's point is really important is how do we know we're really paying attention to that subpopulation,

especially in the chronic disease prevention space and some of the others. I'm glad you raised it and we need to look at that specifically.

Dr. Boufford Any other questions?

Dr. Boufford We could put the panel back.

Dr. Strange My comment will come on the back of Scott's comment just the other way, because again, having sat on the hypotensive task force here in New York City, and as a geriatrician, I think we're doing much better on the wellness prevention and screening for our geriatric patients. In fact, that group is something that's been paid a lot of attention to in some ways because the reimbursement has pushed that in terms of Medicare and value based payments and so on. I think our biggest area has been failing and there's a whole host of reasons here, including determinants of health and so on, is our younger patients who need to get screened for let's pick one. Osteoporosis. That's not a disease of a 50 and a 60 year old that really starts as a disease of a 20 and 30 years old with proper diet and proper exercise. We never talk about it that way. We start talking about osteoporosis at age 50. We don't hear the pediatricians talking about it. We don't start talking about atherosclerotic heart disease, because it's not a disease at age 20 and 30, but it becomes a disease at age 50 and 60 because of what happened at age 20 and 30. I think there needs to be some refocus on the education, which is part of what we're doing here, and it has a lot of factors in this. I do think we're doing a much better job on the geriatric side as a geriatrician, in part because of payment and not so good a job on the younger side, including our pediatric friends, which need to be involved in this.

Dr. Boufford Yeah, I think in this that one of the goals really important point. Back to Priti's notion about sort of getting more specific data in each of these goals, I think, could be helpful. The sort of classic womens, infants and children's health agenda, modified very much of the direction you're talking about. Although that's up there, I think it's an interesting question. Where does that belong? How do we cross between those?

Dr. Boufford Did you want to comment on that?

Dr. Bauer Yeah, excellent point.

Dr. Bauer I just want to emphasize that, you know, all the work that we're doing around obesity prevention, improving nutrition, improving physical activity, reducing smoking, especially at young ages. All of that is hopefully contributing to better health in the later years and preventing that heart disease and that atherosclerosis, that osteoporosis. Looking at that whole population and putting into place those interventions that are going to kind of help people reinforce healthy behaviors, I think drives that population health.

Dr. Boufford Thank you.

Dr. Boufford Harvey Lawrence, last question. We're going to move on to the panel.

Mr. Lawrence Yeah, I'd like to know given all that we've learned with regard to health disparity and access to care, any of this showing up in terms of access and equitable access to health services across the various plans?

Ms. Irani Access to care.

Mr. Lawrence Yeah.

Ms. Irani The way we think...

Mr. Lawrence With equity related issues.

Ms. Santilli This is Laura.

Ms. Santilli Keeping in mind also, as we're talking about all of the data that we're looking to, we have a whole prevention agenda dashboard that monitors all of these different indicators. The dashboard, in addition to having those very specific priority areas, has a whole section on the health disparities promoting health equity. One of our indicators is about access to care. It does break it down. We do look at the various mostly on the when we talk about the health equity is right now, it is based on the racial minority groups, so we can definitely track those. As Priti was saying, it's really on the assessment after the fact. We're trying to compress that gap. How do we know that the programs, the initiatives, the interventions are working with the integrity? That type of evaluation is a little bit harder, right? We can measure the outcome and say, are we closing the gap? What is working to help us close that gap? Those data sources are not as robust as looking at the outcomes and tracking those gaps. I do want to remind everybody about that really robust prevention agenda dashboard that we do have when we're talking about the all payer database, our spark hospitalizations, all payer database. Actually, now we'll have encounter data as well with the outpatients. You're exactly right. Those data sources are really important, but they are too far along the timeline. We really want our data sources to be, as you're all saying, much, much sooner upstream.

Dr. Boufford Maybe we could send the connection to the dashboard to the members so they could take a look at it. It's impressive. I think, Harvey, your question, this has been an area. I would say that this not necessarily access to care specifically, but just the sort of agenda of eliminating disparities has been an issue that I know a lot of the local health departments have raised this. We've made a lot of efforts to cut a crosswalk with other entities within the state that are concerned. I think we'd all admit we have a lot more work to do, but at least especially the data is there. How are we making progress? What more can we do to be better to do it better?

Mr. Lawrence Yeah, I guess I'm just questioning whether some way of collecting data about access and evaluating that because so often, you need to have access to have to even get to the point where you're going to have the quality of outcomes.

Dr. Boufford Absolutely.

Dr. Boufford Any other questions?

Dr. Boufford Thanks very much.

Dr. Boufford Again, please feel free to send your questions in to me, to John or to Laura, and we'll get them answered. Thanks very much. Really good presentation. Thank you very much, Pritiy. I'm very sad to say. I'm sorry. Priti apparently is going to be leaving us in April. It's like heartbreaking. I keep thinking maybe she'll change her mind if we push her hard enough. But anyway, we want to thank you for fantastic yeoman's work and all of this. I hope you'll be able to pass your role on, if not your brilliance to your successor. Thank

you so much for everything you've done for us the last 5 or 6 years I've been involved with this program, so we appreciate it.

Dr. Boufford May I turn it over to you to introduce our panel and sort of facilitate their discussion?

Ms. Santilli Sure can.

Ms. Santilli I am very happy talking, talking about yeoman's work to have three of our local health department partners that said yes despite all of the work that they're doing to be able to join us today. We have three of our local health departments. Dr. Gupta is from the Onondaga County Health Department. She's our Health Commissioner there. Heidi Bond is the Director of Public Health. Dr. Gelman is with the Orange County Health Department, our Commissioner there. All three of them are going to share a little bit like our lives have been consumed by COVID, but a little bit of what we call NO-VID, right? The non-COVID types of work that were occurring in the midst of COVID, right? You can't really separate it out. They'll each share their experiences and then we'll have the opportunity for questions after that. I do note Dr. Gupta in particular has a hard stop at 10:00, so I think we might maybe we'll see how it goes have her address any questions first that way she can log off. We will start with Dr. Gupta.

Dr. Boufford Dr. Gupta, you can share your slides directly,. Give that a try. If it doesn't work, we'll do it from here.

Dr. Boufford Beautiful. We can see it.

Dr. Boufford Thank you very much.

Dr. Boufford Dr. Gupta, we cannot hear you.

Dr. Gupta I'm sorry.

Dr. Boufford There you go.

Dr. Gupta I just am trying to figure it out how to do in this slideshow mode. I need to move a little bit of things here.

Dr. Gupta Can you see my screen?

Dr. Boufford We can.

Dr. Boufford Thank you.

Dr. Gupta Good morning. As I was listening to the presentation for the prevention agenda, I wanted to kind of emphasize some of those things which we were able to do despite being overwhelmed over run by this COVID, like all of you. Our Onondaga County is a population of 471,000. Our population, we actually grew in last 10 years, which is one of those unique places, which is nice. Full county health department that means we have environmental health along with other public health work. At the same time, we have medical examiner's office and crime lab. I wanted to kind of give you a little bit of highlights what we have done out of those priority areas which Pritii was mentioning and holding on to based on our our community health assessment that our community picked two. One

was preventing chronic disease as it was shown in the slides before. The second was promote well-being and prevent substance use. However, at the same time, other five priorities, three priorities were not picked as important one from the perception from the community. However, work in environmental health, sexually transmitted infection and communicable disease, as well as maternal and child health, was really continue to stay relatively strong during the pandemic time. We are just going to focus on that.

Dr. Boufford Your slides are still kind of stuck.

Dr. Gupta Oh, they are?

Dr. Boufford Yeah. Maybe you could try again the slide show from the beginning and see, just because we want to see everything close up.

Dr. Gupta Can you see the second slide?

Dr. Boufford Not yet.

Dr. Bauer Dr. Gupta, I think you have to click on enable.

Dr. Boufford Let me shut up then.

Dr. Boufford Thank you.

Dr. Gupta Wait, what do I click?

Mr. Kraut Hit enable editing at the top in the yellow bar.

Dr. Gupta Hang on. I have to get out.

Mr. Kraut There you go. Go to the yellow bar. Hit enable editing, and that'll take you out of that view and that'll allow you to advance the slides.

Dr. Gupta Enable editing, I can't even see that.

Mr. Kraut Just go on the yellow bar with the cursor.

Dr. Gupta Right, right.

Mr. Kraut Go to the bottom of the page to full screen from beginning.

Mr. Kraut Do that.

Dr. Gupta Is that good now? Can you see?

Dr. Boufford That's good.

Mr. Kraut Thank you.

Dr. Gupta You can see the second slide?

Mr. Kraut Yes.

Dr. Gupta This is what I was talking preventing chronic disease. Pandemic literally tested our capability. Pre-pandemic, we have really great relationship with our community partners because of our work in the public health, both with the hospital and schools and faith based organizations and community based organization. The list is quite long, but the pandemic actually strengthened our relationship. I'll just give you some example how it kind of panned out. 2020 was very harsh. We couldn't do anything during 2020, because we were pretty much ransacked by this COVID. However, in the beginning, once we had the vaccination in the 2021, I started to pull my staff together and say, We really need to think of what other things which are being really impacted by the pandemic. We really need to start to see how we can. In the prevention of chronic disease as a primary care physician, as an internal medicine doctor who practice outpatient patient until 7 years ago when I became Commissioner, this is the core value which the health departments bring is when I'm treating those patients in the E.R. or in the ICU or in the medical ward with the consequences of overweight obesity. The focus health department brings is that how can we do? Rest all the energy and hopefully money also in prevention of chronic disease, focusing on overweight and obesity. Those are pretty hard things to do. You have to look into the policy driven work. We work with the schools. We work not only in treating physical activity, but with the cafeterias to improve their eating habits, which we have been doing it before. It wasn't like it paused in 2020. 2021, we started back again. We also engaged food pantries to develop and implement healthy pantry labeling system. One of the important part of that is that the people who live in poverty. We know that they suffered the most negative consequences, whether it's a substance use, whether they are also exposed to many of the marketing strategy by the tobacco and all. We really wanted to focus on those area with the policies. Food pantries throughout the community, whether they are based in the churches or they're based in somewhere independent as a nonprofit. We have been working with them. It is very amazing to see that how that results in somewhat good, healthy eating habits as well as I would not go on habits, but at least providing food opportunity to those who come to those pantries. We also work with the tobacco to reduce the impact of tobacco by changing the environment. That's the basic foundation of the health department as we change at the policy level. We were able to make continue to inroads in those areas where there are still smoking is allowed. That was a success. Our education and outreach in preventing screening for the cancer screening for the uninsured, for under-insured. Again, people living in poverty, people living in areas where they might not have that access and having the education and outreach really has been a forefront of our work at this point. I'm proud to say that we continue to do at least something. This is a screenshot of my meetings with my team, which when they come, I just wanted to give you an example. This was something when we meet, I meet with my team on a quarterly basis to get an idea when we were talking about evaluation. Evaluation is in the short term and public health is you have to look at the process and in the long term, you will look at the health outcomes. So we as a clinician, I was able to get the outcome right away. If somebody is having acute MI, I would take care of them, get that interventional list and then get all those taking care of it. But here, how do we do that? If you can look at that, we work with the community work at the top. Policies we were able to make change practices. At the same time and we have many non-profit organizations from the boys and girls club, from the churches from different, like their wide variety essentially. And in school, we have been going and working in the schools, including Native-American community, which is part of the Onondaga County. Certainly, we have been able to make policy changes and continue to work with them. Our second priority, the high priority, was promote well-being and prevent substance use. This is quite challenging, especially during the COVID. We have seen escalation of overdose deaths, which is pretty much as though we are scratching the surface. We change some of the work which we do

is for the naloxone training, at least saving lives. We adapted the format of the naloxone training online and we were able to train working with the partners and also one of our staff who is, you know, will continue to provide this online training. The other part is that we have been working with the population in the corrections system, these are people who have been discriminated against and also are victims, not able to get access to care. How do we connect those dots linking to care? It has not been easy. Many challenges. We have been able to establish some relationship with the leadership and with their provider, and also take outpatient mental health provider to get some connectivity while they are in the Justice Center. And then when they are released, they will have a warm sort of welcome and connecting them to care. It's a work in progress. There is partial success, but again, the process I'm looking at is process being handled properly and what can we do to tweak it? We have a very active drug task force, which I am a Co-Chair. It was quiet in 2020. We brought it back again in 2021. We intend to do a lot of more work with that. We are also working with the New York State with the Matters program, which is a referral system which is again working. This is primarily focusing on the health system when they touch points in the emergency room that how they can connect to their links to their care. We try with the regional health information system. Healthy connection here in this region. That part kind of didn't work because hospitals were not willing to spend time. I think somebody asked a question before. The access issue has to be dealt when you connect. Both public health system part as well as the health system along with sites like wraparound services. We are also working at the mental health office there. It's amazing to see that how the data is telling us how many touchpoints, how many preventable maybe events we can have that so those things are happening at this point. I'm just going to close with this one is public health system is this is my favorite diagram. I always put it out there because it reminds me that it's not about I, as a Health Commissioner. It's about we. When we change the theme that we work together and this is the foundation for the Community Health Assessment and Improvement Plan is bringing all the partners together. It is wonderful to see that we have. We had a lot of partnership before. It gotten strengthened during the COVID. I hope to continue to build on that. It's like it's was paying dividends during the pandemic and we will continue to horn onto those is strengthening our relationship. I'll just give you a quick example. When we applied for the accreditation, we had accredited a local health department. In 2018, one of those things asked that have your community partners attend there, so they have to attest that you really work with them. I kind of, you know, I had like a 30 or 40, so I send it to them with a nice letter that invited them. I personally have a quite a bit of existing relationship along with my staff and all of them RSVP'd that we are going to come to your meeting. Which is the accreditation board, said you can't have that many. I'm not going to say no to anybody. I'm not going to resend my invitation. We got a big conference room. It was wonderful to see that so many partners were involved in working with the local health departments because they saw us that we are part of the public health system. My journey from health system to local health department is what you have all been talking about, that working together. That's the only way we can shift the needle, how to have the right processes and how can we see in the long term the good health outcomes.

Dr. Gupta Thank you for your time.

Dr. Boufford Thank you, Dr. Gupta.

Dr. Boufford We're going to switch to Heidi Bond.

Dr. Boufford Heidi, I don't know if you have any slides to share or if you're verbal only.

Ms. Bond I don't have any slides, so it's just me.

Dr. Boufford No worries.

Dr. Boufford Thank you.

Ms. Bond Thank you. Thanks for having me.

Ms. Bond I'm the Public Health Director. We have a population of roughly 59,500. We are not growing. Unfortunately, we have a dwindling population. We are Upstate New York about in the middle of the state. Roughly 1,000 square miles. We have two colleges, two hospitals. We're a really small health department. We have a staff of 11 full time employees. I actually struggled a lot with this topic, trying to think of some successes we had during COVID, because I feel like we have only been doing COVID for the past two years, like everybody else feels that way. Our work, actually, it brought me back to some work we started in 2017. In 2017, we were having a department meeting and we were discussing our community based organizations and how we have a lot of rich resources in the county. We did not feel that people, the public, the residents really knew about them and took advantage of them. We developed a public event, which we held for the first time in 2018, and we called it the Living Healthy Expo. It was really a venue to bring all of our community organizations together and then bring the public in to learn about each organization and what they have to offer everybody. We wanted to really make it broad and not target one population like our work really has done in the past is when we do an event, it's really a targeted population. We really start to have something for everybody. We brought in elementary and high school students to sit in on live presentations. We had seniors center participation from the seniors. We had presentations on various topics. Lead poisoning, Lyme disease, rabies, arthritis, car seat inspections, Narcan administration, drug use awareness for parents. We had a blood donation on site. We had our health care centre smobile cancer screening coach. We had a zoomable. We had lots of giveaways. Wlly we had a great turnout. We held that in 2018 and 2019, and we were scheduled to do our third event in 2020, which it was in April, and we sadly had to cancel that. When I look back on the work that we did in building this event, we really, at the local health department made relationships and connections with our community based organizations that we didn't have in the past. We knew what they did and we knew how to get a hold of them, but we didn't have that connection where we had a name and they knew us and they knew what we did. Before 2018, we weren't comfortable calling them up and saying, Hey, can you help us do this? Kind of moving forward into the pandemic in the past two years. Because we're such a small health department with only 11 staff when we really were tasked with in the beginning with people on isolation and quarantine at home, we were able to reach out to our community based organizations. They provided us and the families that we needed to help with food, with resources. They really came to our rescue. We felt very comfortable picking up the phone and calling them and asking them for help. And that has continued through the entire, you know, for the past two years. They've helped us with the vaccine rollout. They've provided resources beyond what we would have imagined prior to the pandemic. When I think about it going, you know, obviously when we thought about a pandemic before 2020, we in the work we would do, I don't think any of us imagined we'd be doing what we have been doing the past two years, though. The relationship we made were really invaluable. We didn't have really successes that I could point. We did this during COVID because I feel like we and I think my staff was like, we really only did COVID, but I wanted to highlight those connections we made. It was because of work that we we had planned in 2017 and 2018, based around our prevention agenda priorities, ours as Dr. Gupta, the same preventing mental health and substance

use and chronic disease were our two priority areas and the work that we started was to in fact, work towards those goals. It had unintended consequences, I think in providing us the relationships we needed moving forward.

Ms. Bond That's really all I have.

Ms. Bond Thank you.

Dr. Boufford Thank you, Heidi.

Dr. Boufford Oh yeah, those partnerships were invaluable, for sure.

Dr. Boufford Dr. Gelman, we have you up next.

Dr. Gelman Good morning, everyone.

Dr. Boufford Good morning.

Dr. Gelman Just to echo a lot what has been said already, absolutely off ramping from the pandemic. Communication has been an integral part of communication, especially locally with our local community stakeholders. In terms of that off ramping and continuing some of the relationships we have, most certainly just like Dr. Gupta and Heidi Bond have mentioned. We have built upon a lot of relationships that have been established throughout the duration of the pandemic, but there has been a tremendous amount of work done on the local level. We are a full service local health department. We have approximately 400,000, a little over 400,000 residents in Orange County being a full service health department and having kind of a vast area geographically and quite a diverse area. We have quite a few very densely populated areas that continue to develop and that continue to grow exponentially as far as population size. We are one of the few counties that continue to see growth and expansion as far as our population. It did present a number of challenges throughout the pandemic, but the results have been quite surprising in terms of what we were able to do. Even in essence, leverage some of that momentum. We have been able to expand our public health planning and epidemiology division where we have a number of epidemiologists now. We started out as one. Now, we have a number of epidemiologists as well as a biostatistician that will be joining our public health planning and epidemiology division. We're also very fortunate to have a Health Equity Director that has been instrumental in engaging a lot of our local stakeholders and rebuilding some of our local coalitions that are now instrumental in going forward, conducting our community health assessment and really reassessing what the priority areas look like post-pandemic. We were able to build upon our vaccine confidence coalition. We did have the Hudson Valley Vaccine Confidence Coalition prior to the pandemic, but we were able to build upon that and have a vaccine confidence coalition not only during the pandemic, but now again, kind of off ramping through that. We were fortunate enough to engage a lot more stakeholders at this point. In terms of just communication in general, we did mid-pandemic conduct a rapid community health assessment with the help of the CDC and the New York State Department of Health to address some of the vaccine hesitancy specific to COVID-19. But that was a tremendous opportunity to again reengage stakeholders across the county with differing areas of concerns. We have published those findings. We were really able to come out with metric driven goals and a lot of mitigation efforts. The Vaccine Confidence Coalition is really a result of that collaboration locally. We have also started a number of local projects. Prior to the pandemic, we were considering telehealth integration across all sectors. I know

telehealth has been a very loud word during the pandemic in terms of applications for medical and health care fields, but we have been very vocal advocates for telehealth applications across the board in the public health sector, especially when it comes to drills and emergency response, as well as our community paramedic project. We are really bringing together stakeholders to have a more robust community paramedic program that will integrate a lot of the components of telehealth. Telehealth as far as even pods and just mass distribution will be a very kind of interesting and definitely something very useful moving forward and is not just for medical or counseling or other applications. We have also deployed an app shortly prior to the pandemic that was instrumental in having just another platform to get information out there in the modern day and age to more of our public and just keeping our public engaged. It was just another means of engaging the public rather than just social media and the general media platforms. We were also able to deploy our wastewater surveillance project. That was predominantly aimed. This was the SARS-CoV-2 wastewater surveillance project. We did participate in the state pilot program for wastewater surveillance for SARS-CoV-2. That was in Newburgh, one of our cities here that is a very urbanized, densely populated area. From that pilot project, we almost immediately deployed a fairly robust program countywide in all of our densely populated areas that had municipal water sourcing and processing capabilities. We had six points of collection and we have been collecting specimens at regular intervals at the same dates. That way, it really allowed for synchronized data collection. We have quite a robust data table that was made available late in, I would say, August, beginning of September. We were really able to establish baseline for COVID-19 as far as actual viral spread in the wastewater, which allowed us early detection and early notification. That was during a point of low transmission that translated kind of during that surge into being able to detect those viral particles a lot earlier and being able to notify municipalities about a week to a week and a half prior to actually seeing broad community acquired transmission. That early notification system. The reason I'm bringing it up within this context and panel discussion is really interesting to examine moving forward as a tool that may be utilized for other viruses or other potential contaminants. It's definitely a great system to implement, because not only were we able to notify municipalities about a week a week and a half prior to them really seeing that presentation, the symptomatic presentation of patients to the e.R. in the clinical setting, but also allowing us to notify susceptible and vulnerable, more congregate settings in those municipalities where we did have that early detection. Again also as a result of that CDC and the New York State DOH and our local health department collaboration for the Rapid Community Health Assessment. Locally, we were able to partner up with Johns Hopkins on a novel tool as far as just getting information out. It's really for tailored vaccination messaging. This was a grant. It's more of a technological grant. The monetary value, I believe overall is around $100,000, but it's really the fact that we would be able to have a final product that entails tailored local messaging, a website that tailored messaging to our local community that can be shared in Doctors' offices through public health, school districts, community organizations. It's really kind of has three parts; introduction by one or more local personalities, customized animations, local people sharing their experiences in a way to support vaccination. This is not just for COVID 19 moving forward. I think originally was designed as such, but can definitely be expanded later on and adapted. In a nutshell, there have been a lot of kind of frontline novel expansions and improvements that have come out. A lot of them were geared towards communication and just reestablishing the baseline. We're definitely very happy to return to our fundamental public health functions and really getting back to our health planning and a lot of our functions now. Not the least of which I will say as far as positive outcomes of for the local health department that for expansion of our workforce. In expanding the epidemiology and the public health planning division, not only were we able to bring in a biostatistician, but we also took advantage of the New York State Department of Health

offered program for the public health fellows, and our board was able to approve 19 fellows. That's a tremendous help, even kind of short term. Looking to the future, being able to really help stage a future kind of generations for public health. We've already onboarded a number of individuals in the fellow one category, which is a Bachelor degree, and quite a few of those 19 in the fellow two, which is a Master's degree again aimed at re-engaging our local communities. Because, unfortunately, yes, public health may be better known locally. The unfortunate factor that I'm mentioning is it's still within the context of COVID-19, and really re-engaging the communities and making sure that there is that education and outreach and awareness of our fundamental functions as far as public health is also instrumental moving forward.

Dr. Gelman Thank you.

Ms. Santilli Thank you so much, Dr. Gelman.

Ms. Santilli I see Laura and Erin from our public health corps wiggling in their seats when you're talking about your fellow, so thank you so much.

Ms. Santilli Thank you all very much for sharing those experiences and you know, the COVID and non-COVID, it's been quite a ride.

Ms. Santilli What questions do we have from the council members?

Dr. Boufford Laura, I wanted to just emphasize a point that everyone mentioned around the importance of partnerships, which is really, really important. It's one of the things we've been trying to stress in the prevention agenda. I was curious about the involvement of local businesses. I noticed employers in Dr. Gupta's Slide, but really local businesses being involved actively as part of the consortium, there have been efforts to get them in challenges, successes, et cetera?

Dr. Gupta I can answer that question. The local businesses certainly have been involved when it comes to a specific thing, when you are talking about tobacco or even doing the outreach regarding depending on what kind of business they have to have a good eating like health policy, essentially for the good cafeteria. Our team has worked very, very strongly pre-pandemic into those areas, made a lot of changes in many of the businesses for their not only eating habits, but providing opportunity for their employees to have a walkable place outside creating more green spaces. These are pretty small, which we get, but there has been a lot of engagement with the business community. Moving forward with the pandemic, we have strengthened our relationship to a great extent and and I think they have this understanding at this point is that local health department is not just therefore for COVID time, whether it's our faith based community, whether it's a non-profit or it's a for profit company which is selling whether it's food or some other gadget. They really understand the value of the health department from the bigger than the communicable disease. It is our job to make sure we continue to maintain those relationships. The part of the prevention agenda, for not only for the chronic disease, but also mental health and substance use. There are a lot of opioid overdoses which are non-fatal, are happening throughout in different areas. We have a overdose map, which we can see where things are. Our team actually goes and engages them for education and outreach and provide them not only Narcan training, but also try to get to hear from them. What are their needs? How can we be of assistance? How can we connect them to resources? I's a work in progress.

Dr. Gelman Now, I would also add to that not just on the immediate prevention that's just on the health of employees and employers, but also as far as environmental health. I think we were able to quite successfully engage a lot of businesses through the chambers of commerce, local chambers of commerce and via other means. Just to continue those discussions on the environmental health levels. Also, because again, being a full service health department, we do have that connection as well. That can most certainly be leverage. There is quite a bit of interest as far as environmental health issues; water safety, food safety, so on and so forth. I would just like to add that component.

Dr. Boufford Well, I think we have three questions.

Ms. Santilli Oh, I see. Yes, I can do that.

Ms. Santilli Thank you.

Ms. Santilli Ann Monroe.

Ms. Monroe Thank you for that panel. Very, very interesting what's happening.

Ms. Monroe No one today has mentioned health plans. I'm wondering if at the state level or at the county level, you would have health plans at the table building relationships with public health and prevention. To me they seem to play a critical role, could play a critical role in helping to support prevention efforts. It's in their self-interest to do that. I'm wondering if any of you have a dialogue or relationships with health plans?

Dr. Gupta It's a great question.

Dr. Gupta There are some relationship we have with the Blue Cross, some of the other insurers. Some of them are somewhat engaged based on what their mission tells them and their focus will be. Some of them are interested in more of a maternal and child health supporting some of that work, especially the work that they have been engaged. Is one of the very important topic for they have been engaged in those ones. This is a very interesting. I think what we will ask, my ask would be for the New York State Department of Health leadership is that how can they leverage those health plans to sort of say it's like hospitals working with us the same way the health plan should be working with us because they have all the data. I think when the question was asked by Jeff. If you are working with the payers. I mean, do you get the data from the peers? We have so much information out in the cloud, I would say at this point. How do we get those data to make the informed decision? That would be critical centerpiece local health departments certainly can play because our team is the foot soldiers. We know our community like nobody else. We know where things are. We can connect, not only connect, but also we can try to convince and bring those trusted messenger from the community to change the tide. It's a great point. I think I will look for the state to look into that. At the same time, we have our own own relationship with them. There are some other insurers who are interested in those things, but it's more of a soft at this point, it has to be more robust.

Ms. Bond I was just going to say we actually in our event that we had in 2018 and 2019, the health plans were very big partners for us. They provided a lot of resources for the event. I have a lot of community resources which unfortunately through the pandemic, our relationship with the health plans have kind of fallen off. But hopefully now that we're moving on somewhat back to normal work, we can re-engage our work with them.

Ms. Santilli Great, thank you, both.

Ms. Santilli You can go ahead and lower your hand.

Ms. Santilli Harvey Lawrence.

Mr. Lawrence Yes.

Mr. Lawrence Dr. Gupta, from your presentation---

Ms. Monroe Excuse me.

Ms. Monroe Before you ask your question, is at the state level, is there dialogue between the public health part of DOH and health plans?

Mr. Lawrence Sorry, I didn't have my mic on.

Ms. Santilli The part of the department that handles health plans is called the Office of Health Insurance Plans. Health insurance providers maybe. I'm not sure what the P stands for. The health plans are under that group and we absolutely do have that relationship. They work very closely with the health plans and then we then connect with that office as well.

Dr. Bauer I think it's just important to note that that's largely Medicaid health plans. The private health plans actually are not under the jurisdiction of the health department as I understand it.

Ms. Santilli Yeah, good point. They're under the DFS, here's more acronyms for you. The Department of Financial Services, which is its own like state agency comparable to DOH as well. We do have connections with them, especially when we talk about coverage of prevention measures and really having those preventative services be a key focus and data as well.

Dr. Boufford I'm conscious of time, so I just want to be sure we have a little bit of 20/25 minutes of play during the meeting, just to raise the flag.

Ms. Santilli Great.

Ms. Santilli Two questions. We have Harvey Lawrence and then Dr. Lim, and then we'll switch to health across all policies.

Mr. Lawrence Dr. Gupta, thank you for your great presentation as well as the other presenters. I was really impressed with the fact that you sort of demonstrated that you are the foot soldiers and that you are working to expand access and points of entry and creating linkages. Earlier, a presentation survey identify that evaluations of outcomes and success in this area is really tough. What do you do and what are your metrics for evaluating the points of access and how successful you are? I think sometimes when we are looking at the heart of prevention, that is very hard to come up with metrics for some of the things that you're engaging, because I think oftentimes is undervalued and because it's sort of difficult to measure, but it is so important to improving access, ensuring access to the population across a community. What are some of the metrics that you look to and you might offer us for measuring and evaluating the success of these efforts?

Dr. Gupta It's a great question. The ultimate metrics for the chronic disease or any of the like prevent substance use will be that we see the lowering of overdose deaths or we are seeing the lowering of having less population suffering from hypertension or stroke or those kind of things. However, that's a long term goal. In between when we start to invest our effort in there. It's like anything, we have a plan working with our partners throughout the community, and then we fine tune those things and see what processes and process check we can do. The first process check will be for us is that do we have the right partners of the people? If we don't have the right partners, then we won't understand not only the enormity of that, but also will not be able to get their feedback at the same time. We won't know if we are not able to achieve what we are, which we have pretty much thought in a year we'll be able to do. We look for the short term goals and then we look for the long term goals. Short term goals will be building relationships, creating right processes. Working on the processes will be, for example, in the schools. If we are working poor in the church, if we are working. If we are thinking for prevention of chronic disease, that will be do we have the right policies, which the leadership of that certain, whether it's a school or Faith-Based or business, are they willing to adapt some of those right things, which will be good for themselves? At large, it will impact the entire community because we all make part of the community. The same thing will be for the access to care. We measure those. How were we when I meet with my team at least that what I see that what how many policies we were able to propose, where we were successful and also where we were not successful and what was the reason for not being successful. Negative information is as important as the positive information because it challenges us. It really makes us think that there are some things which we are not able to do. When we specifically talk about the access to care issue, which you have raised a question about that is near and dear to my heart. One of those things, which as a physician, practicing physician, I couldn't do when my patient lost their insurance and they could not come and see me despite of my telling them because they were worried about their bankruptcy. All those things do matter. The touchpoints, whether they are in the E.R. or whether they are going for their work, how can we improve the access point? This is the part I think locals along with the state can make a big impact. It's like building that infrastructure, which Europe has pretty good and then we really should have the same situation in there. We have not been that successful in access to care. The fortunate part is that insurance access is significantly increased. That makes the connection linking for those patients, for those individuals, community members, to get a screening done at the right time, so tthey are getting screened when they are pre-diabetic rather than having in the hospital in E.R, when they are having gangrenous toe. A lot of those things is that connecting those dots throughout the community, engaging those community based organization, faith based organizations, along with the hospital system that promoting good health, that take care of yourself and have that connectivity with the doctor or whichever the increased physical activity. It's not only access to care issue. That is something will hopefully will lead to that, but how to take care of yourself and how to find the right resources in the community. A lot of times is connecting those dots to different members in the community, whether medical society, whether it's a hospital and making sure that they are getting the good care at the same time, raising the bar for the prevention for their health.

Dr. Gelman Just to build upon that again stemming from the data collection point. I think it's very important to note that similar to just communicable diseases, we monitor over 60 communicable diseases on a local level through just basic syndromic surveillance. I think similarly, that can be implemented in the chronic disease landscape as far as clinical presentations, ED visits so on and so forth. I think there's a tremendous amount of data points and clearly, as Heidi mentioned previously, engaging the health plans and seeing

what that translates into in terms of use. So access to care, use of preventative services and then outcomes, those can be linked. Similarly in terms of just pure access to care, I cannot stress enough the importance of telehealth and just the implementing and integrating virtual platforms to really connect, whether that's patients or just residents with different platforms for care. It does not necessarily have to be in-person, whether this is for screening purposes, whether this is for prevention, education, so on and so forth. I think a lot of those linkages that cannot be achieved in person can also be successful enough in the virtual landscape and really integrating those telehealth platforms for more than just medical one on one visits. I think there's a lot more to telehealth, and virtual access to care can also equal to expansion of care and better metrics. I cannot stress that enough and we can definitely measure that via outcomes and data points. I just wanted to kind of throw that in there in terms of just sheer data and virtual access.

Mr. Lawrence Yeah, I thank you for that.

Mr. Lawrence I think also the key point is that I believe and I'm hearing from you is that these access points are in the arguable in terms of actually being able to make a difference in terms of outcomes. Unfortunately, I think our system is based on looking at the outcomes and not in undervaluing some of these touchpoints that are in the prevention side of the equation.

Dr. Gupta One more thing is one of the touchpoints, in addition to the electronic version is people, especially the people who live in poverty, communities of color. Those are the one which we are trying to address by looking at the data points in our maps, which is with the GIS mapping, we can see that where those points are and then making sure we do a lot of outreach in those with the people, with the people from the community, with the community health worker model and trying to have those champions in the community who can not only promote what is good health, but also provide that expertise, which will be very helpful for them because for the community, because these are trusted messengers who are providing that information. This is work in progress.I think that will be very helpful as we are looking throughout all across our different programs.

Mr. Lawrence Great.

Dr. Gelman Just to kind of respond to looking at the equation in a different way. Not necessarily from the front in terms of prevention and access, but in terms of outcomes and how do we improve those. A community paramedic program or, as Dr. Gupta has mentioned, the Community Health Outreach Program. Those are tremendous indicators as far as addressing kind of the issue as it stands in the current setting, taking into consideration social determinants of health, access to care, whether that's access to technology or lack thereof, health equity issues and other issues with transportation, with not having necessarily access in terms of being able to leave from work or so on and so forth. Actually, that was one of the points that was very much a point of interest for a lot of our members of the business community as far as remote telehealth integration into the employer, large employer sectors also, because if you don't have time to take off from work, you can always allocate a room or a closet somewhere within the facility to really access whether that's mental health services or other services, whether you're in a school or organizational setting or as an employer. I think that's a tremendous point that you make in terms of if we cannot immediately address the access issues, whether there was a virtual or in-person, we can definitely look at the outcome. Metrics are high utilizers. That's where a lot of the parameters for the community paramedic program comes in, where if those individuals are unable to present into a clinical setting for prevention and

maintenance care, rather than present in a more acute level of care within the ED setting, we can have the community paramedic programs reach out to the community members rather than having that happen, vice versa.

Mr. Lawrence Thank you both very much for that conversation.

Ms. Santilli In the interest of time, I'll pivot to Dr. Limb and in your question, we'll give it a minute or two and then move on to health across our policies.

Dr. Lim Great.

Dr. Lim Thank you and thank you all for the representation.

Dr. Lim Certainly with the crisis of the overdoses that are happening now, certainly totally agree with the focus on that. I think going forward, we have to not only focus on decreasing overdoses, but thinking a little bit more about how can even how can we prevent addiction in the first place, right? I'll direct this to Dr. Gupta, but it's really for the whole council and committee for consideration is, you know, how do we sort of also at the same time, focus on targeting the outreach to the adolescent, the at risk adolescent young adult population and at the same time also looking at the concept of opioid stewardship by prescribers basically. Because a lot of these opioid stewardship programs are sort of hospital based, but the prescribers, the majority prescribers are outside of hospitals and there's all different types. There's dentists. It's not just one prescriber type. If you have any thoughts or plans about how you might address that sort of work.

Dr. Gupta Thank you for this question.

Dr. Gupta It is something which we have been dealing with before. Since 2015, that was the highest number. Now, we have continued to see escalation. Those who know in the DOH, my always sentences that we are spending a lot of money in treatment and all of those things, but not enough in prevention. How do we handle those? How do we address the issue before it becomes a problem? It means you have to again invest from the beginning, from in the schools, in the education and make sure that becomes a part of the curriculum. It's not only substance use, it's mental health has become quite a bit, especially now with COVID. It will become much, even more prominent at this point. We have made actually inroads quite a bit in the prescription habits. If I am seeing my data at the local level is that we are seeing prescription opioid use has significantly reduced or plateaued, but we have the illegal like illicit drug use. Was heroin, now it's fentanyl. It has skyrocketed at this point. How can we educate the community, the families from the beginning that people just know what are the problem will be? Investing all those programs in the schools will be very important part of that. We do work with the schools at the local level quite a bit along with our other community partners. And we have like, for example, I'll give you, I would take the model which we used for the COVID. It was so crucial for our school district to keep the school safe. During this whole pandemic, I continuously met with and like many of our colleagues with the superintendents standing meetings with them and making sure that schools are open so kids can come to school. We changed the policy. I am proud to say that we actually did reduce the three feet distance from six feet, the first in the county, in the state, with the full focus that how can we protect kids because they're not learning at home? And that was the engagement with the superintendents and making sure they understand the value of the problem with the pandemic brings, and they were all on board, they were all on autopilot to a great extent. If we can use the same model and have the education community engage and then make that a part of the education which

will engage the parents at home because I know as a parent I was engaged when the kids brought the the curriculum for the health. I saw that when they were talking about a sexually transmitted infection in their health class, I just feel like, is that what they're teaching you? That opened the door for me to have a good communication with them. The same thing. We have to normalize those things. This is one of the area where we can and then also promoting the prevention among the caretakers for the physicians that they should be. They should promoting that instead of writing prescriptions. Whether I'm not going to advocate for that, they should be paid for that. That is a conversation with you all. But as a primary care provider, I can tell you, I can spend an hour taking care of those patients and trying to prevent that. I won't get paid unless I write a prescription and if I see the patient in 10 minutes versus 50 minutes. A lot of those things is that philosophy for prevention has to come from the 30,000 feet view how we can change it. Those are the things which we need to do it because we are not making inroads. We are going in the wrong direction. We really need to focus on prevention significantly. I'm happy to have an offline conversation if you are interested.

Dr. Gelman I think that's a perfect segue way for actually saying kind of the overarching view. I couldn't agree more with you more in terms of primary prevention and really getting to the primary prevention aspect of it, not just with the prescription, but as you've mentioned with who are the highest at risk groups and when can we get to them prior to that addiction setting in or them even being exposed to it? I think when you bring that up, kind of the higher level discussion would be to really just better definition of the term addiction because anytime we're having panel discussions on addiction, if you addressed the same population, regardless of the cohort and you ask them, what is diabetes? I don't think there will be a question in the room that that's a disease. That disease has a certain treatment protocol. It has a certain screening protocol. Medically and legally, the term addiction is very ambiguous. I don't think it carries with it a screening or treatment, gold standard or protocol. I think we have to kind of step back in order to really see what those changes can be. If we better define the term addiction medically, is it a disease or is it a personal choice? Because if you google that term right now, the Merriam Webster's dictionary has quite a few differences in definition. Whether you look in the mental health realm or in the medical kind of definition of the term, it varies drastically. That definition varies drastically. With it, the consequences of that both medically and legally. Those are the differences in treatment protocols, differences in screening standards and differences, and even payment because it's not legally or medically well defined that payment infrastructure is just simply not in place. That's after the fact. I think your question was primary prevention. Where does primary prevention happen? We all know that the at risk groups are preteens and teens. The American Academy of Pediatrics actually has recommended primary screenings to take place at, and I think they keep diminishing that age at 11/10. It kind of goes back at that. If we were able to define the term and come up with gold standards and treatment protocol just like any other disease, I think with it, it would bring the screening parameters and what pediatricians can do because those at risk populations, the teenagers, the preteens they present for annual wellness visits. If that is made part of the standing screening protocol, you just have a regular drug screening like you would for diabetes or hypertension or any other diseases that you may screen a child for. I think then we can actually have a valid conversation, both with the parents and really talk about primary prevention. That's really addressing the initial use prior to it, starting especially now with legalization of marijuana or who knows what else and other controlled substances that are really ubiquitously available at this point. If we are really to discuss prevention, I think all the really valid tools that we have are empowering our pediatricians in having that as a tool, as a screening protocol that's in place that's part of the wellness visit. Because if we have an opioid epidemic or any other future epidemic of controlled

substances, then we can empower our pediatricians and in that respect, our parents of having valid information on their hands that their teenager may be in fact starting to use illicit substances.

Ms. Santilli Thank you, Dr. Gelman.

Dr. Gelman Thank you.

Ms. Santilli Appreciate it.

Ms. Santilli In the interest of time, this is such a robust conversation and sounds like we definitely have to continue that. But to protect the rest of our agenda, I do want to go ahead and move us to our next panel. I want to thank both Dr. Gupta, Dr. Gelman and Heidi for your willingness to participate, the council members for their questions.

Ms. Santilli Putting these three fantastic representatives are available for offline conversations. The more that we would like to delve into some of these conversations, this is just the tip of the iceberg. Thank you all very, very much.

Ms. Santilli Let's switch now to our panel, Health Across All Policies in Healthy Aging. Charles Williams Charlie, as we all call him, will be leading this section and has a few members of his group as well that will be joining him in this discussion. Both Paul Beyer from the Department of State and John Cochran from Office for the Aging. So Charlie, I'll pass it to you.

Dr. Boufford Lara, can I just make one comment? I just want to follow up on the discussion in regard to Dr. Lim's question. OASAS has been a partner of ours, so I think some of the issues you're raising are really going to them and having them help address some of these issues of definition and getting a little bit more background into the discussions. We have those partners to follow up. I just want to say we will not be taking our break at 10:30, since we're way behind. I trust everyone can turn off their screen and go break on their own. You're used to this from Zoom meetings, so we'll just continue through because I don't want to shortchange our Health Across All Policies. I's been a enormous link to the prevention agenda. Special note to Paul Beyer from Department of State and our colleague, Dr. John Cochran from the Department of Aging, who have brought the money to the conversations on technical assistance and other things, and also Charlie Williams for his work with the task force. This is the effort that is Co-Chaired by the Secretary for Health and Human Services of the Governor and the Commissioner of Health, and has been in place since the Executive Order was issued. Just a little background on the status. These folks have kept this work alive, so I want to give them credit for that as well.

Dr. Boufford Charlie, do you want to lead off?

Ms. Williams Yep.

Ms. Williams Thank you, Dr. Boufford, and thank you, Lara.

Ms. Williams Good morning, all. Thanks for the opportunity to speak on the health across all policies. As mentioned, I'm Charlie Williams. I work in the Commissioner's Office on Aging and Long Term Care Team under the special adviser to the Commissioner on Aging. At a high level, the departments work under the health across all policies build off the Executive Order that was passed in 2018. It sought to pull together all government agencies to consider the inclusion of age friendly and healthy aging considerations into policies programs including spending and procurement actions. The department, along with the State Office for Aging and the Department of State, have taken a leadership role in this, and this approach has served as a basis for outreach to health service providers, our local government partners and others on adopting healthy aging frameworks of care, replicating the Executive Order provisions at a local level and becoming certified as age friendly communities through AARP. The department has articulated this work through the prevention agenda, which has been mentioned. The 2019 to 2024 cycle contain priority areas addressing healthy aging across the lifespan. Under the order, agencies have been required to appoint liaisons to work collaboratively to address social determinants of health. We seek to leverage each agency's resources, network and expertise in order to achieve that. Prior to the pandemic, we had been holding roughly quarterly meetings and had established two working groups. One was program and policy related, and one was procurement and spending related. While the pandemic has kind of halted these quarterly meetings, work has continued in an ad hoc basis, relying on the networks and communications that have been established. Now, I'll briefly go over some of the programs the department has participated in. The first is the Age Friendly Health Systems Initiative through a partnership with the Health Care Association of New York State and regional funders, including the New York State Health Foundation, the Health Foundation for Central and Western New York, the Samuels Foundation and the New York Community Trust with technical support and guidance provided by John Hartford Foundation, the Institute for Health Care Improvement, this program seeks to have health systems incorporate the four M's care model, which considers what matters to the patient, promoting mobility, medication through the detection and reduction in delirium and delirium inducing environments and medication adherence that seeks to coordinate and reduce adverse interactions into the operational and care service provision of these health systems. Additionally, an expansion this year included a Pathway to Achieve Accreditation as a geriatric emergency department through the American Council of Emergency Physicians. This initiative was begun as part of the 2018 state of the state proposal to have 50 percent of health system certified as age friendly within five years. To date, some 40 health systems have achieved this recognition with several others already having been certified prior to it. Which brings us, I think, almost to the goal with about a year to spare. Next, is an age friendly planning grant. This was released in 2019, and utilized one million dollars in grant funding from the Department of State through an RFP issued by the State Office for Aging to engage county based teams to either replicate the provisions of the Executive Order on the local level, become a certified, age friendly community as per AARP guidelines or both. In addition, several regional centers of excellence were established, and these continue the work to certify additional localities, describe the process for replicating the Executive Order, or just provide technical assistance on how they can incorporate these healthy, aging and age friendly considerations into their governance models. This grant, the program ended this past December. Another initiative related to this is the Age Friendly Public Health Systems Recognition Program, and this is put on by the Trust for America's Health. The department as engaged public health departments incorporate incorporating age friendly considerations into their operations. New York itself writ large, was recognized as the first age friendly public health system, and that was based on the 10 point criteria Trust for America's Health developed. Currently, conversations are ongoing with Trust for America's Health in the New York State

Association of County Health Officials about developing a technical assistance program to engage local health departments on achieving similar certification and establishing better linkages with other age friendly institutions and long term care service and support providers. Another program undertaken by the department is an age friendly housing grant. The Association of State and Territorial Health Organizations offered the department a grant to engage local health departments and housing regulators on the incorporation of healthy aging concepts and housing development, policies and spending, as well as the related action and how to determine and address the health impacts related to housing with a special consideration on housing for older adults. Under this, we subcontracted with the New York Academy of Medicine to deliver a 6 month collaborative learning program to assist participants in developing a county specific housing plan, which will include affordable housing for older adults. Also part of this is the department's building out a dashboard for lack of a better word that will provide a public health measure and resource list to track progress and inform future development decisions. Another program that the department has been working on internally. The department been fortunate during the pandemic to have several graduate student interns, so while personnel and staff at the department may be busy and have been sidetracked by the pandemic, work was able to continue on the development of a age friendly dashboard that will be placed on the department's website. Under this dashboard, the department will make a short list of public health indicators and health impact measures related to the AARP eight domains of livability. The dashboard will include a list of information, unrelated programs in the state and those employed elsewhere that have been proven effective and include a list of resources that provides further information on each of the eight domains. Some ad hoc collaborations that we have been involved in that build off of the communications and network that we developed under the Executive Order have been incorporating healthy impact and healthy aging considerations into the Climate Leadership Act and its related recommendations. The department worked in parallel with the Department of State to determine and detail the health impacts related to energy policy as well as recommendations. Another example of this has been the work with the State Office for Aging and the Department of Labor on a grant to engage employed caregivers. The grant was issued by the National Academy for State Health Policy and works to advance access to resources from employers that support working caregivers, as well as promote awareness of and linkage to service and support available caregivers. This work so far has been informed by a survey of public and private businesses and their employees, and sought to identify the number of individuals in the workplace that identify as caregivers. Building off of this, I also wanted to briefly highlight some proposals in the Governor's state of the state that would reform aspects of the state's long term care sector, utilizing a healthy aging lens with a special attention to the Master Plan for Aging. The master plan can be seen, as I said, building off of and supported by the Health Across All Policies age friendly work in the last several years. Under the master plan, it's still an ongoing conversation, but the department has been working with personnel in the Governor's office and the State Office of Aging to determine the optimal process for enacting the master plan, as well as the content and areas to address. There are several states that have recently enacted similar plans, most notably California, which has a five year master plan. I would like to note several advocacy organizations and foundations within the state, including the Health Foundation for Central and Western New York, have been champions of this and funders of the state's efforts on this work. They've released press releases and a report, including recommendations that the department takes to heart and will be considering in the formation and execution of the plan. We anticipate and expect the Department of Health and the State Office for Aging to take a leadership role in the most likely in the form of an Executive Order that would call on the agencies to work collaboratively and with members of the community and representatives of long term care

service and support providers to develop the actual plan, so content to be determined in the near future. In addition to the master plan for aging, they also announced several proposals regarding New York's long term care sector that may be of interest and related to our work on Health Across All Policies approach. The department has begun discussions and working internally on these issues, and some or all of them may become part and parcel of the master plan on aging, but that should be determined. Nevertheless, they include promoting alternatives to institutional settings for older adults. The proposal aims to create affordable and permanent supportive housing units for older adults who might otherwise need to reside in a nursing home or other institutional settings, including the provision of capital support. Another one has been the improving quality of care in nursing homes. This includes providing a definition of memory care and related direct care staffing requirements to care for those with Alzheimer's disease and other dementias. Another is the investing in innovative nursing home model, which includes the greenhouse model that promotes more of an independent living environment that wraps around access to nursing home level of services and supports. Another is the combating social isolation and elder abuse proposal. This would be an expansion of the State Office for Aging Programs to address older adult needs and link them to services, better connectivity through greater broadband and Wi-Fi access, and promotion of web based materials on how to detect social isolation and loneliness, and information on how to best link to services and where to receive them. Finally, under this, the state of the state is the strengthening the long term care ombudsman program. This is mostly a state Office for the Aging program, so I'll let John expand on this. Sorry if I hustled through. I wanted to keep us back on the agenda. I look forward to any of the questions and can build out more detail on any of these when we get to that part.

Ms. Williams Now, I think I'll turn it over to John with the State Office for Aging.

Ms. Williams I think you're still on mute, John.

Ms. Williams Or, Paul, if you want to go?

Dr. Boufford Maybe, Paul, why don't you start because you were listed next. I don't see John's name anymore. He was here before.

Mr. Beyer I'm assuming you can hear me.

Dr. Boufford We can.

Mr. Beyer Good morning, everybody. First of all, I really appreciated the discussion this morning. Robust indeed, and very enlightening. But playing off of the prevailing theme here and at other meetings of partnerships and collaboration. In my world, the world of smart growth and community planning and development, the key partnerships that we are attempting to make and solidify are between the community planners, community development cohort and public health. Tremendous connection between the way we plan and build our communities, our infrastructure decisions and public health outcomes, but also by extension, the connection between those two entities, planning and health and local and regional economic development. That is what we have tried to solidify here with some of the programs that Charlie mentioned, especially the Age Friendly, Healthy Communities Smart Growth Grant Program, which is entirely based on partnerships and collaboration. So with that in mind, I'm going to just tick off a couple of developments in the community development and smart growth world that I think promote both preventive health and curative outcomes. First of all, the crown jewel, in my opinion of community

development and smart growth programs really took a step forward this year with Governor Hochul, and that's the Downtown Revitalization Initiative. Every year we give out a single 10 million grant to one downtown in every one of the states 10 regions to revitalize their downtown. This year, the Governor doubled that amount. Instead of 10 communities, we now actually have 19 communities that have gotten these large grants. Now, what does that have to do with public health? Well, just about everything. We built from the beginning healthy aging concepts into the application process for communities to apply for this big DRI grant. We actually mentioned in the application guidance whether a community is age friendly, certified with AARP and WHO. Does it promote walkable bike able communities, access to fresh food? Things like that are critical, of course, to preventive health, but we have embedded them in the process of downtown redevelopment and community planning. AARP loves this program not just because it serves the older population, but because it serves people of all ages the entire age spectrum. That got a real boost this year, and the Governor has it in her budget for another 100 million next year, which is great news. This year, though, we're going to step further. She is proposing what we call New York Forward, which is something of a complement to the Downtown Revitalization Initiative, but on a smaller scale, adjusted to accommodate smaller communities, hamlets, village centers, communities that may not be able to handle a big 10 million grant, but certainly have projects that can spark revitalization and for purposes of this discussion, physical and mental health outcomes. You'll hear more about that, but we are actually going to go out to the communities, hold their hand, help them apply, help them through the revitalization process focused entirely on rural, smaller communities. Those are the big news items from our end. I will also mention that the Climate Action Council, the state released its Draft State Climate Action Scoping Plan, that's its official long name, the Climate Action Plan. It has a very robust health component to it. People like Charlie and I ensured that health was instilled into the conversation and as a something of an offshoot of that initiative, there's an interagency group forming to address the health implications of what are known as urban heat islands. We keep breaking heat records every Summer, and we're going to look very closely at the effects of the heat islands on public health, of course, but also how we can in my world build communities that are more protective of extreme heat, more urban greenery or shaded areas, things like that. And finally, the Governor within the area of healthy community planning is proposing that we focus on what is known in the planning world as transit oriented development, building around rail and bus stations, making communities more walkable. That clearly reduces car dependence, which has an impact on our efforts to reduce greenhouse gas emissions. But once again, we're creating healthier communities, less automobile emissions, more opportunities to walk and bike, and more opportunities to access transit. I think those are the main items in the world of smart growth that impact public health and healthy aging.

Dr. Boufford John Cochran, we see you now.

John Cochran Yes.

John Cochran Good morning. Sorry about that little technology snafu on my side. I wanted to thank you again for the opportunity to speak with you, and it's been a pleasure working with both Paul, Beyer and Charlie over the years on basically helping to better understand and then to think through from a state perspective, the intersection to smart growth policies, age friendly, livable communities and the Health Across All Policies approach and the prevention agenda. Because for us, it's so important to realize that there is this huge picture that is being drawn and certainly the Governor's state of the state, as Charlie was talking about some of the specifics there of what's in the state of the state. It's

important to understand that the state of the state overall will significantly expand economic, social and other supports and opportunities for older adults in the housing and economic security proposals and other things will have a tremendous benefit to older folks, and we're so grateful for the leadership that the Governor is showing in this space. And part of what Charlie was talking about earlier was this master plan on aging that he referenced. I just wanted to make sure that it's important to note that New York is well on the way to work that's been engaged in for the past 14 years, back to 2008 on basically working through some of the challenges that the master plan on aging when it was announced would be addressing. Many of my colleagues speak about California being a role model leading the way. I have to say that a lot of folks just don't understand all the work that's been ongoing in New York and Dr. Boufford, thanks to your leadership and the role that Charlie has been playing and Paul's been playing, that we've been able to keep this work alive and actually have been able to engage and structure our proposals that presently involve over 15 agencies who are all about working close collaboration with us, about helping develop an environment which people can age in place, stay healthy while avoiding injuries and chronic illness, and avoiding the need for formal services that they can access through their systems. The reason why we're talking about this, and from the get-go, back in 2008, advanced this premise of the community empowerment notion, which was about bringing together community stakeholders around addressing the challenges and opportunities of an aging population. What was driving that was a clear understanding that the long term care system is basically it's non sustainable based on the cost of the system and currently our financial drivers are not successful in terms of developing a system that will allow us to maintain it as currently structured. And so with that being in mind, the Health Across All Policies agenda, the Age Friendly agenda started to take a look at what the problems are that got us to the point of why our system is no longer financially sustainable and trying to think through what we could do to help the system continue to move forward. That kind of generated the high interest in the age friendly community to help the health agenda. Because in New York, we have a population of over 19 million individuals. We ranked fourth in the nation, the number of adults aged 60 and over. What we know is that this demographic characteristics changing over time has tremendous implications on our formal long term care system, but also on what we know is the ability for communities to be more effective and the need to do these types of things to implement policies that will help our communities become more effective because we know that making some choices through local community designed to enhance and encourage more healthy lifestyles that they can serve as an effective vehicle for improving the overall health of the Sate of New York and especially our older adults. Dr. Boufford, I want to thank you so much for the leadership and dedication and the willingness to engage your resources to help support the work being undertaken by community seeking to become age friendly. It's been a pleasure working with your staff over the years as they look to provide technical assistance to help us do our jobs better at the State Office for Aging. At the State Office for Aging, we work through primarily an aging network that seated in our county offices for aging and around the state. Our typical client is age 82, a low income woman living alone whose got five chronic health conditions and several IDL and ADL limitations. The primary vehicle that we're serving people is through our in-home service program through and our case management services of over 46,000 people. Our case managers cannot be successful without branching out to engage all stakeholders and know what resources are available that can assist them to help them live independently. The average timeframe that we're working with a client is between 5 to 7 years, and often we're working with our local public health officials and others to help people live independently for that period of time. It's all about collaboration for us because we know that the collaborations are basically the ways that we can help develop an environment in which people can age in place and stay healthy while avoiding injury and again, chronic

illness. It's been so exciting to have been a part of this. I wanted to also touch base that we are connected with the formal residential system in New York through the long term care ombudsman that Charlie referenced. This program was referenced in the state of the state address because of its important role that it provides and helping residents deal with the challenges that they may face and helping them resolve issues and concerns that they have on a daily basis to help improve their overall quality of life. This is such a critical program, especially at a time when there's a crisis of confidence in our long term care system. We know that many individuals, when asked about whether or not being placed in a residential care facility would be appropriate. Many folks are looking at this system as something that they would rather stay at home. Basically the long term care ombudsman could help provide assistance and resource and peace of mind to residents and their families as they're seeking to deal with the unique challenges that COVID has presented, as well as the unique challenges that we all face as we deal with the challenges of thinking through about the need for placement in the long term care facility. The Governor has asked that we provide a study after taking a look at some of the challenges that are confronting the program, which ranks 39th in the nation because of the level of staffing and trying to figure out how we can better ensure that advocacy service be made available to all residents. I also wanted to reference that on the issue of caregiving, basically spends a great deal of time and our resources to assist caregivers on a daily basis. One of the things that we've been working on is an innovation is working through the Department of Labor and distributing a caregiver guide for employers to share with their employees who are caregivers. It was distributed through a very concerted effort with the Department of Labor to make sure that this information is being put in the hands of employers so that they could pass along to their staff, because what we know is that many people are significantly impacted in the workforce on a daily basis by the challenges they face as being a caregiver for a loved one, especially an older adult relative. This became so much more critical during the COVID pandemic. With that being said, I'm more than happy to answer any questions. I know Paul and Charlie are prepared as well to engage with you on any issues that you'd like to discuss.

John Cochran Thank you again. Thank you so much for all of your leadership in this space, and I greatly appreciate your time.

Dr. Boufford Thanks, John.

Dr. Boufford Ms. Santilli, with your permission, I'm just going to move along with this panel and then should get back to you for the other activities. I want to make two points for the council, especially the new council members, that we've sort of spent. A lot of this program is really talking a good bit this morning about the sort of aging agenda, which is very exciting. I know many people in the council are interested in that and we'll come back to that in just a minute. I do want to emphasize two things for the council. One is that this interagency group has been and I think there's been a really good collaboration, as you saw in the prevention agenda and effort to sort of travel the Health Across All Policies with the Aging Across All Policies work. There's been, I would say, frankly, because of COVID, much more progress on the aging agenda, perhaps in the last couple of years than on activating a set of health specific agenda related to the prevention agenda in public health. I know that will pick up. The other piece is that there is an ad hoc leadership group for the prevention agenda, which involves multiple CBO's around the state. We've had 35 members, I think at the last. We're going to reactivate that with Ms. Santilli's help. Just to double check those that have been members and others that might wish to join the leadership group and hopefully have a meeting of that group, which is a spin off, if you will, of the Public Health Committee in May or June, I hope and really sort of revisit how we can

get more public health visibility in these really important initiatives. I did want to ask one question around long term care, and I know Jeff may have others. As you know, this council has been very interested in and actually asking for a strategic plan and long term care for the last three years or so. It has been difficult. Sound like there's a lot going on. I wanted to ask you about the three sort of big moving parts that may or may not be connected. One is you've mentioned is Governor Hochul's master plan, another was Commissioner Bassett announced recently an initiative on for the state sort of vision or blueprint on healthy ageing. And then finally, the Legislature recently passed, calling for a commission to look at a long term care task force. I don't know. Could you tell us how, maybe if or what the plans are for connecting the dots there because it seems like there'd be a lot of people doing the same thing in parallel play here would really be helpful.

Dr. Boufford Charlie, you want to take that one on first?

Ms. Williams Yeah.

Ms. Williams I think as to the long term care of task force out of the Legislature, the department is currently working on recruiting and vetting members, so that process is already well underway. I believe the thinking is in current discussions are that that task force will be heavily integrated into whatever process finally is determined for the master plan for aging when that Executive Order or however that it is formalized, comes out. I think the Commissioner's announcement was related to both of those. I don't think it's separate and distinct from either the master plan or the legislative task force.

Dr. Boufford As you listed all the initiatives going on and John and others in aging and long term care, we don't need others that are trying to kind of bring these pieces together. I think it would be really, really important that these be umbrella opportunities, I think, to bring all this work together, aligning it. It's good news that you say so.

Dr. Boufford Scott, question?

Scott La Rue Good morning. I'll be very quick because I don't want to take up time, but I want to make a couple of comments. They're too granular and again, I apologize. You hear the greenhouse as an alternative to nursing homes. The challenge with greenhouses is that the only successful greenhouse project are filled with private pay residents. The Medicaid rate is too insufficient to support the model, so it doesn't do anything to help racial disparity. It doesn't do anything to help the poor or those individuals on Medicaid unless reimbursement changed. I always try to encourage when we're having a discussion about alternatives to nursing homes, which everybody supports. PACE is a program that addresses clinical, medical, social determinants, it's a single payer system and a coordinated all services and allows someone to remain in the community. I just encourage PACE to be part of the dialogue in the conversation as we're looking for solutions to what consumers are looking for in terms of remaining in their communities.

Dr. Boufford Thanks, Scott.

Dr. Boufford Ms. Soto.

Ms. Soto Good morning. My question is, the initiatives and the outreach that you have prescribed for the aging. I didn't hear anything in terms of providing services to communities of diverse, racial and ethnic groups like the American Indians in the state and

also to non-English dominant communities. What activities and plans do you have for those groups?

John Cochran Could I jump in on that one?

Dr. Boufford Please.

John Cochran Thank you for that question. I think that that's a critical question for us is something that we're constantly wrestling with through the aging network. One of the things that we're engaged in constantly through our processes is seeking the input from communities about how we can best serve disparate populations within the areas in which they are serving. For us, we go through a local planning process where we expect counties to tell us how they will serve communities that are underserved and to provide us with a detailed accounting of how they are looking to make sure that the individuals who have needs are being addressed. Now, I know we could always do better. There are so many challenges that we're facing, but we have an active process that we go through with our county brethren every four years to give us a plan about what they're looking to do to serve high needs populations who are traditionally underserved as the term of art that we use. Again, what we're doing is we're serving individuals who are pre Medicaid, for the most part. Regards to the PACE program, I just wanted to point out, I understand the great interest in that program model and it does some amazing work, but it also benefits individuals who are on Medicaid. What we're looking to evolve our system is through the aging network to think through about how do we prevent people from going into the Medicaid system in the first place? How do we prevent individuals from impoverishing themselves so that they can live independently for as long as possible and utilize what resources they have and bring into the equation the ability for individuals to self-finance their care or self-finance or basically provide services that help individuals avoid the need for higher levels of assistance. The reason why, again, there's such a strong interest in the age friendly movement is that through changes in the built environment, through changes that will be implemented through the Health Across All Policies initiatives, that these will help provide system changes at the local level or help people live independently, provide them with supports and assistance that help them from becoming impoverished. Again, one of the terms of art that we like to use is that we're trying to develop a pathway to keep people off the road to Medicaid.

Dr. Boufford Thanks, John.

Dr. Boufford I want to mention something also with Paul connected to your question. One of the ways in which we before COVID, we had talked about trying to tackle the disparities issue across the state was to look not only at race ethnicity, but also at economic development and poverty and Paul's department has a lot of information there. We were not able to sort of bring that together as one of the criteria metrics for some of the investments in underserved communities, so I hope we can reactivate that conversation. Paul, did you want to say something quickly and then we're going to have to unfortunately wrap up. We'll come back to this in our first meeting of the leadership for the ad hoc committee leadership development group.

Mr. Beyer Sure.

Mr. Beyer Well, the question and the solution to the question got a real boost through the state climate change legislation and implementation in a very specific and compelling way. We are to direct our services, our money, our benefits 40 percent, 35 to 40 percent of the

benefits and services and grants that we provide to communities in the state are to go to what are known now as disadvantaged communities. The Climate Action Council and its subgroup, the Climate Justice Working Group, came up with the definition of disadvantaged communities. We are building that into nearly every one of our programs now. I know it's much more than just the money, but it's a very good start and it gets us thinking more about this problem and how to get to the root of it and get the services to where they're most needed.

Dr. Boufford Well, I would say also Paul and the Department of State have been crucial in joining their Prevention Agenda Group and the ad hoc committee, along with a number of other agencies like Energy AG and Markets and others. It really has been super helpful.

Dr. Boufford Sorry for this, but I realize we really will run out of time. Ms. Santilli, back to you, and maybe we can ask your colleagues to maybe shave five minutes off of there. I will not do next steps twice. I'll do them at the end, so we'll buy some more time back. Just keep moving ahead. Thanks a lot because we do probably we have Brett at 11:30, and we need to wrap up make sure we don't lose them by running too far over.

Ms. Santilli Understood.

Ms. Santilli Next up, we have Ms. Santilli and Erin, who are with our Public Health Corps fellowship program, and we'll be talking about the workforce there. I asked them to join us because we do hear a lot about developing the workforce and a lot of what we hear out in the press is on the health care side. Again, from our perspective, we need to make sure that we don't forget about the public health workforce from that perspective. Both of them need to be rebuilt, especially after the two year crisis that we went through. Not only supporting our health care workforce infrastructure, but the public health workforce as well.

Ms. Santilli Ms. Santilli and Erin, I'll pass it over to you.

Ms. Santilli I was worried about showing the slides, I forgot the mic. Thanks so much for having us. Hopefully, after our short presentation, you'll get a snapshot of what we've been working on. The New York State Public Health Corps Fellowship Program is a new program that we're really excited to talk to you a little bit about. Erin and I will be moving forward with the presentation. So just to kind of set the stage in January of 2021 in the state of the state address, it was announced that New York State Department of Health was going to be charged for putting together a Public Health Corps Fellowship program that this public health corps will enhance public health capacity to support COVID-19 vaccination operations, as well as respond to future public health emergencies by increasing preparedness in the workforce. By doing that, we were going to work with community partners to recruit and deploy up to 1,000 fellows to be assigned in the communities all across New York State. I will say this with the exception of New York City, as New York City actually receive their own funding and they're employing their own program. There's three goals of the program. One is to bolster the state's public health infrastructure with these fellows to initially provide critical support to COVID-19 efforts, but also for, as I said before, future public health emergencies to local health departments. Secondly, it's to effectively communicate with and educate New Yorkers about key strategies that address public health efforts. Thirdly, to facilitate connections within the community level public health stakeholders so that we can strengthen and sustain public health learning and action partnerships. What is a fellow? A fellow really is anyone that is willing to respond to the public health workforce. We are looking to see recent graduates or students who are in the public health, medical, dental, nursing, you name it. Allied

health is really the stress of our recruitment, public health and allied health focused education and intention for applying that knowledge into the public health workforce. There's clinical and non-clinical expertise that's needed, as well as opportunities that are available at both the local and the state level. We developed the program to hire three different types of fellows. We have our first level, which is an individual who has a high school diploma up to an Associate's or Bachelor's degree, or with equivalent experience that can take on responsibilities that are supervised or task oriented. Then we have a graduate level fellow, which is someone who's completed their Master's degree level or has relevant experience that can focus on including doing more independent project level activities and oversight functions. And then finally, our senior fellows are individuals who have completed their Master's degree level education or have equivalent years of experience that can do more independent technical support activities, as well as significant program level management functions. As you can see, we developed the program to have these different tiers so that the local health departments can identify what type of skill set they're looking for to support their need. This is our landing page to our website, and at the top you can see our URL. This website is always in development, but you can go there and you can find our application. You can find FAQ's. You can find more information about the program. This is the central location that you can really learn more on how to be involved from being a mentor within the program or applying for the program. Hopefully, once we have our local health departments ready to hire, we can even post positions that are available in certain areas so that we can highlight which health departments are hiring and what type of skill set they're seeking. Just to give you a little bit of an overview of how our matching works within the program. We have asked local health departments to complete a survey to identify where their gaps are in their current workforce. We have asked fellows to apply online, as I showed in the previous slide from the website. What we have done is we've asked the local health departments to categorize their need based on the four components in the second half of the slide, whether the job duties are regards to vaccination, testing site, clinical, administrative or logistics support. It's just a broad spectrum of that. Second is epidemiology and data support. Third, communication support and fourth, outreach and partnership development. As you can see, these are all broad range areas of expertise. But this way, we can identify fellows who say that they have this expertise and connect them with the local health departments. Along with the matching, we ask for the applicants to identify their top five counties that they're willing to work or that they have expertise in. The local health departments are in their contracting phase will identify what their job descriptions look like so that we can assist with providing applications with that matching. In addition to the application, I should have mentioned previously, applicants submit their resume, they submit a letter of intent, as well as at least one letter of recommendation along with their application to complete it.

Ms. Santilli With that, I will pass it over to Erin to talk about our infrastructure.

Ms. Knoerl Thanks, Lara.

Ms. Knoerl When we're thinking of the New York State Public Health Corps, we're really thinking about it at three levels. As Ms. Santilli mentioned, there's 1,000 fellows. Over 80 percent of those fellows we want placed at the local level. We're thinking about it on three tiers. At the state, we have our leadership team, which is Ms. Santilli myself, Ashley, our project manager. We've hired 10 fellowship placement coordinators which really oversee the different regions. We have 10 regions, 9 of them geographic, the 10 being the New York State Department of Health, and we wanted staff that are familiar with those regions. And then we also have at the local level then. As I said, over 80 percent. In July, we released a letter of intent to all 57 local health departments, excluding New York City. In It

described the amount of money available, the total number of fellows that a local health department could obtain and then also it outlined the scope of work, which are these bullets that we see here. Just some highlights. We've asked all local health departments to identify a coordinator and that's really to oversee the fellows. One thing I want to note is so our contracts are with the local health departments, but we've encouraged local health departments to think beyond just the department itself. Are there community organizations that might benefit from having a fellow as well? You'll see identify and develop key fellowship projects. That could be at the local health department or could be with partners. We have some local health departments working with rural health centers, hospitals, FQHC's, Office of Mental Health, Department Social Services. Really, we wanted the county to decide what are the key projects that they want to work on that address COVID response and recovery in some capacity. Another key thing to emphasize is that it is with the local health department. Though fellows are applying through our website, all complete applications are sent to the local health department and they decide who they want to interview and ultimately hire. We've also asked local health departments to identify a mentor to work with their fellows in the county. Our region's pretty much exactly aligned with the regional economic development councils with the exception of Western New York, Finger Lakes and the Southern Tier. There was a very purposeful reason why we did that. There are 8 counties that are part of the health network and they all wanted to contract and that kind of went across those three regions. We've defined them slightly. We've hired a regional fellowship placement coordinator to oversee each of these regions. This again, just kind of shows a little bit of our infrastructure. These are conceptual drawings. On the left is what we have our local public health partnerships. You can think about that as a county. Like I said, hiring a local coordinator. These different colored boxes kind of show how fellows could theoretically be broken up. Maybe four are placed at the local health department, two possibly are maybe at each of the hospitals in that county, maybe blue represents a rural health network and then green an FQHC. We've asked that roughly for every 6 to 8 fellows that the county identify a mentor. Again, provide some professional development and provide also a little bit of scope beyond of what public health is. We're calling them local public health partnerships because we're really asking local health workers to work with the partners in their community again to kind of provide a robust experience for our fellows. The regional consortium you'll see is there's a bunch of these local public health partnerships. On that map, we showed the regional consortium are pulling together all of those counties in the distinct region. They're going to be having quarterly meetings where we'll pull together the mentors, the local coordinators, the fellows, have invited speakers again, kind of emphasizing the core competencies of our program. I should also mention, every county is a little bit different, as you know. This structure, we think, allows for the county to really have fellows to work on the projects that are most important to them. Again, on the regional level, what are key topics that all fellows would benefit from? These are just the expectations. I won't go through them all, but really core components are that we're looking for fellows to have at least a one year term. It could go longer than that based on the needs of the local health department. All fellows have to complete a public health essentials course from Cornell University. Really, we're looking for fellows that are from the community and want to give back to their community and then the other ones just kind of outline again key components to make sure we're monitoring progress and that there is a solid foundation to support the fellows within their fellowship. This is just our Public Health Essentials program. It's a 80 hour course over the course of 14 weeks. It emphasizes just kind of five key areas: responding to the COVID related needs, applying fundamental approach of public health, using existing data to understand community priorities, how to support community based health promotion and behavioral change, and engage in planning for public health preparedness and response. Overall, this program continues to evolve and we've gotten a lot of

feedback from local health departments. I just wanted to emphasize that at the core of our program, we kind of have what we're calling these three pillars. The New York State Public Health Core aims to promote opportunities to engage professionals to strengthen our New York State Public Health Workforce. Connect, we want to make and facilitate connections to public health networks with these fellows. Lastly, enhance. To enhance the skill sets and the knowledge of our fellows through diverse opportunities, including trainings. We're convening a number of working groups. We're starting with institutions of higher education, and this just kind of emphasizes our key focuses as of right now again, to kind of expand and build our program. Lastly, I just wanted to emphasize that we have metrics that we're funded through two different CDC grants. Every presentation thus far has spoken about equity, the importance of health equity. And that, again, is at the core of our program. We want to have a diverse workforce. We want a workforce that represents the communities to which they serve. We are developing an extensive kind of evaluation program and trying to make sure that we've got health equity throughout our program.

Ms. Santilli Thank you very much, Ms. Santilli and Erin.

Ms. Santilli In the interest of time, what I'm going to do is Lauren and Erin, if you could put the Public Health Corps email address into the chat and any members that have any questions or comments or want to bring them in to speak to the educational institutions, they are all over the state talking up the Public Health Corps for our partners. I know they'd be very willing to entertain conversations, further questions and discussions. But in the interest of time, I think we'll hold our questions at this point.

Dr. Boufford We're just trying to get the items covered, if it's really important, please, you're the Chair, so you can go ahead.

Mr. Kraut I'll defer to Kevin before I speak up. If you don't want to take questions.

Dr. Boufford No, no. We're just trying to. We're so far behind now, really concerned about the really important agenda items.

Dr. Boufford Kevin.

Kevin You can go ahead. I just wanted to comment that as we know that the infrastructure of public health was really severely depleted prior to the pandemic. We really appreciate this public health fellow program. I know that most local health departments have found the fellows to be amazing so far, and we're just hoping that we can extend this one year term that has been allocated to the local health departments.

Kevin That's my comment.

Mr. Kraut I'll just add on to when we were founded in 1913, there was a lot of work done on describing what the resources of the local public health departments should have. That was headed up by Dr. Herman Biggs, and he spoke to the fact that a public health is purchasable and it's based upon how much a community wants to fund public health and that that was his premise. I appreciate the program you said, but I listened to some of the previous speakers talk about, you know, this one has 11 staff. What we saw during COVID is the variability in staffing in a lot of our local departments of health. I'm just wondering if you've ever done research to look at that staffing across all of our counties and have come up with some sort of recommendation that there's minimal expertise or a minimal amount other than an appointed Commissioner of Health that we should be supporting, because

some some counties had boots on the ground. A lot of other counties didn't. It doesn't really need a response. Just a comment that this is something where we can we should be advocating for not only the Department of Health, but for local departments of health.

Dr. Boufford We've been talking with Ms. Santilli about this essential public health functions, which was mentioned in a couple of the presentations this morning, is really a self-assessment that health departments can conduct on a set of issues as their capabilities and a set of areas that have been defined by CDC and New York was one of the pilot states about 6 or 7 years ago when this was initially done. I think it's really important, Jeff. There are tools to really try to answer those questions, which could help us potentially access hopefully additional state money or federal money should it be released. It's really, really important point for the council to stay on.

Dr. Boufford John Cochran, you're broadcasting your call.

Dr. Boufford Sorry, Ms. Santilli, back to you.

Ms. Santilli That's okay, Dr. Boufford.

Ms. Santilli Thank you very much.

Ms. Santilli Good. Very happy to receive those comments. Again, just the beginning of the conversation. We will definitely continue.

Ms. Santilli We're going to turn our topic areas. We'll turn to maternal mortality. Our division of Family Health Team has joined us. Priti will go ahead and advance the slides. Just let them know when you're ready to do that. Welcome both of you. Thank you for joinging us.

Dr. Kacica Good morning, everybody. Medical Director in the Division of Family Health.

Dr. Siegenthaler Good morning. I'm happy to be here. Thank you for inviting us. If you want to advance the first slide.

Division of Family Health We are very happy to highlight six of the department's efforts to reduce mortality and morbidity among birthing individuals. We will try to keep it short. I welcome any questions if there's time and it's allowed.

Medical Director Division of Family Health Next slide.

Medical Director Division of Family Health The Maternal Mortality Review Board was signed into law in August of 2019, and then we convened the board. The board is a multidisciplinary board from both providers, community members from across the state and has wide representation. The case reviews that are conducted by the board are then all contained and reported in the CDC's Maternal Mortality Reporting Information Application. This is an application that all states report into to get a national picture. The board meets four to six times a year, more like five to six times. We publish the findings in Aggregate and the board will be producing biennial reports. There's currently a report of the 2018 maternal death cohort.

Medical Director Division of Family Health Next slide.

Medical Director Division of Family Health Also in this legislation there was included a Maternal Mortality and Morbidity Advisory Council. This council works collaboratively with the board to review the board's findings and addresses structural and social determinant factors that impact maternal health outcomes. Members of this council come from across the state from many disciplines, which include community members, perinatal network professionals, midwives, Toulouse, home visitors, et cetera.

Medical Director Division of Family Health Next slide.

Medical Director Division of Family Health One of the ways that we have been addressing maternal mortality over the years is when we have identified issues with our reviews or through other data that we've looked at, we have focused on specific areas. So, for example, obstetric hemorrhage was a leading cause of maternal mortality. We worked on this through our perinatal quality collaborative, which works with hospitals facilities across the state for system change in order to improve the way things are done and to improve outcomes. From this obstetric hemorrhage project, what we were able to accomplish was we had as far as transferred to higher care, including to the intensive care unit or a higher level hospital from a lower level hospital to an RBC. We were able to decrease this by two thirds and also hysterectomies were decreased by 29 percent. The second thing one of the other projects that is the current project that we're working on was focusing on preventing, identifying and managing care of people with OUD during pregnancy and then improving the standardization of therapy and coordination of aftercare, especially with the infants, if they had neonatal abstinence syndrome. One of the outcomes that we have accomplished so far was that we're better at connecting these individuals to referral and linkage for care for medication assisted treatment or other treatment of opioid use at the time of discharge.

Medical Director Division of Family Health Next slide.

Medical Director Division of Family Health One of the things that the department conducted in 2018 was we had seven community listening sessions across the state in partnership with our Maternal and Infant Health Collaborative. What we found through these listening sessions was that women of color who were pregnant or postpartum did not feel listened to and often felt disrespected during their interactions with health professionals. Based on that, and through our task force for maternal mortality and disparate racial outcomes, the focus we wanted to focus more on implicit bias, racism and discrimination. We established the Birth Equity Improvement Project, which uses the same framework that I talked about with the Perinatal Quality Collaborative. Here we really are emphasizing structural and systems change within participating facilities and birthing centers to develop anti-racist policies and procedures. One of the things that each of the facilities are doing is that there's an individual survey conducted of all birthing people as their discharge of their experience of care. It's a measurement to see if things are changing over time. Currently, this project has 66 participating facilities from across the state and covers about 70 percent of the births in the state.

Division of Family Health Thank you.

Division of Family Health The next area that we really wanted to focus on was also improving access to care, so ensuring that there were community supports and services as well as other supports for this important time period in the communities people's lives. We expanded and enhanced our community health worker services by increasing the funding for our maternal infant community health collaborative programs and increased

from 70 to 108 health workers. We are actually expanding again. We've renamed the program to Perinatal and Infant Community Health Collaboratives to ensure that we're using very inclusive language. In addition to expanding the number of health workers, we're also including a new data management and information system because accessing and having data from our programs is so critical, as well as ensuring that our community health workers have access to and are being provided training and technical assistance to better serve the community.

Division of Family Health Next slide.

Division of Family Health The other investment is in our perinatal regional system. You can see more of a visualization that the way, as you know, our systems organize with our PC's, having seeing the highest risk pregnancy, but also having a critical role supporting our regional birthing facilities in those levels below them. What we have done is we have worked with community partners to update our regulations. We anticipate that those will be moving forward shortly to be reviewed before being posted for public comment. One of the biggest changes is formally adding the system of care provided by birthing centers, where the births are led by midwives and physicians, ensuring that they are part of the system and so that they can have access to and work with our PC's and the other hospitals, including agreements for transfers and other supports and services.

Division of Family Health You can go to the next slide.

Division of Family Health This will also ensure the appropriate level of care determination. The impact of these regulations will include expanded regionalized system incorporating these birth settings as long as a formalized relationship for training, consultation and quality improvement. Strengthen requirement for the transfer agreement and strengthen requirements to work on and improve maternal and neonatal outcomes, some of which are aligned with the Perinatal Quality Collaborative, as well as local efforts within the birthing network.

Division of Family Health Next slide.

Division of Family Health And then in addition, we have invested in improving training. Looking at issues of racial disparities and ensuring that we have professional development. Here are a few of the activities you can see in front of you. We worked with the association, Women's Health, obstetrical and Neonatal Nurses for Post-Birth Morton Science Education for birthing hospitals. We've worked with our partners, ACOG and an Office of Mental Health, Project Teach, webinars focused on maternal mental health access, as well as integrating mental health into practices. We have implemented some campaigns to promote awareness, including using the Centers for Disease Control and Prevention Hear Her Campaign, which is increasing awareness of serious pregnancy related complications and they're warning signs so that individuals know what they are and can advocate and talk about those as well as a maternal depression or perinatal mood and anxiety disorder. We just wanted to highlight a few of the efforts that the department is undertaking. We do recognize the importance of this and it is a priority to the department.

Ms. Santilli Thank you both very much.

Ms. Santilli Again, in the interest of time, I want to move things along. I do see Ms. Monroe, you had a question. Let's do that quickly.

Ms. Monroe When you said that just 66 facilities cover 70 percent of births, are there particular geographic area or population focus that are not covered by that project or are the rest of the kind of dispersed among the regions?

Medical Director Division of Family Health It is pretty dispersed across the state, so I wouldn't say there's any region that's not represented.

Ms. Monroe What about population focus, Native Americans, Asians?

Medical Director Division of Family Health Yes.

Ms. Monroe They're covered?

Medical Director Division of Family Health Yes, they are.

Ms. Monroe Thank you.

Dr. Boufford Well, I just want to mention this is an area where the council put out a white paper about five years ago, as I said at the beginning of the meeting, that started a lot of attention here. It's an area the public health committee has wanted to monitor ongoing. We'll come back to this in more detail at a future meeting. I think we have Brett Friedman is here.

Ms. Santilli He is, Dr. Boufford, and he does have a hard stop at noon. I was texting Shane on the side. He's very willing to slide, so that we can get Brett in and out and have the conversation around his topic area.

Ms. Santilli So, Brett, thank you very much.

Ms. Santilli I'll go ahead and turn the table to you.

Mr. Friedman Good morning to everyone. It's a pleasure to present. I was asked to give an update from a topic I presented several months ago about our pending 11 15 waiver submission and specifically some comments that we received about the relationship between some of the work under the waiver with regard to the public health planning activities and prevention agenda that I know is near and dear to the hearts of those of you. I will work to project my screen here.

Mr. Friedman Can everyone see the Power Point?

Ms. Santilli It has come up in Power Point, yes.

Mr. Friedman Excellent. It's amazing when it works.

Mr. Friedman In the 30 or so minutes I have, I was going to provide an overview of where we are with our 11 15 waiver demonstration in the planning work that has been undertaken to do a slightly deeper dive into what we're calling health equity regional organizations, which are the primary means of providing regional planning for purposes of waiver activities and how the role of the hero, in our view relates to what we expect local health departments to do and how we expect local health departments to participate in other related activities. Critical is that we do not. We're not intending to duplicate any local public health activities that are being undertaken at the regional level. The goal here is to build on

those activities and build them into the fabric of the Medicaid program, so there is better coordination between what we're doing under the waiver and what's already been going on through the work of the health departments and otherwise. Very quickly just to give you a status update of where we are because this has been many months approaching a year long endeavor. We have been working to develop what we initially called the concept paper, and we're converting into a formal application to submit to the federal government in order to make a new investment of federal dollars up to 17 billion in Medicaid Medicaid delivery system over five years. Not on the slide, but very quickly, we released a concept paper back in August. The concept paper was our intent document for lack of a better word to say this is what we want to do with the waiver, in addition to sharing it publicly and getting a lot of feedback, including from those of you, we've also shared it with CMS and gotten their feedback. The good news is that CMS's feedback has been extremely positive. They had some targeted feedback, namely that they think 17 billion is too much money to ask them for, but we're going to still make sure the request is quite substantial given the need. They also made some targeted feedback around how to describe and build out certain of the goals listed here about the waiver. Since that feedback, which we've had a number of calls from CMS over the last three to four months, we've been converting that concept paper into a formal and extended application. That application will go through by necessity in compliance with federal rules, an extensive transparency process. We're going to post it in the state register, we're going to hold two public hearings and there's going to be 128 day comment period under which we can receive formal public feedback, which we then have to incorporate into the final waiver before formally submitting. We expect that to happen in August of this year. And then it's off to the races in terms of negotiating this, what are called special terms and conditions with CMS and hopefully, you know, under a best case scenario by January of next year to have this new waiver program in place that can be an appropriate successor and fund aspects of the delivery system that have been revealed and underfunded over the course of the COVID-19 pandemic. Consistent with my earlier presentation, there are four goals that we're advancing in the course of the waiver, which CMS has endorsed through its comments to us. One, and I'm not going to rehash what know under each of these goals, but I really want to just remind folks what we're thinking along the lines of the waiver, but to build a more resilient and flexible and integrated delivery system that is capable of reducing racial disparities, promoting health equity and supporting the delivery of social care. Essentially, the full integration of health care and social care services into the Medicaid landscape. We would make investments to develop and strengthen supportive housing services and alternatives institutionalization. We would redesign industry and strengthen safety net facilities and workforce capacity so that they can build back from the COVID-19 pandemic and respond to future pandemics and public health emergencies. We would create and invest public dollars in developing a statewide digital health and telehealth infrastructure. Those were the four. Under goal one, we have this concept of a hero. A hero is a health equity regional organization and as a means of developing a regional approach to ensuring that the waiver investments are targeted. It's a reflection of that the needs in New York City are different than the needs in the North Country or in the Finger Lakes region or in the Southern Tier of Western New York. Although we are trying to very much learn from the mistakes and that's one things CMS told us, which is own up to your mistakes. There was a lot that worked, but there was a lot that didn't work and that you want to improve on. We would say is the regional nature were helpful because they could be customized to address regional needs, but there were other aspects of the system in terms of the prescriptions in their clinical project, the fact that there were multiple competing priorities, the fact that they were not necessarily fully coordinated, didn't have long term futures in terms of delivery system. We wanted to design something that could address that regional need without all of what didn't work. This concept of heroes is to create a regional, mission

based organization that's composed of a coalition of stakeholders in that region. They would serve as hubs for regional coordination, collaboration and decision-making that would inform how the waiver funding gets used, mainly through advance value based payment arrangements that are targeted addressing health equity needs of population. Unlike the multiple per region, we would contract with a single hero per region. We would start with the existing regions that we use for DOH Medicaid rate setting. There are nine of those, but then we would consult with local health departments and other key stakeholders to subdivide, if necessary, those regions so that we can really make sure that the hero is addressing a defined population and public health needs within a specific area. New York City is a big example of this. That's one rate setting region that we use, but we could have multiple heroes if we think Staten Island and the Bronx are not best served by the same entity. A hero may be an existing entity, or it may be a new corporate entity formed by the regional participants for purposes of engaging in the labor activity. Again, it's trying to preserve maximum flexibility. What heroes are not is they're not intermediary funding entities like PPS's that were. For those of you familiar with that construct, we funded all of the funding and distributed that funding to their partners. That's not the role of the heroes. Heroes are not their intermediary funding entities. They're planning entities. They're going to say how the funding could be used to address the needs of the region. But then the funding is going to run through managed care plans in connection with the arrangements consistent with the objectives set by the heroes for that region. In addition, as opposed to having overlapping and competing that we had, I think we had four in the Bronx, for example, we would have one so there's really a single point of truth and decision making within each entity. We did get some questions to ensure that there isn't duplication. How can gross support rather than supplant existing public health efforts within the region? Will hear duplicate existing collaborations and infrastructure surrounding the public health effort? Can local health departments or existing collaboration qualify for designation as a hero so as to avoid duplication? We're clarifying in the application because we very much do not want to create duplication. We want to ensure that the hero can reflect existing public health efforts and that to the extent of local health department or existing collaboration meets the requirements of a hero. We would love for an existing entity to be and serve that function. In working through to answer all of these questions, which are legitimate concerns and ones that we want to avoid, we want to be sure it's abundantly clear that heroes are supporting existing public health efforts. They're not intending to create clinical projects that supplant or create parallels to what's already going on. Duplication is a swear word in my vocabulary. That the hero and the whole real purpose of the hero is to understand inventory and create new collaboration and infrastructure surrounding public health so as to avoid duplication. We're not trying to build anything waiver. We're trying to identify what exists, what's working so that we can fund it better under the labor. And that if there's a local health department that can qualify to hero in a region, that would be great. Local health departments in many ways are ideal entities to be a hero because they have a lot of the data systems necessary to fulfill the role and function, which I'll go through very quickly. To remind people, and this really hasn't changed from the concept paper, but what our heroes? What are they made up of? They're essentially membership organizations that would be composed of the following stakeholders on this slide, if local health departments managed care organizations, the litany of provider types organized by the right direct providers or through existing collaborative or behavioral health care collaborative, consumers, members of the workforce, qualified entities, those that participate and other providers and stakeholders that we think could inform the activities and the needs of a region. This is the diagram that we've been using to sort of reflect, and I'll let my lawyer show for a second there's a lot of structural diagrams, but that this is a reflection of the fact that the hero is an entity. It could be an LLC. It could be a not for profit. It could be an existing governmental or quasi

governmental department and that they would have the participation of the various types of stakeholders to ensure that there's collaboration. A hero entity would be necessary to ensure that there's appropriate data sharing and understanding and integration of activities so that that regional planning can occur. But unlike again, a PPS, we're not slowing the funding through, in large part from the hero. The funding that we're getting is enough money for them to engage in that in those planning activities to inform how the MCO and the providers and CBO's can work together for the funding under the larger waiver. To that end, the functions of the heroes I mentioned earlier is to really serve as a central hub of regional consensus building, planning and coordination around health equity improvement activities. It's a recognition and we've spoken with a lot of stakeholders in the development of the concept paper and the way of application that there's a lot of great work already going on. How do we inventory that in an appropriate manner to ensure that we funded through the larger investment? The hero would be that entity. They would develop an annual regional plan that would enable a holistic, clinically integrated, value driven approach to evaluating, addressing the integration of physical and behavioral health, what the social care needs are of vulnerable populations in the region and how to take those arrangements and make them ready for value based payment in connection with managed care plans that can address the population cohorts that are most effective. Here also working establishing goals, setting quality measures, priority impacts and if there is a change to accomplish the work, and then they would also serve as a central hub of data infrastructure so that they can help collect and analyze data across systems. How do you take the data systems between criminal justice, homeless services, foster care, integrate those effectively in the health care system to really move beyond into these special populations arrangements that we want to fund with the waiver? And then finally, in connection with housing investments, they would assess the existing housing inventory and identify gaps and possible solutions. To step back and look at the functions, there's going to be a lot of regional need and we're looking at the hero as an appropriate membership organization with stakeholders to tell us in a consensus way what that region needs so that when we fund those efforts payment, supportive housing and telehealth, that we're doing so in connection with a single source of truth for that region. To that end, again, the goals are especially moving towards more advanced that promotes health equity and provides sustainable cash flow during health crises to develop a delivery system that's built for well care that accounts for the whole person. It's movement beyond physical health and integration of physical behavioral health that appropriately integrates the social determinants and social care services that can meet patients where they are, that there's providers to have flex and surge capacity during public health crises and then improve outcomes for all patients, particularly the most vulnerable and underserved. That will allow us to build on the successes around the regional customization and coordination. But that is informed by the challenges and lessons learned. I covered this sort of upfront, but duplication is critical projects were not appropriately reflective of existing public health efforts in that area. What we think by having a narrow role for the hero and it's important, but it's really assessing what exists currently building those partnerships, generating that additional data analysis capacity across systems that then when the funding occurs through supportive housing and through telehealth, we're funding what is the agreed upon need for that area. And that goes to the funding rate, so in a 17 billion waiver, what we expect to fund and directed it to the heroes, is 325 million. Again, that's a reflection of the fact that the hero is not a funding intermediate self. It's not pushing up money to the provider organizations like CPS's did. That 325 million is going to the hero on the collaborative in order to engage in those regional planning efforts. We've done some budgetary analysis of entities that we think are kind of heroes that we think that money would go towards some of that system integration work, some of the planning work, the meetings, the collaboration, the development for probably a whole lot of consultants then.

But that would be a way for the hero to generate that regional plan that could then form the bigger funding pockets under the waiver. A good example in sort of our research is what --- Health does in Rochester in terms of being that convener that collaborator that has a data analytics function and that could inform regional need for purposes of larger system planning work. That is an entity that we think is a good example of what a hero is and what a hero isn't. In terms of the role of local health department, we thought it was important to emphasize that we view heroes as complementing the work of local health departments in their efforts to promote public health. Again, we want them to work with local systems and entities to develop a coordinated and cohesive plan. Local health departments we know in the concept paper, but it was missed in some of the comments we received that again, depending on the regional local health department, could be the hero if it covers that region. We think in some ways that's a benefit because they could have the necessary data infrastructure in place and have those existing relationships to perform that data analysis function to inform the regional planning and the annual plan that we're going to expect. If they're not the hero entity itself, we view local health departments as being part and really a leading participant in the hero governance and participation. Outside the heroes, which is, again, the centralized coordination entity, we do view local health departments as having a substantial role in other aspects of the waiver funding including the formation of a separate entity, what we would create social determinants of health networks, as well as the advanced arrangements. As a reminder, the SDHN's is a separate investment we're making to create networks of CBO's that would provide a streamlined, closed loop referral system for social care services in that region. Ideally, we would have a single per region because they could be that coordination body to provide an integrated close referral for the social care services required of those population. We would expect local health departments to be able to influence the composition of the executions in that region. And then in the advanced arrangements, again, the arrangements that are available for funding under the massive bucket that we intend to create through the waiver would have to be authorized under the annual regional plan developed by the hero. The heroes would detail the needs of the region, the methods for addressing them and then that's what we would find under these arrangements when we're presented with adequate qualifying contracts between the groups. Local health departments again would serve as the heroes and be part of your governance structure that would inform the regional need to authorize payment under these arrangements. We wanted to highlight too that. And as part of the executive budget this year and through the managed care procurement that we're proposing, we would give state and local partners the ability to compel to engage in the regional work on the different arrangements contemplated by the waiver. All of these pieces are trying to work together to avoid the concerns we've heard around duplication, to ensure better coordination and to assure that the funding under the waiver is really going towards advancing what already exists and make it work better, so that we can avoid some of those and do this more cohesively. I want to make sure we stop for questions. I covered this pretty quickly and assume the sort of a very substantial understanding of the concept paper already, given the presentation I made a few months back, but if there's any more basic questions, I'm happy to answer them or certainly entertain follow up questions at a later time.

Ms. Santilli Great.

Ms. Santilli Thank you very much, Brett.

Dr. Rugge This is John Rugge.

Dr. Rugge Experiences with multiple payers, there are multiple approaches to DPP, model standards to follow. Will there be a process to standardize expectations and hold the payers to a common grid?

Mr. Friedman Absolutely. We're doing this in two ways. The first is that we've recently reissued for public comment the value based payment roadmap, which was a document that started. We wanted to refresh it in anticipation of the waiver because that's the document that states the expectations on payers. The problem and what we've heard from claims, especially, is that without adequate funding, the plans are limiting their ability to make investments in the type of social care services to address the social elements of health that are necessary. Through the waiver, we're using a process of incentives as opposed to penalties that we used historically. What we would say is plan. If you enter into a arrangement that A, meets the regional goals of the hero for these specific populations and B, achieves all these other features that we put into place through the waiver at higher level risk is with an appropriately composed network of providers including health care, behavioral health and social care providers. It's addressing a population that has historical health disparities. Then we will unlock the waiver funding above and beyond what's in the plan premium to fund those interventions and services. The waiver is very advanced in the sense of it's understanding the incentives and priorities and how to speak the language of the MCO's and providing that funding that was missing and has been missing over the last couple of years.

Mr. Friedman A great question.

Dr. Rugge Just as a follow up. Do you see any impact on this kind of model on the commercial payers? Would there be any parallel activity, so there again, reaching not only one group of insured patients, but everyone?

Mr. Friedman Yeah, so one thing and I didn't get into it here, and I would love to have a separate discussion. We are seeking authorization as part of the waiver to move into what we're calling global payment pilots. I know Jeff Kraut and others have been proponents of this in the past. We want to move to regional structures where we all align all payers; Medicare, Medicaid and commercial into a global arrangement with whether it's an ACO or a leading health system in the area. We've been doing a lot of planning work over the last year and a half in certain areas of the state to try and get the global payment pilot like they have in Maryland and Pennsylvania, which brings commercial payers in for the reasons you mentioned. Part of the struggle is that, you know, certainly not for self-insured, but even for fully insured, we have limited mechanisms to require them to play ball in the way we can do with Medicare and Medicaid. The way that they've done it in Maryland and Pennsylvania is, I call it the field of Dreams process for those baseball fans, which is if you build it, they will come. You build a mobile payment pilot and then because you have an integrated, you have plans with integrated products, Medicare, Medicaid, commercial, if they're in with Medicare or Medicaid, they'll get in for commercial out of convenience and business needs. We're testing that concept. I mentioned it driving some of the procurement proposals that we made as part of this year's budget, which is we want to if a plan is in here for commercial and they review with Medicare and Medicaid, we want them to do what we need them to do, including these global payment arrangements, but that question is definitely in line with our thinking in our movement to these models, which we think have a transformational impact on the way that large health systems in the region, especially those anchors health systems, can deliver care most effectively for their populations.

Dr. Boufford Laura, could you see hands? My hand is up and Mr. Lawrence's hand is up.

Ms. Santilli I do.

Ms. Santilli Going to you guys next.

Ms. Santilli Dr. Boufford, why don't you take the mic first.

Mr. Friedman I do have to run in just a few minutes. I'm a little bit late, but I do want to take your question, Dr Boufford.

Dr. Boufford I just want to highlight one of the things when you said duplication is your enemy. One of the issues and we've talked about this that is not included in the waiver concept paper to date is the prevention agenda structure. We've been listening to that this morning. I think one of the issues, if already at the county level, which presumably aggregate up with some issues into your payment, into your service, your reimbursement regions are doing, have already done or doing community needs assessments or doing community health plans and doing community service plans already. Whether bringing those groups together in some fashion, whatever the governance mechanism is for the heroes, would not take advantage of that work already done rather than having an entity yet again repeat that work. I just want to raise that as an issue and a concern and potentially a good contribution. As we've heard, it's going to be pretty hard for a local health department to become a hero because of the lack of infrastructure. But just that one consideration, I think.

Mr. Friedman Is something that we're working to integrate into the next version of the application. When that goes out, you'll see and I hope we've captured it right, but if not, we have another opportunity to fix it.

Dr. Boufford Okay.

Dr. Boufford Thanks.

Ms. Santilli Our last question from Harvey Lawrence.

Mr. Lawrence I'm happy to hear that you're going to build on the successes. We all went through it. There were some successes and also some major failures. I guess I have a more general question in how do you ensure that at the end of the day, the 17 billion that we should get actually ends up in those communities in where there's significant health disparities and that the outcomes are in fact we move the needle on the outcomes? I guess also part of that is, how is it that the managed care would be a conduit for ensuring that that happens and through the funding mechanism? I think more importantly, how do we get some guarantees that regionally that those neighborhoods and those folks that are suffering the most disparities across the state, in fact, do see some health equity outcomes here?

Mr. Friedman Yeah, I mean, it's a really important question and one that I don't want to give short shrift to in the few minutes we have, but there's one aspect of the hero level is to set quality measures and outcomes that reflect the needs of the population. We've done a lot of work through the clinical advisory groups in trying to understand and measure quality and outcomes in a way that shows that our investments are making sense. One of the challenges that this wavers intending to address is the fact that we have not been able to

adequately to date understand and stratify those health outcomes measures by race, ethnicity or other demographic criteria because our data collection is so poor. One of the elements that was surprising to me when we embarked on this waiver design process is that we only have about 60 percent data collection on race and ethnicity is just one measure of the Medicaid population. It's generally self-reported. It's generally pretty unreliable. And as a result, when you're looking at quality measures that development and consistency and guidance, you want to be able to stratify those measures based on race and ethnicity. You can't do that unless you have a more complete information on the underlying patient population. One of the critical aspects of the waiver, and it's not a piece I covered today, but in the last meeting is to do a comprehensive social care or uniform social care needs assessment of every Medicaid member as part of this process. As part of that social care that uniform needs assessment, we be able to more accurately collect race and ethnicity data. And so by doing that, we can do a few things. One is we can then start stratifying this measure to see whether these interventions are truly successful at improving outcomes for populations with historical disparities and then too, we can then ultimately sustain these investments through a means of social care risk adjustment so that when you have uniform collection based on experience and validated tool, we can start paying differently based on the social care acuity of the underlying membership. If you have Health First in York City that has a population experiencing more historical food insecurity, we can then pay them more as part of the risk adjusted plan premium to do that work, and we create more of a data driven, risk adjusted feedback loop based on just our baseline ability to collect better data and use it more effectively. That's built into the scope of the data. That is structural. And then with any waiver, we're going to have to do it in a very comprehensive evaluation design, whether off the quality and patient safety, to ensure that we are working to improve outcomes in an effective way. And part of that and the challenge I've been working with them is to develop new measures steps specific to health equity, which, like Oregon, is trying to do as part of their waiver submission this week and that we want to do that in New York as a leader in the health equity agenda. Those are great questions and ones that we're struggling with and trying to really develop as part of the waiver design process and will undergo substantial negotiation as we work to finalize this.

Mr. Lawrence I think that's really key because at the end of the day, if you're going to tackle food insecurity, especially on the ground level, then there will have to be, in fact, the way to get resources to those providers that are working in that space and also others. I think more generally, it's a question about allocation to ensure that their funds are reallocated in that direction.

Mr. Friedman Agree.

Ms. Santilli Thank you.

Mr. Friedman Thank you.

Dr. Boufford Thanks very much. We appreciate it.

Dr. Boufford Laura, let me come back on the community benefit. We're going to skip that. We thank Shane for preparing. We're going to skip that presentation. I just want to put the marker down for the council. We had raised this. This has been an element that we've talked about initially in the concept of category four, some of you may remember, which was do you have begun to align the hospital investments of the health system investments in their communities along the lines of the prevention agenda over the last couple of years.

I think that was sort of had mixed response or mixed success, some success and some beginning, so we could see how it could be done. The areas of community benefit the Commissioner will be, I understand, in the past, sending out a letter to health system providers to report in their Schedule H reports that they submit to the Internal Revenue Service. These are public documents, but I think we have asked for them in past years and help to get them again to really analyze what health systems are saying they're investing in community benefit areas and the two that we're interested in. There are a lot of categories. There are 11, I think in the Schedule H. We're focusing only on the community health improvement and the community building segments of the Schedule H, because they are, the definitions of those categories are aligned with the prevention agenda goals and with the sort of prevention goals. I want to remember, and I don't know if Shane has any update, I see him on the screen now. Sorry for preempt. We were just real, really scrambling here on time. In 2019, the last time we saw this report, just in those two categories, there was a little under 200 million a year reported by hospitals and that money to begin to move that money into alignment in terms of supporting prevention agenda of which they're partners in these coalitions and or other community investments continues to be one of the issues we'll be addressing. We'll come back to the community benefit discussion at future council members.

Dr. Boufford Shane, introduce yourself and then if you want to say a word or two, then we'll go into public comment.

Mr. Roberts Thank you, Dr. Boufford.

Mr. Roberts Shane Roberts, the Assistant Director of the Office of Public Health Practice under Laura and and yeah, I think, Dr. Boufford, which you said is accurate. I think the 2016 numbers look like that. It was again, it was less than 1 percent. It's a 258 million invested in that category.

Dr. Boufford For public health, it's a serious amount of money. What we want to do, especially as the heroes develop social determinants, networks develop that we really begin to align the commitments with the prevention agenda, goals in various communities and hopefully bringing county level work together in these regions that are going to be of concern.

Dr. Boufford Harvey, did you have another another question? Your hand still up, because I need to go to public comment period.

Mr. Lawrence No. I'm sorry. I need to put it down.

Dr. Boufford That's okay.

Mr. Lawrence Thank you.

Dr. Boufford Thanks.

Dr. Boufford Just a marker. I think we have one, according to Laura, unless there's anybody else in the room. Karen Lipson from Leading Age New York has asked for the mic in the public comment period.

Dr. Boufford Karen, are you there?

Ms. Santilli She is. She's coming to the microphone right now.

Ms. Santilli Is there anything else in the gallery that would like to do public comments?

Ms. Santilli Okay, that is the only one, Dr. Boufford.

Dr. Boufford Okay.

Dr. Boufford Thank you.

Ms. Lipson Good afternoon. Can everyone hear me? Great. Thank you very much for the opportunity to provide public comment today. Let me introduce myself. I'm with Leading Age New York, which is an association of not for profit and public long term care and aging services providers. Our members cover the entire continuum of aging services from senior housing, home care, adult day health care, assisted living, nursing home care, managed long term care and PACE. I was very pleased today to see the focus on healthy aging and the needs of older adults in today's discussions. Our members are partners with local health departments and are engaged in primary and secondary prevention on a daily basis for the older adults and people with disabilities that they serve. For too long, as you know, older adults have been marginalized in our health policies, our health care financing and the providers that serve them similarly have not been treated as integrated components of the health care delivery system. 87 percent of New Yorkers who died of COVID were over age 60. We lost 47,000 older adults in New York State to COVID. Today, our older adults are in greater need than ever before. They have suffered tremendously from the isolation that has been required of them as a result of the pandemic. They have been physically deconditioned due to isolation. They've experienced cognitive decline. They've had delayed access to medically necessary services. They're experiencing anxiety and depression. We really need to come together and have a concerted focus on the needs of older adults and the systems that serve them. I was happy to hear Dr. Boufford talk about connecting the dots, because I think that's really the most important thing we can do. I understand the appeal of weaving the needs of aging New Yorkers into every component of the prevention agenda, but too often when older adults are not singled out for a focused approach, they are overshadowed by the needs of other populations. I think the pandemic has shown us that. We are concerned that for all the commendable work we're seeing on healthy aging and on the 11 15 waiver that older adults will be left behind once again. For example, I just want to speak a little bit about the waiver concept paper, and I am cognizant of the time you have.

Dr. Boufford Please, maybe about two or three minutes, Karen.

Ms. Lipson Okay, I will be quick. The concept paper seems to be designed for the non-elderly population that is enrolled in mainstream managed care plans. It does not appear to take into consideration the interplay with Medicare and the challenges that poses. As you know, most older adults are enrolled in Medicare. The waiver does not appear to take into consideration the unique needs social and health care needs of older adults and the long term care system. There is a reliance on value based payment arrangements to provide the funding that will be invested under that waiver and for a variety of reasons value based payment arrangements in long term care do not generate Medicaid savings and as a result will not generate dollars to invest in our long term care system. As we saw with the waiver, where only 2 percent of funds were allocated to long term care, we are concerned that the same mistake will be repeated and long term care will be overlooked under this new waiver. There are a few concrete things that can be done to help the

situation. One is we need to bring Medicaid and OHIP into the conversations on healthy ageing, and we need to bring SOFA and area agencies on aging into the conversations on the 11 15 waiver and heroes. I didn't see area agencies on aging as a participant in the heroes. I'm sure they would be welcome, but I think that shows that there hasn't been a focus on older adults. There has been some talk about housing and we are very involved with creating affordable senior housing through our membership. We have a proven model of service coordination and affordable senior housing that helps keep residents independent and healthy in the community and saves Medicaid and Medicare dollars. It is not called supportive housing. Supportive housing is typically for people with mental illness and formerly homeless individuals, but service coordination and affordable senior housing is designed for low income seniors who are living independently in the community, and we should be bringing that model to scale and supporting it. We should also be investing in options that seniors can choose among low income seniors in the community, such as the Medicaid Assisted Living Program. We should be looking at geriatricians and the supply of geriatricians in New York State. I haven't seen any up to date data on this. I don't know whether anyone is looking at it. Anecdotally, there seems to be a shortage of geriatricians, and I think there needs to be some public policy attention to that. Finally, there was a brief discussion about the managed care procurement proposal in the executive budget and how that will help to support value based payment arrangements. We are concerned that that procurement proposal will result in the absorption of specialized managed long term care plans that are sponsored by provider based organizations into larger plans that don't focus on the needs of older adults, and that it will just exacerbate the marginalization of the health and social needs of older adults if that proposal goes forward. We would argue that that proposal should be abandoned, at least for the older adult population.

Dr. Boufford Thank you very much.

Dr. Boufford Any other public comment, Laura, that you can see in the room?

Ms. Santilli Nope. I'm seeing shaking heads, so we're all set.

Dr. Boufford Okay.

Dr. Boufford I want to save a little bit of time for John and Ursula to comment, but any other comments from members of the council who've been at the meeting?

Dr. Boufford John, I'm going to wrap up. I'm going to save the last word is prerogative.

Dr. Boufford Kevin, did you want to say something?

Dr. Boufford No.

Kevin I just think we've had a really good meeting. I really appreciate how we've integrated the local public health departments in most of the conversation today. It's really meaningful to us. I'm looking forward to our next meeting.

Dr. Boufford Thanks, Kevin.

Dr. Boufford Any other comments from council members?

Mr. Kraut I just want to thank you, John, the department for putting on a phenomenal day. I mean, you raised and touched on so many issues that we've been talking about. The challenge is the follow up.

Mr. Kraut Thank you.

Dr. Boufford Thanks.

Dr. Boufford Thanks, Jeff. Thanks for your support.

Dr. Boufford John and then to Ursula, and then I'll wrap up

Dr. Rugge Just to repeat. Thank you very much to Joe, to all the people participating and certainly all our presenters really very special. It's kind of a hint at what we could do going forward together and we hope to do.

Dr. Rugge Thank you.

Dr. Boufford Ursula.

Dr. Boufford Laura, may be fine, I don't see Ursula still on the screen, maybe you want us just on the behalf of the department, do you want to have a word or two and then I'll sort of finish this up.

Ms. Santilli Yeah. I feel the energy, right? I really love the fact that we can pick our heads up from the COVID well, and look at the broader public health. Learn from what COVID really elucidated. Sometimes the best way to figure out how to fix the problem is to shine a light right on it. Unfortunately, COVID did that in some of our spaces. I'm very much looking forward to re-energizing this group, the broader ad hoc group and the public health community in general as we move forward and, as we do our own rebuilding within the department, I will continue to be the department's public health champion and working through that and really excited to work with the new leadership. It's really refreshing to hear the conversations and the focus on public health, and I think we'll be able to rally the whole team around it.

Ms. Santilli Michael, anything that you have to add at all?

Ms. Santilli Okay.

Ms. Santilli Thank you very much.

Ms. Santilli Dr. Boufford, back to you for the wrap up.

Dr. Boufford Okay, thanks.

Dr. Boufford Yeah, I just again, I can't thank Laura and her team, Priti and Ursula Bauer enough for helping us get this meeting going. I think we're very excited about the level of staff enthusiasm, really for getting back on to the public health agenda and in many instances, a shared agenda with the planning committee, as you've heard with John, and I just want to say what we wanted to do today. One, was really give you an update on the prevention agenda for those of you. We have a number of new council members who haven't heard a conference or presentation and to let you know what's going on there and

also to really highlight the partnership between the state health department and the local health departments, which is a fundamental piece of the infrastructure of this committee going forward. Also the links to the multi-agency work. We didn't have a chance to get too much into that because the sort of aging agenda has been much more active, I think. We do have a vehicle for linking in other agencies around the state on the health agenda and on the aging agenda. Together, we do want them to travel together and the prevention agenda. We've gotten a lot of good ideas about how to work on this. I want to channel Lito Gutierrez on the workforce. He's been raising this for about four years, and I think both on the delivery side and on the public health side, we do want to come back to look at that. The fellowship is very exciting and sort of A, continuity of that and B, the context for dealing with workforce issues. Maternal mortality has been an issue of this group of the council really for over five years. There are areas that we need to hear more about, especially around some of the intervention strategies on family planning, availability and early identification of high risk women to get them into the kind of specialty prenatal care they may need, which has been identified as a priority for the department as well community benefit, I mentioned. I think really trying to begin to look at, it's very it's hard with all the pressures on public health to look at the connections with this waiver opportunity, which does open some doors that I think have not been opened in the past and we're going to try to walk through them. Brett has been very responsive and as John mentioned earlier on the primary care agenda and the public health agenda. This meeting is kind of a table of contents for the story of the public health and civic for 2022. We're going to come back pretty systematically to many of these issues for your consideration, really look forward to comments, feedback from everybody on the areas that you want to hear more from, more about. We've taken good notes and we'll consult with Laura and her team and John and we get staff in the Office of Primary Care and Health Systems Management soon, similarly to keep our collaboration going. Thank you all so much for your attendance and participation and your support of the broader prevention agenda and health promotion agenda and primary care agenda.

Dr. Boufford Thanks very much.

Dr. Boufford I think we're off on time.

Ms. Santilli Excellent. Thank you for taking us on track. Thanks, everybody. Have a great day. Talk to you soon.