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PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
AD HOC COMMITTEE MEETING
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TRANSCRIPT

Dr. Boufford Call our third Ad Hoc meeting of this year to order. Welcome everyone. I think virtually, everyone is virtual. I'm sitting here in a nice little group with Colleen and Michael in New York City. I don't know how many folks are live in Albany, but this will be maybe a little bit challenging. Hopefully everyone can really share their screen, especially if you're speaking it would be really, helpful. As we begin, I want to remind council members, staff, and audience that this meeting is subject to the Open Meetings Law. It is being broadcast over the internet. The webcasts are accessed at the Department of Health's website. The on-demand webcast will be available no later than seven days after this meeting for a minimum of thirty days. The department will keep a copy for four months. Because we are all virtual it will be, I think, really important if we're doing synchronized captioning, we don't talk over each other and when you speak and identify yourself the first time you speak. Those of you in Albany I believe do have microphones. Recall that these mics are hot. Please turn them off if you're having slide conversation. I think that's all the business of the opening remarks. I do want to welcome all the members, especially the Public Health Committee and other members of the State Public Health Planning Council who are the, if you will, the parent organization of the Ad Hoc committee. These are organizations that we're delighted to have the committees of organizations working at state level across the state, nonprofit organizations, professional associations, academic institutions, advocacy groups, hoping to bring together the broadest range of experience and expertise to advise the PHHPC and the state health department on the prevention agenda, which also has been the vehicle for the state health improvement plan for the last really decade or more. As I mentioned, this is our third meeting, our first meeting in April. What we've been doing in these meetings is really reviewing the current structure and priorities of the prevention agenda cycle of 2019 to 2024, where we have five priority areas; preventing chronic disease, promoting healthy and safe environments, promoting the health of women, infants, and children, and promoting health and well-being and preventing mental illness and substance use disorders and preventing communicable diseases. Each of our meetings we've invited key agencies and other colleagues who have been working with us in partnership on the prevention agenda over the last several years, really to get their reactions on how it's worked for them, what they see as its strengths and weaknesses in making recommendations to us. The department and the committee consider the revisions that will undoubtedly be made for the next cycle, which is 2025 to 2030. Just to sort of recall what we have done in our April meeting. We sort of reviewed the process, got an update on what's been accomplished over time by the reporting for the local health department. This is obviously significantly disrupted by COVID and we thank the local health departments for maintaining their commitment to the prevention agenda. During that time, we were able to get reports from 2020. In our July meeting, we heard from really core partners in the department in the prevention agenda, the Office of Mental Health, OASAS and NYSOFA commissioners and senior officials gave us their feedback on how attention to prevention has really, in many cases, I think, modified their own approach to the issue of prevention within their agencies, but also feedback on the role of the prevention agenda, their collaboration and recommendations to us. We also, thanks to staff, Shane Roberts and colleagues. We did hear about what other states are doing relative to their statewide health improvement plans and had some ideas

for our own sort of data collection priority settings going forward. And then in our August meeting with Adam Herbst, Public Health Committee meeting in the meantime. We heard from Adam Herbst on the Master Plan for Aging, which also has a committee focusing on health and well-being. I happened to Co-Chair like committee. We're hoping to try to make connections, if we can, going forward with the master plan activities. We are going to continue hearing from critical partners in the prevention agenda process. We will have one additional meeting before the end of the calendar year, December 5th, to hopefully hear from the department. The results, what they're taking forward and the results of this feedback and how proposals they will make to the Public Health Committee and meetings, hopefully in October and November and then again, we'll discuss it at the December meeting of this group. We have another meeting set aside for this group in February for this cycle of review. We have a presentation on community benefit, and I'll be talking about that in a minute before we get started. We will have a panel discussion of key participants in the prevention agenda. The idea, the infrastructure really has been on that at local level or county level, in some instances in different geographic areas hospitals and health system leadership would be partnering with local health department leadership and other stakeholders in that community to identify and work on priorities from the prevention agenda in that community, along with their own shared community agenda. We'll be hearing from NYSACHO, local health department leadership, as well as the New York Hospital Association and HANYS Hospital Association of New York State on their feedback. We'll be hearing from the Department of State on their smart growth initiatives. I want to say the department of state has been incredibly helpful in working with NYSOFA supporting technical assistance to local health departments on the prevention agenda and on making New York the first state for healthy aging, but also helping to further that agenda and bringing really the important issue of not only environmental justice but also economic development into our discussions, especially around social justice and equity, which has been a cross-cutting theme in the prevention agenda that we really want significantly to strengthen in this next round. I want to congratulate Commissioner Morne, Johanne Morne, who has been promoted since she began with us. She's been with us from the beginning. We really appreciate the support of her group and hopefully her ongoing support in her new role. Let me invite Deputy Commissioner for Public Health Ursula Bauer if she'd like to make any opening comments. I would like to do a quick round of just names and organizational affiliations, because this is Ad Hoc committee. I think it's important for us to know who's represented from Public Health Committee and council members.

Dr. Boufford Over to Dr. Bauer.

Dr. Bauer Thanks so much, Dr. Boufford, and welcome everyone. We have a great group here in Albany of stakeholders, state agencies, staff, PHHPC members. I can see we have some robust participation virtually and welcome our group from New York City. Dr. Boufford, thanks so much for that review of where we have been this year. We have done quite a bit of outreach, gotten a substantial amount of input and feedback and ideas, heard about what's working and what we can strengthen and improve upon as we move into the next planning cycle, the next prevention agenda cycle. We have lots of good ideas. We're going to hear more good ideas today. We look forward to wrapping up the year with a presentation of what I'll call some straw proposals. We are assembling the feedback. We are trying to incorporate that. We have a couple of ideas and those will really be for the group to roll up your sleeves and wrestle with as we try to get ever closer to a final prevention agenda for the 2025 to 2030 cycle.

Dr. Bauer Dr. Boufford, shall we start in Albany and around the room of who's here?

Dr. Boufford Please do, Ursula and then we can catch folks that are on the line.

Dr. Bauer Great.

Dr. Bauer Ursula Bauer with the New York State Department of Health.

Ms. Ravenhall Sarah Ravenhall, Executive Director at the New York State Association of County Health Officials.

Ms. Phillips Kristen Phillips, Director of Community Health Policy with HANYS, the Health Care Association of New York State.

Ms. Green Hi. I'm Theresa Green. I'm at the University of Rochester Medical Center. I'm here on behalf of HANYS with Kristen.

Mr. Michaels Hi. I'm Isaac Michaels. I'm a Public Health Doctoral Student at the University of Albany School of Public Health.

Mr. Williams Hi. Charles Williams, Assistant Director for Healthy Aging and Longevity at the New York State Office for Aging.

Ms. David Good morning. Courtney David, Executive Director for the New York State Conference of Local Mental Hygiene Directors.

Ms. Zuber-Wilson Good morning. Pat. Zuber-Wilson, Associate Commissioner for the Division of Prevention Services at the Office of Addiction Services and supports.

Ms. Bennett Good morning. Barbara Bennett, Office of Addiction Services and Support and the Division of Prevention.

Mr. Davis Good morning, everyone. Chris Davis, Population Health Data Manager New York State Department of Health Office of Science.

Ms. Wetterhahn My name is Lauren Wetterhahn. I'm the Executive Director of Inclusive Alliance.

Mr. Moore Jeff Moore from the Medical Society of State of New York.

Dr. Rugge John Rugge, member of the Public Health and Health Planning Council.

Ms. Alaai Good morning. Alaai, Prevention Agenda Coordinator, Office of Public Health Practice, New York State Department of Health.

Mr. Roberts Good morning. Shane Roberts, Assistant Director of Office of Public Health Practice, New York State Department of Health.

Dr. Bauer That wraps it up for Albany, New York.

Dr. Boufford Shall we try to see what we can do virtually? I'll just try to read the names of people that I think have not spoken.

Dr. Boufford Maria Pherson.

Dr. Pherson Central New York regional office.

Dr. Pherson Thank you.

Dr. Boufford Thanks.

Dr. Boufford Dan Lang.

Dr. Boufford I'm trying to read with bifocals from a distance.

Mr. Lang Yep, no problem. Dan Lang. I'm the Deputy Director for the Center for Environmental Health at DOH.

Dr. Boufford Patricia Clancy.

Ms. Clancey Pat Clancey, Medical Society for the State of New York.

Dr. Boufford Yvette Santiago

Ms. Santiago Good morning. Yvette Santiago, Department of Health.

Dr. Boufford Wilma Alvarado-Little.

Ms. Wilma Alvarado-Little Greetings. Wilma Alvarado-Little, Associate Commissioner, New York State Department of Health and Director Office of Minority Health and Health Disparities Prevention.

Dr. Boufford Stephanie Mack.

Ms. Mack Hi. Stephanie Mack, Office of Science, New York State Department of Health.

Dr. Boufford Barbara Wallace.

Ms. Wallace Good morning, Barb Wallace. I'm the Director for the Division of Chronic Disease Prevention.

Dr. Boufford Barbara Stubblebine.

Ms. Stubblebine Good morning. Barbara Stubblebine, Office of the Commissioner in New York State Department of Health.

Dr. Boufford Joan Guzik.

Ms. Guzik Joan Guzik, Director of Quality at United Hospital Fund in New York.

Dr. Boufford Amy Lyn Clarke.

Ms. Clarke Hi. This is Amy Clarke with DOH representing Western Region.

Dr. Boufford Terry Fulmer.

Ms. Fulmer Terry Fulmer at the Johnny Hartford Foundation, New York City. Thank you.

Dr. Boufford Kevin Watkins.

Dr. Watkins Kevin Watkins on the council and Public Health Director Cattaraugus County Health Department.

Dr. Boufford Nora OBrien-Suric.

Ms. OBrien-Suric Nora OBrien-Suric with the Health Foundation for Western and Central New York located in Buffalo.

Dr. Boufford Michael Suesserman.

Mr. Suesserman Good morning. Michael Suesserman with the American Cancer Society.

Dr. Boufford Merrill Rotter.

Mr. Rotter Merrill Rotter with the Office of Prevention Health Initiative at the New York State Office of Mental Health.

Dr. Boufford Last name, Ms. Foti. I can't see your first name.

Ms. Foti Good morning, everyone. Ali Foti, Program Officer for Primary Care with the New York Health Foundation.

Dr. Boufford Thank you.

Dr. Boufford Denise Soffel.

Dr. Soffel Denise Soffel, PHHPC member.

Dr. Soffel Audrey Erazo-Trivino.

Dr. Erazo-Trivino Good morning, everyone. My name is Audrey Erazo-Trivino. I am the Associate Commissioner for the Office of Prevention Health Initiatives here at the New York State Office of Mental Health. Thank you.

Dr. Boufford Leslie Moran.

Ms. Moran Good morning. Leslie Moran with the New York Government Association. I'm sitting in today for Kathy Preston.

Dr. Boufford Thank you.

Dr. Boufford Joe Kerwin.

Mr. Kerwin Good morning, everyone. Joe Kerwin, Director of the AIDS Institute here at the Health Department.

Dr. Boufford Trang Nguyen.

Ms. Nguyen Good morning. Trang Nguyen from Office of Science, Officer of Public Health. Thank you.

Dr. Boufford Did I miss anybody?

Ms. Warren Good morning, everyone. This is Joanne Warren.

Dr. Boufford Nice to have you.

Mr. Lawrence Good morning, everyone. Harvey Lawrence, member of PHHPC.

Dr. Strange Hi. Dr. Ted Strange, member of PHHPC.

Mr. Grasso Vito Grasso, the CEO of the New York State Academy of Family Physicians.

Dr. Boufford You guys are doing very well. I just got my second screen here on the laptop. Keep going. You're doing very well.

Ms. Kim Hi. Tina Kim, Acting Deputy Commissioner of the Office of Health Equity and Human Rights.

Mr. Bishop Jo, it's Lloyd Bishop from the Greater New York Hospital Association.

Dr. Boufford Great.

Dr. Boufford Thank you.

Ms. Logan Hi. It's Janine Logan, VP Communications Population Health with Suburban Hospital Alliance and Director of the Long Island Collaborative. Good morning, all.

Dr. Boufford Patricia?

Ms. Ruppert Good morning. I'm the former Commissioner of Health of Rockland County. I'm here also representing NYSACHO. Good morning, all. Thank you.

Dr. Boufford Lauren Ashley.

Ms. Ashley Hi, everyone. Lauren Ashley, Senior Director of Quality and Point on Workforce for HANYS.

Dr. Boufford Marthe Ngwashi.

Ms. Ngwashi Marthe Ngwashi, attorney at the Department of Health.

Dr. Boufford Kelly Firenze.

Ms. Firenze Hi. This is Kelly Firenze, Central New York Regional Office DOH Communicable Disease Control Program Manager.

Dr. Boufford Damali Wynter.

Ms. Wynter Good morning. Damali Wynter, Assistant Commissioner with New York State Department of Agriculture and Markets.

Dr. Boufford Also a crossover from the Master Plan on Aging. It's great to see you here.

Dr. Boufford Lora Santilli.

Ms. Santilli Good morning, everybody. It's Lora Santilli. I'm the Director of Operations in the Office of the Chief Medical Officer here at the New York State Office of Mental Health.

Dr. Boufford Nice to see you again.

Ms. Santilli Yes, you too.

Dr. Boufford Tina Cobb.

Ms. Cobb Morning. Tina Cobb, Association of Perinatal Networks.

Dr. Boufford Emily Lutterloh.

Ms. Lutterloh Emily Lutterloh. I'm the Director of the Division of Epidemiology here at the New York State Department of Health.

Dr. Boufford Sandra Ribeiro.

Ms. Ribeiro Sandra Ribeiro, Government Affairs.

Dr. Boufford My memory may not serve me well. I think I got everybody from before.

Dr. Harrison Good morning. It's Dr. Myla Harrison, Psychiatric Medical Director and Office of Health Insurance Programs at Department of Health.

Dr. Boufford Amy Gildemeister.

Ms. Gildemeister I'm Associate Director in the Division of Nutrition for New York State.

Dr. Boufford My colleague, Anderson Torres, Deputy.

Dr. Torres Buenos días. President and CEO of RAIN, and a member of the Master Plan for Aging.

Dr. Boufford Anyone else?

Ms. Weiss Hi. This is Linda Weiss from the New York Academy of Medicine.

Dr. Boufford Anybody that we missed, please introduce yourself.

Dr. Boufford We have a, I think, a very rich program. We'll sort of go straight through. If people have to take breaks, as many of you are presumably in your homes or your offices you could take advantage. If you need you to take a break, please do and we'll just keep going in the interest of time. The first presentation is from Isaac Michaels, who is as he indicated a doctoral student at the University of Albany School of Public Health. We're very

fortunate having Michael pursuing his doctoral degree. His dissertation is on the issue of community benefits. He worked on that in the department and now as a doctoral student and is continuing to work on. The reason this is on the agenda is that there has been a part of the important thing to remember about the prevention agenda is that it has been the vehicle for New York State in a sense, to implement elements of the state health improvement plan. This requires hospitals are required to provide community benefit in exchange for federal tax exemption, both for income taxes, property taxes and others. This was reinforced in the Affordable Care Act requiring hospitals to conduct a community health needs assessment and develop community service plans at the intervals of a couple of years, every three years. Similarly, local health departments are required to conduct a community health needs assessment and community health plan every couple of years. We've trying to get these cycles in sync, and I think there was some discussion in this revision process to get them not only in sync but on a longer cycle so they could work together. But from the beginning, the idea was that the prevention agenda would encourage, try to create, if you will, coalitions of multiple stakeholders co-led by local health departments and hospital leadership and critically involving our colleagues at the local level, from OASAS, from OMH, from NYSOFA, at the county level or community level to identify relevant priorities from the overall prevention agenda statewide effort and also to tackle a health disparity that was particularly relevant to their communities. Not doing these, obviously the headings are quite broad. We felt that was pretty flexible. The idea is those plans would be developed as much as possible together. I think as you look at the last cycle, 2019 to 2024, the idea was there would be a voluntary effort to develop these together in these coalitions with hospitals and local health departments. The overlap has been about 41% in the last time we looked at this. Again, with the interruptions on COVID, which makes sort of a smooth trajectory difficult to measure. One of the issues we wanted to look at, given the obviously the constant challenges of local funding for public health interventions, is how we might look at the community benefit spending across New York State as an opportunity really within the next round of the prevention agenda to even more strongly align the investments in hospitals are making at local level with evidence-based interventions in conjunction with local health departments and local multi-stakeholder groups. We wanted to just have a presentation on what this a community benefit is, and what the amounts of funding are involved and just open to have it on the table as part of the background information for the work on the revision.

Dr. Boufford Let me turn it over to Isaac Michaels and welcome to the stage, as they say.

Mr. Michaels Thank you, Dr. Boufford.

Mr. Michaels Can everyone hear me?

Mr. Michaels How's this?

Mr. Michaels Great.

Mr. Michaels Thank you again.

Mr. Michaels I'm Isaac Michaels. I'm a doctoral student at the University of Albany. As Dr. Boufford mentioned, the topic of my dissertation is Hospital Community Benefit. I suspect that people on this committee, some of you are highly versed in this topic and actively engaged in it, but there may be others for whom this is new. What I hope to accomplish through this presentation is to share some of the basic concepts and definitions that

underlie hospital community benefit and to share some of the data for New York State from tax year 2010 through 2020 and open that up for further discussion.

Mr. Michaels Next slide, please.

Mr. Michaels I'll just begin with some of the basic concepts and definitions.

Mr. Michaels Next slide, please.

Mr. Michaels What is community benefit? 501C3 Nonprofit Organizations are tax exempt. The expectation is that these organizations will provide what's known as community benefits, which are services to the broader community in lieu of paying taxes.

Mr. Michaels Next slide, please.

Mr. Michaels There are a special set of defined community benefit activities or categories specifically for hospitals. IRS defines eight categories. Hospitals report on their expenditures in those categories via Form 990 Schedule H. You can see in the slide here there is a picture of the table on line 7 of Schedule H through which the hospitals will report those numbers to IRS each year. On the next slide, I'll share what those categories are.

Mr. Michaels Next slide, please.

Mr. Michaels Here are the categories. There's financial assistance at cost, which is commonly known as charity care. These are free or discounted services for those who cannot afford to pay and meet the hospital's financial assistance criteria. Medicaid, which is really the unreimbursed costs from providing care that's reimbursed by Medicaid. Costs of other means tested government programs. That's the same idea, but for other government health insurance types like CHIP. Here we've highlighted for the next one, community health improvement services and community benefit operations. The reason this is highlighted is because it's the category under which some of the traditional community health and public health interventions that we associate with initiatives like the prevention agenda would be captured. These are costs associated with planning or operating community benefit programs. We'll have a more thorough definition on the next slide. The other categories are health professions education. Training new clinicians and other providers. Subsidized health services. This is care that is provided at a financial loss. Funding for research and also cash and in-kind contributions for community benefits. This is when cash is paid to other organizations to carry out these activities rather than expended by the hospital itself to perform them.

Mr. Michaels Next slide, please.

Mr. Michaels Community Health Improvement Services and Community Benefit Operations is sort of two distinct subcategories, but it's captured as a combined line item on that schedule table that we saw a couple of slides earlier. Community health improvement services, and this comes from the IRS Form 990 instructions. I'll just quote verbatim. Activities or programs subsidized by the health care organization carried out or supported for the express purpose of improving community health. These are the sorts of interventions that we might associate with the New York State Prevention Agenda or other population health and community health initiatives. Also captured in this category, though, are community benefit operations. These can be things like activities associated with

conducting community health needs assessments, community benefit program administration, or the organization's activities associated with fundraising or grant writing for community benefit programs. The last caveat here is that activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. That's the fine print.

Mr. Michaels Next slide, please.

Mr. Michaels Another one of the basic concepts specific to hospital community benefit is that some states have instituted policies that require nonprofit hospitals to spend on community benefit. Here are some examples of other states, Illinois, Nevada, Oregon, Pennsylvania and Utah. However, neither New York State nor the federal government have instituted minimum spending requirements for nonprofit hospitals. One additional point of context is that there are three types of hospitals to consider with respect to this. There are private nonprofit hospitals for whom all of this community benefit reporting is applicable. There's private for-profit hospitals for whom this is not applicable. There are also public hospitals for whom this is also not applicable. New York is unique in that there are no for-profit hospitals in New York State. However, there are some publics. The majority of hospitals in New York State are private nonprofit. That’s why this is especially relevant.

Mr. Michaels Next slide, please.

Mr. Michaels Why is this of interest to this group, to the prevention agenda and to all of us? It's because of the opportunities for collaboration around community health initiatives with hospitals. Because hospitals have unique resources, infrastructure and expertise, they can play important roles in improving community health by performing and funding community benefit activities. These activities can be used to improve health outcomes, to improve access to care and other services, to reduce disparities, prevent disease, or to promote overall wellness. Here's my $0.02 on the matter. Public health officials and hospitals should work together closely to align community benefit programs with local public health priorities. I'm about to show some of the data on spending in community benefit by hospitals in New York State. This is primarily about the number of dollars that are spent. I hope that this will lead into a broader conversation, not only about the number of dollars, but about the impact of each one of those dollars. One way of improving the impact, I think, is by strengthening the alignment between how these dollars are expended by hospitals and the broader community public health goals for local health departments, for community-based organizations, for community individuals and others.

Mr. Michaels Next slide, please.

Mr. Michaels Here I'll be talking about some of the data. For your reference, these data I acquired from the Community Benefit Insight website. This is a non-profit organizations research team that has compiled community benefit data nationally for hospitals or from hospitals, rather. They have a really amazing user-friendly dashboard that you can interact with and point and click. I acquired a full dataset on New York hospitals using their API. I am doing further analysis with it. These data have some limitations that we should keep in mind. These are only the electronically filed. They're only capturing data from the electronic tax filings, which is the vast majority of the tax filings that are collected by IRS. Also, the data are lagged. So, for example, one of the reasons that we don't have data for tax year 2023 is that we're still in the tax year 2023. These data won't be submitted to IRS, and therefore later on collected by community benefit insight until at least the end of the

current tax year. Additionally, the data are lag because it takes some time for IRS to receive those filings or for them to be filed in the first place for IRS to receive them, upload them, and then for Community Benefit Insight or other organizations that do similar work to put them into their own databases where they can be accessed. The latest data that I'm going to share are for tax year 2020. Tax year 2021 data are nearly complete, but because they're still incomplete enough, I decided to omit them from today's presentation.

Mr. Michaels Next slide, please.

Mr. Michaels Here are some of the data for New York. This shows data from tax year 2020, the latest year for which we have data. This shows three statistics, the total operating expense cumulatively for all of the nonprofit hospitals that electronically filed that year, which exceeds $80 billion. From that total, the total amount that was spent on all of the community benefit categories, which is somewhere exceeding $10 billion. Within that category, the amount that was spent specifically on the Community Health Improvement Services and Community Benefit Operations category.

Mr. Michaels Next slide, please.

Mr. Michaels Whereas the previous slide showed those data for a single tax year, this slide shows the same statistics trended over the period from tax year 2010 through tax year 2020. We can see that over that time the total operating expenses for non-profit hospitals has increased over almost every one of those years. Although there's been a relatively steep increase in total operating expenses there's been a more modest increase in spending on all of the community benefit categories and a very small increase mostly in that latest year, 2020, in Community Health and Human Services and Community Benefit Operations.

Mr. Michaels Next slide, please.

Mr. Michaels This graph implements a technique that you'll see through some of the upcoming graphs, which is that to control for the differences in sizes between one hospital or another it can be useful to look at these spending totals as a percentage of total operating expense. What you see on this graph are two trend lines. One is the trend in total community benefit spending as a percentage of total operating expenses. The red line at the bottom is the spending on community health improvement services and community benefit operations, specifically as a percentage of total operating expenses. While we see both increase in 2020, we see a much smaller increase in Community Health and Human Services and Community Benefit Operations over that time.

Mr. Michaels Next slide, please.

Mr. Michaels This graph shows the absolute spending in each one of those categories of community benefit during tax year 2020. The largest single category of spending is unreimbursed Medicaid. That's followed by health professions education, then subsidized health services, then charity care and then next is the community health improving services and community benefit operations. The idea here is just to show the distribution of spending in each of these categories. You can see how that varies between the categories associated with providing clinical services versus the ones that are finding work outside the four walls of the hospital.

Mr. Michaels Next slide, please.

Mr. Michaels If you looked at the trend in each of those categories over time. That's what we see here in this graph. Each panel represents a different category of community benefit spending. Here we're looking at absolute dollars. It's not on a percentage basis. Again, unreimbursed Medicaid is the category with the single highest amount of spending. It increased precipitously over some of the recent tax years. There's been fewer steep inclines in the successive categories, as you can see from this graph. I'll call your attention to the Community Health Improvement Services and Community Benefit Operations category just to get a sense again of the trend there.

Mr. Michaels Next slide, please.

Mr. Michaels This stacked bar graph shows the percentages of this time total community benefit expense spent on each one of the community benefit categories. The Y axis goes from 0% to 100%. You can see sort of the trend in the spending over time in another way. This is to convey a similar idea, but sometimes it's helpful to look at it this way.

Mr. Michaels Next slide, please.

Mr. Michaels Because the previous slide showed these as a stacked bar graph, it can be difficult sometimes to look at one category for one year compared to the same category in the next year. To solve that problem, here those data are visualized another way where we separate them out in panels. Again, this time the Y axis is a percentage basis. It's the percent of total community benefit spending. You can see how that percentage changes over time in each of the categories. One thing to keep in mind is that although the trend in the percentages can look one way the trend in absolute spending can look a different way because the denominator is changing over that time.

Mr. Michaels Next slide, please.

Mr. Michaels Now, this is a different sort of graph. We're looking at the total operating expenses, the total community benefit spending and the community health improvement services and community benefit operations spending for each of the non-profit hospitals that filed in tax year 2020. The X axis shows absolute dollars. It's not a percentage. You can see the gray shading represents the total amount that was expanded by each hospital total operating expenses. The turquoise section of that bar is the portion that was spent on total community benefit. Spending on each one of those categories, including unreimbursed Medicaid, research and then within that is the red portion of the bar, which is the spending on community health improvement services and community benefit operations.

Mr. Michaels Next slide, please.

Mr. Michaels Here this is a similar graph, but again, the distinction is that the X axis is shown on a percentage basis. The X axis represents the total expenditures by each hospital. We're using a percentage to make small hospitals and large hospitals more comparable. The turquoise section, again, as with the previous graph, represents the percentage of spending on total community benefit. Whereas the red section of these bars represents the percentage of total spending on community health and human services and community benefit operations specifically.

Mr. Michaels Next slide, please.

Mr. Michaels This graph and the next one, which is the last one, both come directly from the Community Benefit Insight website. I just took the screenshots. They're quite interesting. They're a hybrid of graphs and a map. Each panel here represents a different state in the US. The blue section of each panel shows the amount that was appended cumulatively in that state on community benefits across all categories. You can see that New York is distinct in a couple of ways. First, New York has been increasing over the period from 2010 through tax year 2020. There was a precipitous increase in that last year, the tax year 2020. New York is also distinct in that we spend the most on hospital community benefit among all states, and that's including large states like Florida, Texas and California. New York spends more on community benefit.

Mr. Michaels Next slide, please.

Mr. Michaels This graph is formatted in the same way, but this time, instead of showing total community benefit, as the last slide showed, this slide shows the spending specifically on community health improvement services and community benefit operations. Here too New York in tax year 2020 spent more than any other state. There was a precipitous jump up in that last 2020 tax year. I'll let you look at this to see, you know, how that compares to trends in other states.

Mr. Michaels Next slide, please.

Mr. Michaels First of all, thank you for letting me share this information today. I know I went quickly through some of these concepts and also through the data, but that was somewhat intentional because I wanted to save some time for open discussion. If you have questions, if there are particular slides that you'd like to look at, I'm hoping that we can use this time to go back and review them. Thank you.

Dr. Boufford Thanks very much. I really appreciate.

Dr. Boufford Ursula, why don't I ask you to solicit any questions in Albany and we'll get our screen queued up here for folks that are online.

Dr. Bauer Do I see a question for Dr. Rugge?

Dr. Rugge You indicated there's no minimum standard established in New York. Are there incentives and expectations that are communicated? How so?

Mr. Michaels I feel more comfortable talking about the data specifically and less on sort of opining about some of the policy baselines and implications. Although there's not a regulatory or statutory minimum spending floor on hospital community benefit, I would like to believe that there is an incentive that cuts across the board. Hospitals have community health and population health goals. They invest heavily in them. I think in the interest of furthering that work that's an intrinsic motivation that hospitals already have. Furthermore, initiatives like this New York State Prevention Agenda, I think bring more opportunities for hospitals to work with community partners on these public health priorities and in furthering each of those priorities, you know, there's more opportunities and perhaps more motivation to spend on categories like community health improvement services and community benefit operations.

Dr. Boufford John, it's Jo Boufford. I just want to add, I think the only... You asked the question about any sort of requirements, if you will. There have not been any. The reason this is particularly relevant to the prevention agenda is that in the introductory language to the prevention agenda hospitals and local health departments with partners have been quote/unquote encouraged to work together to arguably share community health needs assessment and to develop at least collaborative planning on the choices they make from the prevention agenda itself two of the five priorities or for the work on health disparities. As I mentioned earlier that sort of encouragement to date has resulted in about a 40%, 41% overlap in the reporting you've been getting from meaning at the local level, hospitals and partners with local health departments and collaborators working, sharing this information and collaborating on one priority setting and action planning. Part of the idea had been to understand that hospitals are making these investments is to align these with local concerns with multi-stakeholder engagement and make them more evidence based, which is partially the foundation of the prevention agenda.

Dr. Boufford I have some hands on the screen.

Dr. Boufford Anyone else in the room and also in Albany?

Dr. Bauer Sara Ravenhall and Dr. Moore and then we can go to the screen.

Ms. Ravenhall Thank you so much, Isaac, for that presentation. Very interesting. Did your data show any of the types of spending or services that were funded using the Community Health Improvement benefit dollars from hospitals?

Mr. Michaels First of all, thank you. The data that I was looking at are the numeric data from that line 7 of Schedule H of IRS Form 990. They only show the numbers that are in aggregate. They don't get broken out into spending on individual interventions. Some filings have more complete data and some less on the specific activities that those funds are expended on. They're in the narrative portion of Schedule H, where the hospitals can describe the programs that they're working on during that year.

Ms. Ravenhall Thank you.

Mr. Michaels Sure.

Mr. Moore Jeff Moore, Medical Society. First a comment and then a specific question. I guess it's not surprising that hospitals under the current environment would be spending on forms of charity care, whether it's Medicaid or charity. It's like that's sort of their mission. Regarding your third to last slide if we can go to that slide, which was a comparison of the two forms of community investment, including the health improvement. There were several hospitals. This was a listing of all the hospitals in the state. There were several hospitals that spent a whole lot more than all the other hospitals as a percentage. I'm curious if we understand the characteristics in this side of the hospitals in red.

Mr. Michaels Thanks for the question. I won't speculate based on the numbers that I ascertained from Community Benefit Insight. These numbers come from the hospital's own tax filings. I'm sure the story varies in the reasons for spending more or less on one category versus another from hospital filing organization to another hospital or filing organization. Anyway, here's the distribution for tax year 2020. I think that it would require further study maybe talking with some of the hospitals about, you know, what factors led

them to spend more or less or in one category another to get a more complete picture of the reasons for doing it one way versus another?

Mr. Moore Well, I humbly suggest that's something that we put on the agenda.

Dr. Bauer I'll just follow up before we go to the screen. Ffor the unreimbursed Medicaid, New York certainly stood out from the rest of the country there. One explanation would be that New York has a greater Medicaid coverage and therefore there's more unreimbursed Medicaid. That's a good thing that we're covering more. Alternatively, our costs could be higher. Given the Medicaid rates, there would be more unreimbursed care. Do you have a sense of what's driving that difference?

Mr. Michaels Yeah, and here I will speculate. I would need further study to confirm. I do suspect that the increase in unreimbursed Medicaid spending probably corresponds with increases in Medicaid enrollment. I'll continue to look at that for my project, but that's my hypothesis.

Dr. Boufford Everybody else in person covered in Albany?

Dr. Bauer Go ahead.

Mr. Lawrence Thank you for really a great presentation. I guess I'm a little curious as to whether there's a difference in spend and patterns of spending between safety net hospitals and sort of the larger systems and also whether you found a difference, geographical difference around the state.

Mr. Michaels First of all, thanks for the kind words and thanks for the questions. I am interested in that topic and will do further study on it. There are some interesting findings in the literature there's been published on community benefit nationally and in other states that looks into that question. Depending on the sample that those studies are based on you see some slight variations on which categories do more. The recent studies that I've read have found that academic medical centers that are larger and in urban places tend to spend more. I think that that question deserves further study for New York specifically. The other thing that I would just say is that some of the questions that are very interesting are a little bit difficult to explore further. Not to say that they're impossible. They just are a little bit more. This is because hospitals often don't file IRIS Form 990 individually. If a facility is part of a broader system, they may be a single 501C3 nonprofit entity. Therefore, all of the hospitals under that entity will submit a single schedule H in a single form 990. Where that becomes a problem for questions like the ones that you just asked is if the system is large or even if it's not large, but facilities span multiple geographic regions, counties, or if they contain a large academic medical center and perhaps even a community hospital. It's all captured under one number. There needs to be some thoughtful method of attributing the spending or estimating how much was expended in one hospital under that entity versus another, or just being selective in which one of those questions we ask.

Mr. Lawrence Thank you.

Dr. Boufford Thank you.

Dr. Boufford Any other members? Anyone else on screen?

Dr. Boufford Denise Soffel.

Dr. Soffel Hi. I think I know the answer to my question, but I'm going to ask it anyway. Is there any requirement in the community benefit regulations that says that the decisions that a hospital makes about spending on community benefit reflect the priorities of the community itself? Is it up to the hospital completely on its own to determine what they consider community benefit and community benefit priorities?

Mr. Michaels Thank you for the question. I'm actually going to pass on that only because although I've read about that part of the deregulation. I don't have it fresh enough in my memory. I would be guessing. I want to leave it to others to look it up.

Dr. Soffel Does anybody else know?

Dr. Boufford The language in New York or from the Feds or, I don't know, Lloyd Bishop or colleague from HANYS, perhaps.

GNYHA Boardroom There is a requirement in the register, federal regulations that are very similar to New York, that there has to be a deal with the community and a setting of the priorities to determine what the priorities that would be included in the federal term is the CHNA, the community health needs assessment. You do have to reflect the priorities as determined with the communities. Very similar in New York for Community Health intervention spending.

Dr. Boufford I appreciate the response to that because I think the notion had been that at least historically, the prevention agenda had potentially been a platform for broader multi-stakeholder engagement. I think one thing we heard from colleagues in OASAS, OMH and NYSOFA, all of them have some degree of infrastructure now at local level or regional level in terms of local offices and resources and connecting those dots on behalf of communities with an alignment on evidence-based investment and shared priorities. It's really kind of been the vision, I think, of the opportunity and the prevention agenda infrastructure, and that will hopefully further strengthen that. We've heard some of the ways in which it's worked not worked from our previous panels. We want to hear more today.

Dr. Boufford Are there any other questions of Isaac?

Dr. Bauer We do have a question in the room.

Dr. Bauer Dr. Davis.

Dr. Davis Thank you very much, Isaac, for that presentation. It was very informational. You started the presentation by saying you had looked at the 2021 data, but it was a little bit incomplete, so you didn't want to include it. Since we noticed a precipitous bump in the 2020 tax year for New York State, I'm curious what the impact of COVID had on that spending and the distribution and if there was any normalization in 2021 with the early data.

Mr. Michaels Thank you for the question and the kind words. I'm actually wondering the same thing. I've not looked at 2021 data yet only because of the incompleteness but I'm interested to do so. Maybe I'll look at the preliminary data that are available. I think that they'll be complete relatively soon. We'll be able to answer more of those pre post COVID emergence questions. At the moment, I don't have any insight on 2021 just yet.

Dr. Boufford I think some of the important points. I just want to acknowledge also a college graduate student, now a graduate of the NYU School of Public Health, Riley Fitzpatrick, who's also been looking at community benefit requirements across other states. We've been having a sort of conversation about some things that might be able to be strengthened in the next iteration of the prevention agenda to get at some of the issues that an Isaac mentioned relative to sort of how could we encourage or provide incentives for greater alignment at the local level on shared goals and a little bit more qualitative understanding of the kinds of investments that are being made in the prevention and the prevention agenda priorities. Those could be part of some conversations that might take place going forward because obviously New York hospitals in general are making quite generous investments here. The issue is are they aligned with other efforts in those sort of public private sector partnerships, if you will.? Similarly, we want to really use the resources that are available at local level to achieve maximum health effects and health outcomes. That's the other challenge we face in moving the prevention agenda along. I think there are some recommendations that we could take forward, including perhaps looking if there's a future dashboard of activity at local level looking at those investments in a more qualitative way. Those are all opportunities to put on the table as we think about the next generation of prevention agenda. Again, thank you very much for your work.

Dr. Boufford I think it's a good segue way to our next panel where we're going to sort of talk with sort of key sort of the core members, if you will, of the local stakeholder partnerships meeting the local health around representatives, the local health directors through NYSACHO and Sarah Ravenhall and her colleague, Kristen Phillips. I see Dr. Theresa Green there, and then also from HANYS Theresa Green. I'm sorry, Kristen Phillips and Theresa Green from HANYS, Lloyd Bishop from Greater New York and Sarah Ravenhall from NYSACHO who sort of represent the state associations of partners that the provincial agenda had sought to bring together at local level over the past several years. I'm going to moderate this panel. In preparation for the panel. We did ask our colleagues to address three questions. We'll take those on. I'll keep my eye on the clock. We have a good hour for this discussion, which is great. The first question was really for those that may or may not be as familiar to ask each of our panelists to really discuss from or sort of present from their general organizations experience and also giving you a sort of overview of what their organization is and who the members of their organizations are just to give a sense of the overall value of the prevention agenda in addressing public health challenges that sort of bringing greater attention to prevention in general, and a sense about sort of what works and doesn't work. We're going to get into more granular set of questions later, but just in general. I think one thing we learned from our agency colleagues last meeting was that it had it had succeeded, at least in bringing more attention to prevention in general and to those to the members of their association.

Dr. Boufford Why don't I start off with Sarah Ravenhall, and then maybe we'll move to HANYS and then Greater New York.

Ms. Ravenhall Thank you. Dr. Boufford.

Ms. Ravenhall I'm Sarah Ravenhall. I represent the 58 local health departments across New York State in my role at the New York State Association of County Health Officials. We provide technical assistance and training, support the public health workforce, and we also influence policy at the state and federal levels. Excited to be here. Thank you for the invitation. I look forward to being a part of the development of the next iteration of the Prevention Agenda framework. As you know, local health departments are primary utilizers

of the prevention agenda. They develop along with community partners, including their hospital counterparts, a community health needs assessment that reflects the priorities of their community. They also put together a community health improvement plan which outlines specific interventions that they follow to address and improve health outcomes in alignment with those community priorities. They definitely involve community members, collect primary data from the community to help influence what the priorities are. It's a process that is actually statutorily required. It's an article 6 core public health service. In statute it is to take place no more frequently than every two years. We're on a two-to-three-year schedule in alignment with the hospitals because we want to continue working with the hospitals. I know that they have an IRS requirement there. One of the things we do hear from them is that thinking about the capacity of local health departments right now and we're all in the same boat, very limited resources trying to rebuild after COVID, hiring new public health workers, that the cycle kind of interrupts their flow and ability to meet the needs of the community. One of the things that we'll be looking at is trying to extend that cycle, maybe aligning it with the next prevention agenda cycle. We're thinking that every six years would be a more appropriate frequency for the local health departments to follow that and go through the process with an update in the middle to make sure that we're not missing anything that's happening in the community. One of the other reasons, aside from capacity on that is really we don't see the data changing that much. The priorities don't change as significantly every two years as needed. The six-year cycle seems to be more realistic so that we can continue uninterrupted focus on supporting the community. Program positives, you know, I think being in the prevention agenda, being key stakeholders there has really helped us to engage community partners, build public awareness around community health improvement priority areas and getting folks involved and also engaging community members from the point of view of the local health department. It helps build that community trust around public health. Those are some of the positives that the local health departments have seen from their work in the prevention agenda. In addition to challenges, as you know, pandemic response, staffing shortages and lack of specific funding resulting in not much progress being made in those priority areas. The prevention agenda is vast. There are a lot of different components. I sincerely respect that because there have been so many voices at the table invested in putting the priorities together. You're going to see that. It touches everything. The ability to kind of narrow in our focus on two to five different initiatives or prevention agenda focus areas would be more valuable in terms of moving the needle on some of these health outcomes that need to be addressed. I think that I will stop there. I have some ideas about capacity for local health departments and what is on the horizon for this this program, but that kind of just sets the tone from the local health department perspective on the prevention agenda.

Ms. Ravenhall Turn it to Kristen.

Ms. Phillips Hi, everyone. Can you hear me okay?

Dr. Boufford Yes.

Ms. Phillips Thank you.

Ms. Phillips I'm Kristen Phillips, Director of Community Health Policy with HANYS, the Health Care Association of New York City. Joining me today is Dr. Theresa Green from URNC. She is the Chair of our Community Health Task Force. I represent the Community Health Task Force with HANYS. It is a representation of our community health members. I work very closely with the community health staff of our hospitals. As you know and as

Sarah mentioned, the hospitals do have to submit. They have to conduct a community health needs assessment every three years and in between a community service plan and one-year updates in between those three years. They do utilize a prevention agenda in setting their goals and priorities and target areas. What they have expressed that they find beneficial is that the flexibility that they have in selecting the priority areas so that they can personalize it for their community and address their community's needs. They do like partnering with the CBOs to leverage their experience and share resources. They find that the metrics provided are helpful and so are the evidence-based interventions and best practices are helpful. A few issues or challenges that they've experienced would be identifying the CBOs that are out there that they can partner with has been a little bit of a challenge. They could use some more evidence-based interventions, especially for rural hospitals that would apply to them. More consistency with the language. We hear CHIP, CHNA, CSP. There are many different acronyms. They've requested more consistency with that. A very big challenge I've heard over the last several years is that they really struggle with measuring the impact of their interventions and measuring those intermediate metrics has been challenging. They definitely need some more guidance with that. If we can figure that out for the next cycle as well.

Ms. Phillips I invite Dr. Green to provide her comments.

Dr. Green Thank you.

Dr. Green I agree with everything Kristen said. We did solicit input from our member groups. I just wanted to make a point of clarity that leads to what I think about the prevention agenda. I work in a local academic medical center on the hospital side, but I did spend ten years working in local public health before I came to the hospital. I am bridging both. I'm in charge of not only writing the 990 for our hospital, but also, I lead the community health improvement planning process for our community. We use the prevention agenda all the time. We love the fact that it's there. We love that there's goals. As opposed to your suggestion of narrowing it, I really like that it's so broad that anybody can kind of plug in to it, which was beneficial to us because we picked two very different focus areas and that was helpful. I think the metrics are wonderful. However, it seemed like the metrics sort of changed somewhere in the middle of the cycle and changing them and taking away the disparity ones and then putting back some other ones. That was very confusing and hard because if we're measuring those, the effects of our interventions, certainly we have short term interventions, but we want to tie them to the long-term goals. If they keep changing all the time, we don't know which long term goal we're supposed to be looking at. My point of clarity on the issue of collaborating with between hospitals and health departments. This is so important. However, I think we're a little bit off the mark. Reporting on community benefits is something that hospitals do in a grid that's not dictated and there is no requirement for community engagement. Writing a Community Health Needs Assessment and improvement plan is another section of the 990 which does require collaboration. New York has been great, and the prevention agenda has been great on reiterating that and really asking us please collaborate, please work together. This is great. In Monroe County, we do have a collaborative group and we all work together and it's awesome, but it's not because community benefit reporting requires it. In fact, there's nothing that requires that the community health improvement plan should be included in the grid. That's in the 990 community benefits. There's nothing in the 990 that says, hey, go look at your community benefits plan. One great thing and I don't know how to solve this, is to somehow get those things tied together. I don't know if that's the job of the prevention agenda, but they're very disjoint at this point. Requiring minimal or making language around the grid is not the answer, because people then have to figure out a way

to collect all that information. Hospitals don't know how to collect if so-and-so went to a health fair or if someone was working with a community agency. That's really onerous on the hospital to be able to collect all that information. Big, big questions here that won't be solved in an easy thing, but tying those two together is my big, big push for the prevention agenda.

Dr. Boufford Thanks, Dr. Green.

Dr. Boufford Lloyd Bishop.

Mr. Bishop Hi, everyone. Lloyd Bishop, Senior Vice President for Community Health at the Greater New York Hospital Association. I'm joined by my colleague Ben Gonzalez, who is Director of Community Health Engagement. I'll start off by saying that for the question, Jo, that you asked. I think for us and our members, the notion that the prevention agenda is out there is a provides an area of focus on the work that hospitals do in the area of prevention. We have and they have appreciated the prevention agenda as providing that focus and attention. I think just by way of some background, I think as... I know as DOH knows and Jo, I think you know as well, you know, Greater New York, we're not just bystanders on this, but we're very engaged on these issues with our members. We have a Community Affairs Committee, which is comprised of people who do community affairs and community health who work on these issues day to day in terms of planning and helping to implement. We provide all kinds of technical assistance and support to our members on these issues. We'll talk about that a little bit in a second. We use the Community Health Committee as a forum for discussions on best practices and also to bring in speakers who can help talk about these issues and provide technical assistance. Over the years, that has included both our colleagues from State DOH. As the introductions went around the horn, I recognized some names of folks who were at Greater New York meetings and New York City DOH as well. Our TA is based on a couple of things. Knowing our members needs from our routine engagements. We actually read all of the CSPs. When I say we, most going to point that Ben and one of our colleagues as well. We actually read all the CCP's as we did this year to gain some insight as to some of the technical assistance that might be needed. It's also based on an understanding of, obviously, Frank, the financial standing of many of our hospitals in across our membership. Great financial stress. And of course, that has an impact on what happens on these activities. That includes adequate Medicaid funding for hospitals that serve our communities of color. We made some inroads in the last budget, but there is more work to be done. And for us, that is health justice issues. The advocacy for us is not finished on that. Knowing all that helps us work with our members in a very focused way. Just to hearken back to Isaac's presentation, I was excited very much for that presentation. Very thoughtful. Our work also includes technical assistance on the collection of community benefit. We are in the process of starting another round of technical assistance on that collection. It's not just the spending our community benefits, but it is also that collecting. As the previous speaker said, there is a lot of work that goes into that needs to go into the collection of community benefit, both for community health interventions, which is among the hardest to collect and therefore report, but also for other areas as well. Think about subsidized health services, all of those services that are providing in hospital clinics that is subsidized. You might lose money on. You have to capture all of that. Our technical assistance really has to do with making sure that the forms are as robust as possible. One of the stories that we have from a few years ago when we sort of started this. There was one hospital in particular that had zero on the community health intervention category. We knew it wasn't zero because we knew they did a lot in the community. Their challenge was they are so busy surviving and providing health care that they didn't have the staff to do

the collecting and reporting. What you see on the schedule8 forms is not reflective of the actual level of activity as well. Now, since then, that hospital and other hospitals have gone up some of that. I'm glad to see that reflected in some of the numbers. That's some of the technical assistance that we do. Let me talk about or let me have Ben talk about some of the work we did this year in terms of helping our members to do the community service plans, in terms of preparing to get them done and providing the data.

Mr. Gonzalez Again, my name is Benjamin Gonzalez. I'm Senior Director of Community Engagement here at Greater New York. I work with Lloyd technical assistance and researchers on community health planning to our members. A brief overview, we at Greater New York have provided support over several years for members in conducting their community health needs assessments. That really culminated last year in 2022, when we developed with our members a model needs assessment survey with our member input. This included community and safety net hospitals, small health systems and large academic medical centers serving in New York City, Long Island, Westchester and Hudson Valley. These collaborative members were invited to participate, and they enthusiastically did so. They are the ones who recruited the survey participants from their communities. In total, they received more than 17,000 community members responding to the survey. What we did is we took that data and then developed customized reports for each hospital or health system in their community defined level. We also provided the technology to post that survey online template materials to assist hospitals and community outreach efforts and data analysis to support members primary data collection. We say that primary data collection because this survey was just one part of hospitals broader effort to receive input from the community and other stakeholders. For example, some hospitals would review their survey findings at an ongoing community advisory board or other wellness meetings as part of their data review and selection process. This collaborative Ness from March through August of 2022 completing their community service plans by the end of the year, which all of our members. They did note that their outreach efforts would have been severely limited and much harder without Greater New York because of lingering financial and staffing hardships owing to COVID. For example, we provided the survey in eleven languages for free. We translated it. We made it available both in print and online. One told us that their goal was just to double their last cycle of survey response total. With our help they almost tripled their reach. You can imagine with all of COVID and limited staff and support they really appreciated our both data and expertise to help them make do with the research that they had. Moving on to 2023, as Lloyd mentioned, I'm one of the two people who read several hundred CSPs from our members. We invited members to submit the service plans to us for comments in addition to the states plan to color coding feedback. What we did is first we read them all. We conducted an analysis of the most frequently selected priorities, even drilling down to the intervention level. One comment I'll make here about feedback for areas of improvement, but for the members on our side, I'll say that the current structure of that DOH's workplan spreadsheet limits both the states and our ability to automate some of the analysis at the intervention level. Because the way the document is structured there's no dropdown menu for the interventions in addition to the existing free text field. We appreciate that ability. Again, that keyword. I'm sure would take much more time to get that data in were it a little bit differently. That's just the one point I wanted to mention. I'll also say our analysis matches. I think also the obvious the last Ad Hoc committee presented on the data from the previous cycle. We have the same top three priorities selected from within our memberships and the state overall that being to prevent chronic disease, promote well-being and prevent mental and substance use disorders and promote healthy women, infants and children. As Lloyd said, we do this analysis one, because we are constantly with our members trying to split them no matter where they are in the process. Currently,

they're in their implementation phase. This CSP analysis is part of our ongoing team to help them with identifying shared expansion as I mentioned, technical assistance on identifying and measuring health disparities, especially the key focus on intermediate measures and as well as inviting local health departments to speak, including other guys, not just local health departments to speak as Lloyd mentioned at our regular ongoing community affairs representatives' forums.

Mr. Gonzalez With that, I'll turn it back to Lloyd.

Mr. Bishop We're done.

Dr. Boufford Great.

Dr. Boufford Thank you very much.

Dr. Boufford This is great. Really, helpful. Sort of provides a good opening for the next question, which is to really drill down a little bit. I'm going to leave out a couple of things you've already tackled, but one of the real priority areas that has been mentioned several times. There's a lot going on, obviously. Some of the issues maybe where the reports are going. We've talked about the issues of sufficient qualitative information. There's sort of three big emphasis areas. We've talked a lot about community engagement and partnerships, but I think one of the questions is how could the prevention agenda be more effective or how has it been effective in really trying to get people to get hospitals, local health departments, other stakeholders to kind of align their priorities setting together? Obviously, they're within, let's say, chronic disease prevention there are a lot of opportunities there as people who are familiar with the prevention agenda will know. Under the overall goal there are usually a set of objectives, sometimes six, eight, ten, which provide a level of specificity. I think a little bit of what Sarah was talking about in the specificity. Maybe there are too many of those things. Others are saying they like the generalness, but it's hard to align if there are a number of objectives and say on cardiovascular. Some communities are working on X. Some on Y. It sort of makes it challenging. One of the things we were hoping to do is get more partnership at the front end. How might we be more effective so that a lot of the work that is being done individually or perhaps in a looser consultation or conversation could be more focused on evidence-based interventions for impact, which is something people were mentioning. The other issue would be effectiveness in addressing. We self-diagnosed a problem. Johanne Morne, Commissioner Morne's group. We're delighted at her former office is there now to really help with the issue of health disparities and equity, which we know was an area that had not been addressed as well as any of the local groups had, which because they did not have the technical expertise either in that area or in in evaluating the impact and results. We have sort of three areas maybe ask you to drill down in one or more that you could give us some feedback on. One with the more incentives for aligning partnerships. The second on being more effective on the disparities inequity issue and then talking a bit about evaluation and the question of evaluating impact on results.

Dr. Boufford Should we do Greater New York first and then we'll go to HANYS and then back to NYSACHO?

Mr. Bishop Sure.

Mr. Bishop On alignment, there are always those opportunities, of course. What we've found is where there is, even here in New York City, there are lots of hospitals, a very

large employment of public health where there are examples of county or borough offices that hospitals can work with directly. That is an area where you see more alignment. We step in and provide that sort of alignment for the broader New York City community as well. Through our meetings we've had, you know, the City Department of Health talk about their priorities. Hospitals over the years have directly aligned themselves with some programming that the City Department of Health has put in place, including things like tobacco cessation and other kinds of things. Where things are particularly called out and there is some programming that the Department of Health has available. Hospitals have aligned with those. I think providing some specific examples and programming is always very helpful on that front. In terms of disparities that's been a long challenge. Part of what we learned from leading the CSPs and talking to our members is that we have a lot of work to do with DOH and others to help local coalitions, both identify health disparities and how to measure them and how to talk about them. That has been a challenge. The same with evaluation. Early on we did sort of our own list of evidence-based approaches. We dropped that because the list from DOH of evidence based approaches has expanded greatly. That is something that I think that is going to be a continuing area of our work. That's my answer on all three of those things, as much flexibility as possible to work on those issues is going to be important.

Dr. Boufford Thanks very much, Lloyd.

Dr. Boufford Kristen or Dr. Green, whichever one of you wish to pick it up.

Ms. Phillips I'll get started. I echo a lot of Lloyd's comments that the hospitals and the local health departments have been working together. As you said, 41% submitted collaborative plans, which actually I believe is double than in the past. We are seeing an increase in that, which is excellent. I've seen a lot of great work between some of the hospitals and local health departments and surrounding agencies. Really impressive work going on out there. As Lloyd said, they really do like the flexibility of being able to meet the needs of their communities. That's the biggest message we can deliver today, is maintaining that flexibility because of the workforce and financial challenges that they are experiencing right now. It's not just hospitals who are experiencing that. The community organizations are as well. Maintaining that flexibility is very important. As far as the disparities, I think the community health needs assessment does a great job with helping them determine the needs of their communities. Again, measuring the impact of their interventions is something that they do find challenging, as I mentioned earlier.

Ms. Phillips Now, I'll turn it to Dr. Green.

Dr. Green If I can work the buttons.

Dr. Green Thanks.

Dr. Green I agree with everything that's been said. I think regarding the partnerships between hospitals and health departments and other community-based organizations, there is a requirement in the reporting. I don't know that anything's in the prevention agenda per se, but in the reporting that we have to do for the Department of Health, it is very much asked about. You have to describe it. All of that really encourages that collaboration. I like that the prevention agenda used to be clearer. It's kind of mixed in. They used to have special sections like if you're a hospital person here's some good interventions that work for this focus area. If you're a CBO here's some good interventions. Hospital leaders are not thinking, Gee, I'm going to go run a food bank. Gee, I'm going to

address housing there. Maybe they should. We can argue that. They are thinking, wow, maybe I should collect data. Is anybody making me do that? Wow, we should analyze our quality improvement metrics by race. Making those kinds of hospital specific from a hospital perspective intervention. Some part of the evidence-based interventions in the prevention agenda. I think for disparities and community engagement I think the prevention agenda talks a lot in this came up in our conversation, talks a lot about how important those things are. When you whittle it down, the focus lines and the interventions don't really reflect that. I think that's not the intent. I think they want that to. As a personal example, we picked addressing disparities in maternal child health. There was one intervention that said work collaboratively with agencies in your community. How do I do that? Which agencies? What should we be working on? What metrics should we be looking at? Where other focus action areas had much more evidence-based interventions. Where it mentioned disparities not so much. I agree with the comment on the data, the data by disparity and not just race, but there used to be social economic data in there, geographic data in there that showed. Here's another thing with prevention agenda. It would be great if those metrics matched with the intervention. If the intervention is smoking rates, then you right there are the metrics regarding smoking and the disparities related to it. I think there's a great cadre of metrics and a great cadre of interventions, but it took a minute to figure out what goes with what. It's a huge endeavor. It's going to get better every year for sure. Again, I'm very happy that it's there. I teach a lot and recommend to all my students go to the prevention agenda. It's great. A good resource for evidence-based interventions throughout the country, which is wonderful. I have presented on this stuff and people have said, Yeah, but you live in New York. You have that evidence. Everybody can use that. Great work, but lots to be done. I do agree that there's best practices out there for community engagement and partnership that should be included in the prevention agenda is here's how you can do this work.

Dr. Boufford Thanks.

Dr. Boufford Sarah.

Ms. Ravenhall Hi again. I think this has been a great discussion. I'm glad that Kristen, Dr. Green and Lloyd are here because you've given me some ideas. First of all, you know, local health departments are really, really good at collecting and reporting data for prevention related initiatives, right? We focus on the preventative care part of the health care continuum before a person gets sick and goes to the hospital. They use a lot of and implement a lot of evidence-based practices. If a hospital were to say, hey, we really want to invest our community benefit dollars in going into homes, addressing prenatal health so that these people do not come into the hospital, reducing avoidable hospital admissions. It may be that the local health department is willing to do the data collection in turn that you can put on that 990. I know that makes it sounds so simple, but there are a lot of logistics that would go into that. My hope is that it would be a mutually beneficial partnership there. I think we all want reduced hospital admissions and readmissions to save the health care system money, which nobody has. That is that. Also we can help with suggesting evidence based interventions, which is something our members are very skilled at. In regard to health equity, our members definitely agree that health equity should be a stronger focus in the next iteration of the prevention agenda. One of the ways we feel we can address that is through a lot of the local health departments are now looking toward hiring community health workers, peer navigators, people who reflect the community to help make those connections, build trust and address prevention in their community. Whether it's people living with substance use disorder and supporting them in injury prevention and harm reduction. Whether it's addressing maternal mortality. Preventing chronic disease

doing diabetes self-management programs or chronic disease health management programs and of course, tobacco prevention. There are so many things that I think that we can collaborate on as local health departments and hospitals. I will say that I would say that the majority of my members have great relationships with their hospital partners. Particularly post-pandemic they did a lot of communicating with hospital administrators and have that trust. I do hear that some local health departments haven't been as successful in working with their hospitals. That is local health departments in larger counties and counties with multiple hospital or health systems. I know that because we did some data collection at the last meeting. My colleague Molly was here, and she did a kind of an analysis on that. That was one of the findings from our analysis from our members in regard to them working with hospitals. I think we also have a great opportunity to continue to work together as local health departments in hospitals with whatever happens with the Medicaid 1115 waiver, which the focus is health equity, right? With the prevention agenda and a greater focus on health equity it's really critical that hospitals and local health departments build those relationships where they may not exist. In addition, local health departments and this is a local health department specific program, but the annual performance incentive that we work with the Department of Health on, instead of developing different initiatives that aren't aligned with prevention agenda, I think we could use that program to help fund what they're already doing in relation to the prevention agenda. That's one other thought there. If there were incentives to get these hospitals and local health departments to work together, perhaps there's an opportunity for that within the 1115 waiver so that we can kind of help to establish that. I don't think strong arming anyone is the answer. I don't think that's the right way to go. Incentivizing and recognizing those fruitful partnerships I think would be valuable.

Mr. Bishop Jo, if I could just jump on that last point. Thank you very much. I forgot to say that as I said in previous meetings, the 1115 waiver is coming. There were these social determinants of health networks that will be existing. I don't know what they will exactly look like. We haven't seen of course, any terms and conditions. That's an opportunity that has some money attached to it for some local structure to also be part of the conversation. I don't want us to forget that.

Dr. Boufford No really important point. I think we're all eager and have been having our ongoing conversations, hoping we can align that effort a good bit.

Dr. Boufford Last question for the panel is sort of a fairly general one. Obviously, as we've discussed, the general umbrella priority areas have been preventing chronic disease, promoting healthy and safe environments, promoting healthy women, infants and children's promoting well-being and preventing mental illness and substance use disorders and preventing communicable diseases. There are five very large headlines, if you will. Under those, there were specific objectives for each of them. I think also cross cutting the previous iteration had been attention to older people. I think in reality the goals were to have specific objectives for individuals over 50 that were relevant in the five different umbrella areas. I think that in the light of the current emphasis of the Master Plan on Aging, I wanted to raise that or perhaps encouraging you to comment a little bit in my question, just sort of what else might we be focusing on or what might we be emphasizing differently than what the previous work had done? We've identified the equity disparities question. The other area, I think because we looked at the reports, the progress reports, the areas of environmental health and safety were was probably one of the least selected of all of the areas, which I think speaks to this question of cross agency collaboration in this next iteration. We've had we have an agency speaking after this. We've had our colleagues in the other agency speaking earlier. Let me just ask for a final, very brief

comments from the panelists on what other areas of emphasis would you see needing more attention in the next iteration of the prevention agenda? We'll move to open to the audience questions.

Dr. Boufford Why don't we start with HANYS first, because I put you in the middle each time.

Ms. Phillips The only additional area of emphasis, which is what you were just speaking to, is focusing more on the geriatric population and adding them to a current priority area or even as a sixth area, because they still would like to see more focus on that population.

Dr. Green I think the point there was that although it was mentioned, we are going to focus on the geriatric population, it was hard pressed to find interventions that related to that or data that related to that. It may be in there now, but to really build that up. If we're going to say let's focus on geriatrics, either call it out as a focus area or really put metrics and interventions in that support that. Same with environmental health. I wondered about that because no one ever picks environmental health, but it is really important. When we think about chronic disease our group immediately went to prevention and building an environment that supports healthy eating, but that wasn't what environmental health was about. It may be pulling environmental health and thinking about how that relates to each of the other larger buckets so that you have to look at it if it's in your space and you're picking something else. I don't know. I also want to give a plug to mental health. Certainly, there is a section on mental health, but our group really wants to work on low level mental health, depression, general unease. This has only gotten worse with COVID. Much of the work in the prevention agenda towards mental health is very downstream, if you will. We're really looking for upstream. There's really not a lot in there to help with upstream. I know that's lacking in the literature and probably in the... And I know in the data as well. I would really push for that as a new area or a built-up area.

Dr. Boufford Thanks very much.

Dr. Boufford Lloyd.

Mr. Bishop I'll associate myself with what was just said. My colleagues from HANYS, Dr. Green, who last spoke about calling out certain issues of climate change and environmental. Absolutely. One of the things about community service plans that folks may not realize is that it is when you read those plans it's not a representation of all the things that go on that the hospital does in the community to improve health. One of the areas that hospitals are working on, primarily because of federal and state and city challenges, is the reduction of emissions and those kinds of things. My colleague, Susan, who many of you know is the expert that is working on that climate change issue. If that was called out we might have seen more of that in the community service plans. Also, gun violence. I'm calling that out and everything else that was mentioned. I think just emphasizing those issues so communities, community coalitions know that that is something to work on that's sort of maybe a little hidden in the broad array of the kinds of things the hospital to work on and counties to work on as part of the prevention agenda activity.

Dr. Boufford Thanks, Lloyd.

Ms. Ravenhall Sure.

Ms. Ravenhall Health equity is a cross-cutting issue. Climate change. We saw that certainly with the air quality issues earlier this year. Our members really played a role in communicating to the public about what they needed to know, helped to help get information, suggestions out, worked with schools. Should school activities be taking place? That's more relevant than ever. I think because we could visually see smoke in the air people are really recognizing that now, which is, fortunate and unfortunate and then agree on the violence prevention. In regard to mental health, I know we have Courtney David here from the Conference of Local Mental Hygiene directors. Our members work absolutely hand in hand on public health and mental health initiatives in communities. I would say all of these things impact mental health, the climate, violence, gun violence. It all plays a part. Having conversations with your local government leaders about these topics is critical in addressing prevention agenda initiatives.

Dr. Boufford Thank you all very much.

Dr. Boufford I want to open it up for comments. We have some really meaty comments in our chat box here, especially our new Katie Bush is identified as the new Director of Strategic Operations for the Health Department in the environmental space, and I think will be good timing for her arrival because this is an area that I know we've all wanted to see build out of it.

Dr. Boufford Let me call in Harvey Lawrence and then others that would like to make comments. I'd like to encourage colleagues from OMH, OASAS and NYSOFA that are with us today. Maybe want to make a quick comment and join in on the equity question. We'll get to before we close out this session.

Dr. Boufford Harvey.

Mr. Lawrence Great conversation. The only thing that I am a little concerned about is unless I sleep through that part of it, there was no mention of community health centers, unless it's understood that they're CBOs. When you're talking about prevention and reduce hospital admissions or unavoidable hospital admissions and E.R. access, you are looking at community health centers that are on the front line that are making a difference. Often I hear from my colleagues that some hospitals, not many, are in very difficult to strike up a relationship. There are some that have excellent relationships with the community health centers in their area. There doesn't seem to be a a unified approach to how they should engage with community health centers, because the community health centers are actually in the communities. They have collaborations with CBOs, with health departments, with everyone, faith-based institutions. They are sort of in many of the neighborhoods are the hub within those neighborhoods. It seems like it's an opportunity that is missed for hospitals to really have a formal approach to collaboration to partnership that is not simply left up to the individual hospitals. There's some way to encourage that among the members of the various hospital associations.

Dr. Boufford I think it speaks to your point. There are a couple of reporting areas in the prevention agenda historically who's at the table at the local level. Track that as it happens, I think committee health that are actually quite actively involved in a lot of the counties in the work in the prevention agenda activities. I think it's trickier in New York City for reasons that Lloyd explained and others, but absolutely key partners. They are really very much on the front lines. I think the other one of the other areas that...well, I'll come back to that. Let me keep it open here. I lost my thought. There's plenty folks that want to make comments.

Mr. Lawrence Response from any of the representatives.

Dr. Boufford Oh, I'm sorry. I didn't know it was a question I thought it was an observation. Sorry about that. Lloyd or HANYS or Greater New York responding to the Community Health Center question.

Dr. Green I'll just say it brings attention to the unusual nature of hospitals working on the prevention agenda because it's so outside the realm of what hospitals are used to thinking about. Where do you put them in? Certainly, we have our Anthony Jordan, our local clinic at the at our table. They're collaborative partners. We certainly engage them in collaborative partnership. Again, that speaks to the issue we said earlier about can the prevention agenda help us identify, hey, check out these community partners. Here's a great place to look if you're looking for somebody to do prevention. A great point well taken. It's weird to think how that how to put that in the prevention agenda to encourage people to look for their locals.

Dr. Boufford Dr. Green, you mentioned exactly. I think I was trying to remember, which is there in earlier iterations there had been, I think a lot of it based on CBCs, community health improvement, guidance, actual roles for multiple stakeholders identified explicitly with their sort of evidence-based intervention opportunities. I just want to emphasize that that you raised. It's very relevant to this conversation.

Dr. Boufford Lloyd or colleagues.

Mr. Bishop The only the only thing I would add is, I guess, the notion of having more players at the table statewide as well. Hopefully that would provide more opportunities to trickle down to more opportunities for local engagement. I can't speak to every local community's hospital relationships, of course, but to the extent that there are examples given from statewide discussions. You're talking about bringing in business groups and state agencies that you have around the table now together on a statewide level to the extent that any of those groups that are at the statewide level can provide information about local connections that can be made would be helpful.

Dr. Boufford That has been a traditional role of the Ad Hoc committee representatives is really communicating with their networks as well as bringing this feedback in. That's really helpful.

Ms. Ravenhall Dr. Boufford, I would just say the local health department's value incredibly the partnership that they have with health clinics and FQHCs. I have some really awesome examples of work that they do in collaboration with them, whether it's community gardens or partnering on holding back to school vaccine clinics. It's wonderful. I would also say health clinics are severely stretched in terms of in terms of resources. We certainly wish there were more of them. In rural settings sometimes where there isn't a hospital within the county, those health clinics really step up. It's wonderful.

Dr. Boufford I think as a member of our group. I didn't hear anybody represented here today, but they're certainly part of the group.

Mr. Rotter Just a quick comment. Medical Director for the Office of Prevention and Health Initiatives for the Office of Mental Health. Just responding to your invitation to weigh in here. Just a couple of quick things, one of which is the health equity issue that we're

talking about with the prevention agenda really are already sort of party making for our making our break into across all agency initiatives. In fact, there's a dashboard that perhaps we can share with you all that captures the equity issues in the variety of spaces in which OMH work with direct care as well as regulatory oversight. Picking up a couple of other things here. Using upstream in two different ways here, both of which I think are relevant for the prevention agenda. One of which is the lower level, if you will, more routine run of the mill mental health issues people is facing on. Certainly, we're working at some of that stuff that we'd love to be able to incorporate into the prevention agenda with some models offer doing so because it is indeed a major focus, particularly post-COVID. We totally agree with that. We appreciate that call out. The second is the upstream from the interagency perspective of climate change, pollution, transportation and the like. The need to find ways in which we can continue to collaborate at the state level across agencies, perhaps to help across all policies which we discussed last time. I'm not sure I'm smart enough to know how that gets into the prevention agenda specifically, but certainly the kinds of thing we're talking about upstream require that kind of interagency collaboration. One last point I want to pick up on that Harvey was talking about earlier. A question here. Referencing for good reason, evidence based. I wanted to suggest being specific about models, for example, for community integration or versus what's evidence based, because some of this is very new. The kinds of evidence base that they were talking about, frankly, evidence based doesn't exist. There are models that we can. I think part of the reason that we haven't had the uptake as Harvey was suggesting that we might have had, or we could have is because we don't know where. We haven't specified what that could look like for a community or for a locality to pick up one of the interventions. I wonder about whether or not there's a way in which we can. In addition to have evidence-based interventions that are indeed evidence based we can think about identifying specific models with outcomes, of course, but specific models of integration, specific models of inter-agency collaboration with specific models of outreach that people can pick up and implement without that fall short of the kind of evidence base known in certainly in the mental health world. There's a promising practice is sort of the. For stuff that doesn't have the randomized controlled studies. I just want to share those thoughts. We're looking forward to the opportunity that you've given us to give OMH, to give very good feedback on the how to move the needle on these upstream, lower level upstream interagency mental health related outcomes. Thank you.

Dr. Boufford Now, this is great because I know Dr. Bauer and others in the Department of Health have articulated a really strong desire to have more engagement on the broader determinants of health, social determinants of health than the last iteration did. As you say, it has to come from other agencies and from other sectors. We appreciate that.

Dr. Boufford Dr. Torres has a comment or question here.

Dr. Torres I have both actually. In listening to this robust discussion on equity I'm just wondering if there's a way to look at the zip codes where the distressed hospital areas are having difficulties of meeting appointment requests from the community at large. We're listening to people trying to access health care. Appointments are several months down the line. Additionally, as we were talking about the priority alignment, I was just wondering how feasible it would be to coordinate a community meeting that would include key organizations that are addressing the social determinants of health so that they can broker a discussion that would be closer in alignment with the hospital and the hospitals be aware of the challenges that are in their backyard, especially in the distressed areas just as a strategy.

Dr. Boufford Thanks very much.

Dr. Boufford Any comments from the panel on that observation?

Dr. Soffel I do, in fact, and it really sort of follows up nicely on what Dr. Torres just said. I am reminded when... I was interesting, when I heard Dr. Green talk about how challenging it is for hospitals to find the appropriate CBO partners to bring into the conversation. Lloyd Bishop talked about the potential for social determinants of health networks as part of the new 1115 waiver. I think about what we learned from this work where we had an explicit goal of bringing CBOs into conversations with hospitals and health systems, and in some cases it went very well, but in many cases it went very poorly. I think that there were lessons about the bandwidth of CBOs and the lack of resources in many CBOs so that they don't have a staff person that they can free up to go to a three-hour meeting because there was nobody there who has that kind of free time to attend a meeting, even this meeting. I've said this before, but I'm going to say it again. I think that we need to be respectful of the challenges that CBOs face and value their time. If we want them to participate in these kinds of conversations around the prevention agenda or the public health initiatives or health equity, we need to value that perhaps financially, because it may be the only way we can actually bring really essential partners to the table to engage in conversations about community. I think that there are lots of opportunities. I think that the challenge is for hospitals to figure out how to find the CBO partners are real, but I think it's essential that we collectively find a way to do that. As I say, one of the ways in my mind is acknowledging the value of that participation.

Dr. Boufford I think it's one of the things we have not had before, partially because of the sort of ability to talk about it as a sort of presentation, read the presentation on the waiver itself and on the social determinant's networks, because quite fundamental for a lot of the conversation here is actually providing capacity. CBOs I think was part of the idea in geographic areas as well.

Dr. Boufford Dr. Watkins.

Dr. Watkins I really enjoyed the conversation so far. The discussion has really been informative. I just have a quick suggestion or an opportunity to push on something that Sarah Ravenhall has talked about earlier. That is having the opportunity for hospitals and local health departments and CBOs to work together on this common health needs assessment. I think it's just a stupendous community project that we all come together to make this happen for our community. After collecting all of the data that we've talked about and we've collected ideas for goals in order to move the dial or to make inroads in our community, I think there is a shortfall after the next version or coming up to the next version of a new prevention agenda. We see this shortfall in our progress reports. Oftentimes, we're just not able to move that dial. What Sarah referred to w the need for resources in order to make that happen. We know that hospitals may have the resources, but they have no time to make it happen. We have local health departments who may have staff that can go out and do some of the groundwork for it. There are CBOs that work with us as well. We need to bring to the table are business partners and foundations who could support some of these great ideas that we would come up with and could provide some of those resources in order to make some inroads in these communities. I think that part of the progress reports, we have to include some ways that the hospitals and the local health departments have brought in some business partners, some foundations who could provide those resources in order to make some inroads into these community health improvement plans that have come up each year.

Dr. Boufford Local business, again, this Ad Hoc group are state associations and we have hoped, but not yet succeeded in having a local business council involved. I would be glad to have the Association of Health Plans because they are important, but it's really a good reminder to bring them in because so many businesses are very invested in improving situations in their own communities at the local level. It's a missed opportunity. We have a number of foundation folks on the phone. I don't know if they want to make any particular comments at all. I'm just watching them. I'm not seeing any comments on this. Have been very active on advocating around the issue of older persons, the needs of older persons and very active in the Master Plan for Aging. You want to just comment on this issue of local investment? I know it's a major priority for you, Nora.

Ms. OBrien-Suric Yes, I came on video so that I can answer this. I really appreciate your comments, Dr. Watkins, who is now on our board, which is wonderful. Yes, you're right. This is an interest of the Health foundation. I know many other foundations in New York State and across the country trying to assist community-based organizations in really working with public health, with hospitals and with community centers in order to provide that continuum of care in the community. Actually, it reduces health care costs. It increases satisfaction with services. One of the issues, though, that there's many, many issues that we're facing with this, and I know I don't need to list them to everybody here is the workforce. It's really understanding between the hospitals and the CBOs. There needs to be a lot more information, education and assistance in helping CBOs understand how to partner community hospitals and health clinics, understand what services CBOs provide and the value of them. I don't remember her name who said that, but we have to show appreciation for that value of the services that the CBOs are bringing, which I don't think is there. I agree with everybody's statement. Since I've been with the Health Foundation now six and a half years, and actually when I was with Terry at the Hartford Foundation trying to figure out ways to help community-based organizations partner. Part of the Obamacare right to do this on what was it? Section 3086. Anyway, really trying to figure out how to do this and looking for any assistance, any ideas, any working together to bring business community. I like what you said, Jo, about the insurance as well. Bring them in. It's something that we've been discussing a lot. I know Diane is also in this meeting and she and I constantly are talking about how we can actually move this forward in especially looking at the 1115 waiver and knowing that this is a vehicle in which we can do this and maybe provide that incentive to do it. I am open for anything we can do to help support a pilot project or support convenings to support more education and public awareness. Count me in and bring ideas, suggestions, people to me. Thank you.

Dr. Boufford Thanks very much, Nora.

Dr. Boufford I understand there were some comments from Albany.

Dr. Boufford Any comments or questions in Albany can you emcee and then we'll wrap up.

Dr. Bauer Yes.

Dr. Bauer Thank you, Dr. Boufford.

Dr. Bauer We'll hear from OASAS.

Dr. Bauer We'll hear from Courtney and then we'll get to Sarah and Dr. Moore.

Ms. Zuber-Wilson First of all, I want to thank you for the work that you're doing with our agency and our colleagues around overdose prevention, around medications for opioid use disorder. The hospital system has been a tremendous partner in our work around treatment, around harm reduction, supporting our work around recovery. One of the things that I did not hear was around primary prevention, that upstream prevention work to delay initiation of underage use to address substance misuse that does not meet the criteria for treatment services. It's a concern because every other disease we talk about when we talk about heart disease, we talk about cancer, we talk about diabetes. There's that upstream prevention work going on. I heard mental health, but I didn't hear substance use disorder. We have over 150 prevention coalitions in communities across the state. Those prevention coalitions have twelve sectors sitting at the table, from businesses to our treatment system to the faith community, to the business community. Everyone is sitting at the table. I will tell you one of the challenges we hear from the coalitions community is getting hospitals to the table. They're an important part of the work that we do for primary prevention, upstream prevention. The other thing I wanted to mention, too, is the work around screening brief intervention referral to treatment. We really have some challenges when it comes to that partnership. We've done a lot of work with Northwell. We worked together on a grant, but really talking about how do you screen individuals when they come into an emergency department? When have they come in for a visit? We do blood pressure checks. We do heart checks, oxygen checks, all of these things. How do we make those checks with people substance use? How do we make those checks with individuals with their mental health? Most importantly, if they need some support, if they need an intervention, not treatment, but an intervention. How do we get that? I just want to bring that to the table, because the primary prevention area is... I mean, the prevention area, substance use mental health area is very broad. Sometimes that primary prevention seems to get dropped off of the conversation.

Dr. Bauer Thanks so much.

Dr. Bauer Courtney.

Ms. David Thank you.

Ms. David I fully agree with everything Pat just said. We work very closely with OASAS, our folks. I do also want to thank Dr. Green for raising the focus of mental health as part of this discussion. This is my first year as part of the committee. I'm really excited to hear mental health being pulled into a conversation for the prevention agenda. Again, thank you to Sarah. We do work very closely as we're representing on the state level, the local county mental health department. Sarah and I work very closely as part of our association. I've heard a lot about the focus of the aging population and an opportunity to talk about other top priority areas. When it comes to the mental hygiene system, I think looking closer at a focus with children and youth is a really big piece from what we see on the local level. Suicide prevention, how that's tying in what we're folks are seeing around social media usage as well on the SUD side with OUD, opioid use disorder, alcoholism and again, the biggest thing that we're seeing is the cannabis use with underage children. The other thing I also wanted to raise to the group was as people may or may not know, as the public health officials also do the local service planning, we do as well. DCS is our directors of community services do annual local service planning. If folks are not aware of those plans that are out there, they are posted publicly. They identify the gaps and the needs locally for... Specifically, there's a prevention piece attached to that. I think that's an important resource to use when we're looking at the development for the plan going forward.

Dr. Boufford One or two more minutes and then we need to move on.

Dr. Bauer We have two more comments and then we'll move on.

Dr. Bauer Thanks.

Ms. Ravenhall This is Sarah. I wanted to comment on the resources for prevention and local health departments. I found out recently that in Nebraska every single Medicaid managed care organization pays their public health agencies for prevention related services, whether that's providing immunizations, providing chronic disease, self-management programs, working on supporting people who use drugs and harm reduction services. I'm waiting for data to show the outcomes of that, but I think it's really interesting they noticed after the pandemic if we had had stronger public health partnerships and invested in public health we may have saved some money and kept people out of the hospital who didn't need to be in the hospital during the pandemic. It's very interesting. I'll keep you guys posted. I'll mention it whenever I can. In regard to substance use disorder we've got local health departments doing really awesome stuff. Community health workers working with their schools to get in front of kids. Do that prevention training. We've got local health departments putting together kiosks in the community like a vending machine that provides harm reduction programs to prevent injuries, passing out fentanyl test strips, test strips, naloxone training. We are definitely working to address that top priority. One of the things I'll say on the record as well is make sure that there's a focus on prevention when we're thinking about opioid settlement funding for anybody who's making decisions about or involved in that. I'll stop there.

Dr. Bauer Dr. Moore.

Dr. Moore I'm going to comment three domains; stakeholders, complexity of services and the flexibility of interventions. It was mentioned about community health centers. As I've said this before in these meetings, it's about primary care more generally. It can't be limited because in particularly family medicine and internal medicine because prevention in geriatric populations is secondary prevention. Most people over 65 have like five chronic conditions. You can't do it without primary care. With regard to complexity of interventions, I couldn't agree more. As an exercise medicine doc there's a lot of things that are evidence informed but not evidence based. Because the interventions involve too many domains of life to be able to be controlled. As a clinician trying to engage in weight management with patients, now back twenty years ago the only thing really available was the manual from Kelly Brownell, which was twenty-six weeks. I can tell you as a clinical investigator you can get patients to do things and in a research project that you can't get them to do for themselves in the real world. You can't just follow things that are in the literature. You have got to use the literature as a guide, not as your Bible. One example of that is mentioned with regard to mental health is that not people anxiety and depression, but just comorbid anxiety and depression with other chronic conditions, visa v social determinants of health. There's not a lot of evidence base on what you're going to do there, but that's a real need, particularly post-9/11 and then post-COVID, because there's a lot of anxiety and depression related to those. We really need to look at evidence informed. With regard to that the last thing on flexibilit. In meeting across all the cost cutting measures and all of that sort of stuff I'm going to pick representing medical practices insisting on the PAM was not a good move. Because there is need for evidence informed there are going to have to be different tools that are involved. I think looking at grid enabled measures project for flexibility of kinds of using different kinds of data is probably helpful. I know that in our

attempts to collaborate with Meals On Wheels one barrier has been that they're mandated, I believe, by the Department of Ageing to use a particular data collection tool that doesn't interface with the EMRs. How do you get them to collaborate with automated data collection services? The last comment is having been through 66 years of life and watched urban renewal and gentrification processes and all that, I couldn't agree more that the half-life of change is probably not two to three years. It's probably more like a decade. I think it's probably reasonable to try to synchronize things and let projects go for an extended period of time before we're having to reevaluate and re redesign them. Thank you very much.

Dr. Bauer Great.

Dr. Bauer Thank you.

Dr. Bauer We actually do have one more comment in Albany.

Ms. Wetterhahn Thank you very much.

Ms. Wetterhahn I'm Lauren Wetterhahn with Inclusive Alliance, probably one of the only CBO people that can show up for a three-hour meeting like this. In addition to echoing the comments around needing to invest in CBOs, if you want them at the table, I think you also already have, as I mentioned, state funded networks across the state, whether it's prevention coalitions, networks coordinated by the area agencies on aging. You also have OMH funded behavioral health care collaboratives, some of which have now become behavioral health IPAs. We also have two one ones across the state, which are fabulous resources around community services. I think those are all existing things that could be tapped into to accomplish some of the things that we've been discussing.

Dr. Bauer Thanks so much.

Dr. Boufford Thank you.

Dr. Boufford Thanks for such a very rich discussion. Thanks to the panel for your great presentations and also great comments and responses. We'll look forward to pulling a lot of this.

Dr. Boufford I want to segway into our last presentation, which is from the Department of State. I mean, one might ask yourself, what are they doing here? The answer is they have been unbelievably helpful from the beginning. A buyer who is going to be presenting on behalf of the Secretary Rodriguez on the Smart Growth Program, as well as I hope he'll also mention his Environmental Justice Initiative is an example along with AG and Markets earlier that had really. Department of Energy and Parks have actually been involved over the last four or five years at different points from the agenda on the prevention agenda. I want to in addition to obviously our core partners, NYSOFA and OMH and OASAS, but the origins of the interagency work, which has been I think is increasingly important going forward, is a 2018 Executive Order that really was promoting health at all policies across state agencies and also healthy aging with the idea that each agency was asked to look at their policies, their programs and their financing, their contracting to be sure they were making decisions that were promoting health and promoting healthy aging. That interagency group did meet for a couple of years. It was interrupted by COVID. It still stands relative to help at all. And then again, on the Master Plan for Aging Governor Hochul has issued, I have acknowledged that interagency group and also created another

interagency group to advise on the Master Plan for Aging. Increasingly, I think we're seeing the importance of other agencies ability to really deliver on especially action in the communities we've talked about and some of the broader determinants of health in addition to sectors like the nonprofit sector and the business sector. Let me with thanks introduce Paul Beyer, who's the Director of Smart Growth Planning at the New York Department of State. I only want to say that his boss, Robert Rodriguez, started out in East Harlem when I was at the Newark Academy and had the pleasure of working with them. East Harlem was the pilot site for Age Friendly New York City. Similarly, he has always been very committed to health issues. We're very happy to have someone in the DOS who's on to it aligned with our concerns and our commitment.

Dr. Boufford Paul, over to you.

Mr. Beyer Wonderful introduction. Thank you, Dr. Boufford. Thank you, Dr. Bauer, your colleagues, for even inviting us to the table. We think the work that we do has tremendous impact on public health outcomes, particularly in disadvantaged communities. That's a term of law now. I prefer under-resourced and overburdened communities, but it's really nice to be at this big table. Department of State does a lot of things, many of which don't even interact with one another. We do boxing, we do cemeteries, licensing, corporations, but we also house what's known as the Office of Planning Development and Community Infrastructure. That's where I serve as the Smart Growth Director. The general thesis here we do community development, community planning and development, but we do it smartly, sustainably and equitably. We conduct our business across programs according to the principles of smart growth, which I'll expound on in a moment. We know that the way we plan and develop our communities, including our infrastructure decisions, have profound effects on public health outcomes, both physical and mental, and Cortney and others, I'm going to underscore mental post-COVID, because I think we all learned that communities that fostered social engagement and those that fostered more isolation really rose to the top during COVID. I lived in a community. It was very walkable, plenty of people around me. Whenever I was on the precipice of going crazy, I could engage with people in my community. I could walk to my downtown. Many communities are not built according to those principles. The built environment and the natural environment and the way we arrange those pieces on the landscape; parks, public spaces, commercial, residential, civic, entertainment does affect our physical and mental health. I also want to point out that it is particularly relevant to older New Yorkers where we're seeking to Master Plan on Aging to avoid long term care by prolonging health. Also, communities of color who have suffered disproportionately from discriminatory land use and development decisions and policies. We all know of redlining. That's probably the most famous of those discriminatory or infamous, I should say, land use policies but it goes much deeper than that. Before I describe the principles of Smart Growth and how some of our programs can lead to public health outcomes and are much more measurable now, I just want to punctuate the fact that what I'm talking about; sustainable community development, smart growth overlaps almost entirely with the WHO and AARP domains of livability forms the foundation of New York's status as the first state to be certified as age friendly. They also comport almost entirely with the initiative that Dr. Boufford mentioned, Health Across All Policies and Age Friendly New York. We're not talking about something foreign here. We're talking about concepts that are already built into state policy, law and programs. What is Smart Growth? Very quickly, the overarching philosophy is that when you plan a community you should adhere to and integrate the four E's: equity, economy, environment and now the fourth E, energy/climate. You might know it as the triple bottom line of sustainability, people, planet profits. We've made it the quadruple bottom line with the four E's. That's the philosophy. It works. When it works it creates tremendous outcomes on

many, many levels, not just public health. Drilling it down to the details Smart Growth adheres to incorporate a number of planning principles; creating walkable, bikeable transit friendly communities, creating safe and accessible public spaces, mixing land uses together, housing, residential, civic, recreational, creating a variety of housing choices for people of all incomes, backgrounds and ages. Those are some of the principles, the raw planning principles that we promote and achieve through our planning and development programs. Very quickly, here are the main programs we administer that carry out those goals, and then I'll get to their public health, mental and physical benefits. We do Smart Growth planning and zoning. Most communities have comprehensive plans and zoning ordinances, their legal documents that determine land use outcomes. We fund that those plans and zoning ordinances because you really do need a blueprint for sustainable development if you're going to address it effectively and comprehensively. We revitalize waterfront communities. It's called the Local Waterfront Revitalization Program. We have a brownfield opportunity area program. We serve largely underserved communities. I think 80% of the communities we serve are now considered disadvantaged communities, but we help to clean up and redevelop contaminated sites. Of course, direct public health implications there, particularly for communities of color. The crown jewel of Smart Growth, my own programmatic commentary, is the Downtown Revitalization Initiative and its rural progeny, what's called New York Forward. It's really a microcosm of Smart Growth. We're reinvesting in neglected disinvested cities and urban and rural and suburban centers. It really, I think, exemplifies what we're trying to do writ large in every community. A vibrant downtown we feel has all the components of a healthy community, really is a paragon of the joinder of public health and community development. Let's get right to these outcomes in these principles of Smart Growth and how I think they're relevant to the prevention agenda. I mentioned that we create walkable, bikeable, transit friendly communities. The public health benefits there are obvious. You can walk and bike more in these communities. If you walk to a transit station, you're not just hopping in your car outside of your home. That also has mental benefits too. My colleagues or one of my colleagues, at least referred to sidewalks as linear parks. During COVID that's probably where we interacted most at a distance, of course. They're not just modes of transportation. They're opportunities for social engagement and opportunities to address social isolation. Many of our downtown revitalization projects start with that raw infrastructure. How is that measurable? I remember ten years ago when we were doing the prevention agenda, we addressed the built environment, and it was sketchy. In that ten-year period, these outcomes and these components are very measurable, particularly in what's called the Communities Walk Score. It looks at sidewalks and bike lanes and actually drives the real estate market. Many realtors use walk scores to try to sell their properties. We think we can measure that. We know we can measure that. It goes beyond walkable, bikeable and transit friendly communities into the way we assemble our land uses in our communities. Smart Growth, I mentioned creates compact, denser, mixed use development. That means you have all of what you need in a condensed area, all of your daily destinations. You hear about live, work, play communities. That's what we're trying to integrate there. If you arrange those pieces compactly and you mix those destinations, you also foster walkability and bike ability. Even if you have to drive to, say, a downtown, you can access several different destinations by foot or bike. Ideally, public transportation too. I mention that in part because those are considerations that go into the walk score. I think we can connect these pieces just in a walk score. There are other iterations of walk score to promote both physical health and mental health outcomes. One issue that we're drilling in on at the Master Plan for Aging I Co-Chair the Community Development Community Design Subcommittee is accessible public spaces. Again, going to mental health. That's where people gather. If you can walk to a park or a town square or a trail you not only are getting physical exercise. You're getting mental exercise by being able to interact with other

community members. We're going to try to drill in on that and come up with some concrete recommendations that I think cross-pollinate very well here. As the Surgeon General just recently reported, when we're talking about, we can't compartmentalize mental and physical health anymore. Social isolation causes depression and anxiety. The Surgeon General just reported that those conditions exacerbate and even cause physical health problems. Greater access to fresh, local, nutritious food. Most of us have not confronted food deserts, but they're very real. When we're talking about community planning and development we're talking about food as a land use matter. Not just the stores, but the farmland that we seek to preserve. I think we can measure that access to food, access to nutritious food, again, especially in communities that experience hunger, malnutrition and food deserts. Open space preservation a key factor in community development. Communing with nature has a mental and physical benefits to it. As I mentioned, preserving agricultural land provides access to local food and nutritious food. One of the things about open space, green space, let me use that phrase, is that they're green. There are a lot of trees. There's more foliage what some of us referred to as urban forestry, urban greenery. That can have a direct effect on public health. Greenery cools the community. We are addressing the urban heat island effect in another agency, inter-agency initiative that DOH and NYSOFA are very involved with, and we are too that is trying to promote more trees and greenery for mental health for cooling effects. This is a burgeoning industry on the local level that can be measured because many communities now are actually doing greenery and tree master plans. They're measuring the number of trees, the extent of greenery. They're comparing it to communities, disadvantaged communities that suffer a severe lack of trees and greenery. This is another disparity, health care disparity that we can address. There are studies out there. Finally, we're addressing climate change, especially through our downtown revitalization initiative. Of course, if you're walking and biking and taking transit, you're not taking your car. You're cutting down on emissions. Ideally, the buses are green. You zero out emissions. Their climate has, as I mentioned, a urban heat island effect. That's a public health hazard as we saw recently. When we do our planning and development, we have our state energy authority, NYSERDA, at the table to decarbonize our buildings and to provide electric vehicle charging stations. All these pieces mix together to create more healthy, sustainable, equitable communities that once again have direct public health outcomes. I really want to go a little bit deeper outside of this meeting on how we measure those. That's obviously what we need to do. Let me just wrap up on a theme that many have brought up today, but Sarah, Kristen and Theresa have raised and that's interactions with folks outside of the public health world, this collaborative partnership-based approach. Back in 2019, we used some of my Smart Growth money for what we called the Age Friendly Livable New York Community Planning Grant Program. We did it with DOH. We did it with NYSOFA. I'm glad that Nora had a chance to chime in because they liked this program so much, they almost matched our million dollar grant program. They provided $700,000 to us to create county and local based age friendly health across all policy plans. Now, that's wonderful, but for me as a planner, my ulterior motive was to bring the planning and development departments on the local level to the same table with the county health officials and the county and local offices for the aging. That's a flashpoint for collaboration across those lines because there is a division. It's harder to do this type of collaboration on the local level. Local governments, local institutions are stretched in just keeping their heads above water. We did bring those folks to the table. I think that's a good basis because the health care world has been somewhat separated from the community development world. Just one quick example before I finish is that hospitals used to be viewed as islands, as fiefdoms on their own. Now, in part through our programming they become anchor institutions. We immediately invite them to the table because a hospital has land use outcomes, housing, transportation, equity, walkability. I think there's a

tremendous opportunity there for these sorts of partnerships and to bring these... You know, we talk about CBOs, we talk about community development organizations, housing developers to the same table as the public health and ageing constituencies. There's tremendous opportunity, I think, for collaboration. Planners are supposed to be generalists. We are a big table profession. We think we do that through our programming. We think that can contribute to the prevention agenda. Thank you.

Dr. Boufford Thanks, Paul.

Dr. Boufford Could you make a brief comment on the Environmental Justice Initiative? I think you've been leading that to the degree that it maybe touches some things you haven't mentioned as much in your remarks.

Mr. Beyer I'm not sure which... Environmental justice is kind of a broad based, cross-disciplinary cross programmatic concept. We see it. We've seen it elevated mostly in the context of the state's new Climate Action Plan, where we have a Climate Justice Group that watched everything, we did in relation to climate change to keep us honest and keep us focused on environmental justice communities. That concept is embedded in everything we do at the DOS, especially in our Brownfields Redevelopment Program and the Downtown Revitalization Initiative. Just one example is that we are locating affordable housing in desirable areas, downtown waterfront communities. We know that in the past, in past decades, affordable housing tended to be located in the less desirable areas. We're incorporating affordability, overcoming to the extent that we can displacement and gentrification there. We also have an eye towards clean land use. When we build projects through the Downtown Revitalization Initiative and others, like I said, we have folks at the table, the state and local level that are creating green buildings, which combat climate change, but they also provide a cleaner environment indoor and outdoor for residents. The environmental justice concept, fortunately, has evolved to the point where it's not an isolated initiative. We just embed it in everything we do. We have to in community development, again, because of the history of discriminatory zoning and land use policies.

Dr. Boufford Thank you.

Dr. Boufford While people are maybe thinking of questions for Paul perhaps ask again our Acting Director. I'm sorry. I can't remember your name. I know she was on the line. Just maybe thinking about commenting on the equity question again. Historically, the focus of the prevention had been more on race, ethnicity and less on economic inequities. I think there had been a desire to really connect the two going forward. Obviously, calls for racial geographic issues. I don't know if anyone from the State Office of Inclusion and Human Rights wants to say anything or whether Commissioner Morne wants to say anything. If not, we'll move to questions from the audience.

Dr. Boufford Anybody still with us?

Dr. Boufford Maybe not.

Dr. Boufford AG and markets joined. I know you're still with us, but again, they have been like Department of State have been very involved, especially looking at, as Paul said, really understanding and others have said, understanding the infrastructure networks that many of our state agencies have in communities and connecting those dots. I will invite. I can't see if they are still with us. If not, I wanted to call out the AG and Markets and Energy again who have been really active.

Mr. Lawrence Thank you.

Mr. Lawrence It's great to hear that all of the things that are going into planning and especially around equity and sort of trying to correct some of the historical injustices that have been, I guess, that have occurred in land use over time. One of the challenges, I think that we confront often in underserved neighborhoods is that as the livable space, livable environment begins to improve and you add trees and you add the ability to walk those streets safely, that you bump up against displacement, because as you mentioned, the real estate market responds in a market way. As neighborhoods improve people want to move into safer neighborhoods, more walkable and friendly neighborhoods. What strategies have you seen that are effective in mitigating displacement? Because there are a bunch of downtowns that have been improved and the people that were there are gone. There are other neighborhoods whereas you make these improvements people are displaced. They're displaced, primarily, I think, as a result of income. Because especially if the real estate is privately owned it's a free market. People are displaced. As a planning expert, what strategies are you seeing to mitigate that type of displacement?

Mr. Beyer Yes, Sir.

Mr. Beyer We do have strategies. Mitigate is a good word. I don't know if you can totally overcome gentrification because a revitalized community is now more desirable and real estate prices ultimately go up. The first line of defense is that we have homes in community renewal, the state agency handles affordable housing right at the table from the beginning of the planning process and right through to implementation of projects. We're putting affordable housing right out on the table and encouraging these communities when they repopulate their downtowns. That's a key to any community revitalization. You have to repopulate. We have affordable housing front and center through the DRI, Downtown Revitalization Initiative. Over half of the housing units, we're creating in these downtowns are affordable. Again, the first line is to get as many subsidized, affordable housing units created in a downtown. Those are... I wish I knew the complete answer to this. They are long term affordability. Locked in. They're not affected by the private market and surrounding real estate prices. To the extent that we can do that, not just in individual buildings containing affordable housing, but in what we call mixed income projects where we're integrating a level of affordability. 10% to 20%, many communities require that now that they be affordable. That is the first line is just lock in a certain number of affordable units that are just going to stay affordable. They're protected by the market and the gentrification process. The other thing we can do as an agency committed to equitable development is to insist upon affordability components to encourage, cajole, exhort. Remember, when we're doing our programming, especially the Downtown Revitalization Initiative, we have all the stakeholders at the table, the state agencies and the local stakeholders. When we put this on the table, and we encourage this in their applications to us to show us how they're not going to displace it's a pretty powerful force. I also think that the way we bring housing... Let's say affordable housing to the table with all of the other stakeholders and agencies there through a community development lens. Community development is so broad. We have to pull all those pieces together. I think part of the reason we've attained such a high level of affordable units through our programs is that we're not just looking at isolated affordable housing projects which often engender rancor, opposition, racism and such. We're saying to communities think of affordable housing units as one piece of a big fabric of a sustainable, equitable community. We do extensive community engagement upfront where we encourage this. I think we incorporate and

preserve affordability because we just have this big table where we're constantly driving it home on both the local and the state level.

Mr. Lawrence I think, you know, affordability it's pretty large basket. There's a segment of the population that's often displaced that can't even afford affordable housing. That's also a concern. As we improve their living environment we're also sort of, you know, I guess, lighting a match for potential later on displacement. Have you done any of the deal deed restrictions or covenants in any of your planning?

Mr. Beyer No, I don't think we have.

Dr. Boufford Maybe you can talk about that offline.

Mr. Beyer There was a time when deed restrictions were much more popular. I don't see them brought up a lot. The tricky part is we can encourage a community to deed restrict through community land trusts. They're a burgeoning industry now. They create affordability in perpetuity by owning the land under the property. The problem is that when you're dealing with land use and development mandates don't go over real well. We encourage localities to use those tools like an affordability quota. Many of them do. We just built a huge project in Westbury on Long Island near a train station that had its own affordability quota built into it. We can encourage communities to use deed restrictions and zoning and the community land trust. We're just real leery about telling them to do that or mandating it.

Dr. Boufford I'm going to move on, Harvey, if I may.

Mr. Lawrence Thank you.

Dr. Boufford Now, that's fine. They're important questions I'm glad you're asking them.

Mr. Beyer Absolutely.

Dr. Boufford Tina Kim from our Human Rights.

Ms. Kim I apologize. I was on another meeting. I know I was called. I did hear the remarks leading up to that point. Tina Kim, Acting Deputy Commissioner in the Office of Health Equity and Human Rights at the New York State Department of Health. I simply wanted to acknowledge the remarks and comments made regarding the various dimensions that contribute to inequities which inevitably impact health and well-being, but also impact a number of different areas in one's life. We recognize health equity can never truly be achieved without racial equity. At the same time, the Office of Health Equity in Human Rights is also actively working with program areas across the department to critically think about the dimensions outside of race and ethnicity such as but not limited to; geographic, cultural, socioeconomic, lived experience and life stage and other dimensions. While we recognize that health equity and racial equity are two different things, we understand and acknowledge and are advising the department's efforts on how best to address eliminating racism and racial health inequities. I just wanted to quickly comment and acknowledge that is a key focal point when it comes to the work that the Office of Health Equity and Human Rights are driving here within the Department of Health. Thank you.

Dr. Boufford Thanks, Tina.

Dr. Boufford I think there are, as you have heard during this meeting, there has been considerable appetite at improving the ability of initiatives like the prevention agenda to address health inequities, health disparities, etc., and also a desire for technical assistance, both in thinking about types of interventions and also measuring the outcomes, the effects of those interventions. We're delighted that your office is the consolidation has gone on to create the office and that division of the department is very exciting as a resource.

Mr. Beyer I think we're getting there in our community engagement programs at DOS. Good development starts with good planning. Good planning starts with effective community outreach. We are moving into the world of what's called trauma informed engagement, particularly in underserved communities of color. It was really enlightening to me. This should have been apparent that before you even start planning a distressed, disadvantaged communities of color you have to understand not just the trauma they've been through, but the layers upon layers of trauma. They all go to health really. We're testing this out in East Buffalo. Nora was involved with some of our outreach efforts. They're focusing largely on health, on access to food, on a history of proximity to contamination, not just in their homes, but in their communities. There's food security, contamination, protection against and response to natural disasters. These are all safety and health issues that communities have dealt with for decades. What was told to me. We got trained in this. If you don't acknowledge and address the trauma one, you'll ignore them. You may actually exacerbate them in your planning processes. That's just another approach of just that bottom-up infusion of equity right up front into the engagement, planning and then development process.

Dr. Boufford Other questions or comments taken out from Paul's presentation?

Dr. Bauer We have a comment here in Albany.

Dr. Moore A question.

Dr. Moore Having been involved in providing care at a federally qualified health center in rural communities here in New York and Pulaski, New York, and knowing the reason I was brought there was because if you look at the counties of New York and the average body mass index, Jefferson County and the counties in the North Country have the highest BMIs in the state and therefore then the highest development of Type Two diabetes and so forth. People on Medicaid. There are a lot of Medicare, about a third Medicare and a third Medicaid. The problems there are New York State's tax requirements that the local county do it's 50% match puts these communities in a spiral that they can't escape. Because they can't draw business there because of the tax burden people won't move there. Therefore, it's hard to get physicians to practice in those communities because as one of my mentors used to say, hard to keep them down on the farm once they've seen gay Paree. Physicians have a privileged educational life experience and not many want to go practice in rural New York. How does community planning address these issues here?

Mr. Beyer We did five... Four rounds of the downtown revitalization. We had an epiphany. We were not getting to the rural communities. I can speak to that from a resource and capacity side. Some of the communities that we wanted to get to the smallest rural communities. Because once you revitalize the downtown, you're attracting all types of investments, health care, housing. What we realized is many communities couldn't even put a grant together. They just don't have grant writers. I had a mayor at one of our forums. He said, I'm the Mayor of 100 people. He said, I do this on weekends and at the diner or at

the pub. He said, I can't write a grant. Here's how we addressed it. It goes all the way up the ladder. Not just grant writing, but some of these communities think, okay, if we get a grant who's going to administer it? We load it up with this new program, New York Forward. Equal amount of money to the urban downtown. $100 million a year. We loaded it up, loaded up on front end, technical assistance and capacity building, overarching issues in the planning world. We made it easy to start applying for these large grants. You just have to write a letter to us. You write a letter, one- or two-page letter. You get a consultant assigned to your community to help you develop your application and implement your grant if you're successful. Now, think about this for a moment. Some of these small rural communities have never had consultants. They just have never had the money or, like I said, the opportunity to apply for grants that bring consultants. We are, for lack of a better term, holding their hands guiding them through the process and building capacity. Again, from the planning and development world perspective it's all about local capacity.

Dr. Boufford Thanks, Paul.

Dr. Bauer Sorry, Dr. Boufford. One more comment in the room.

Dr. Bauer Dr. Greene.

Dr. Greene Just very quickly to wrap it up, if we're talking about the prevention agenda. Thank you so much for your talk and your principles and how much they impact health equity. If we're trying to build the next iteration of a prevention agenda that focuses on health equity, especially if we're having a built environment section, those principles should be right there. I mean, that was wonderful. If there's resources that you can bring to bear to local communities, if they pick one of those things, that would be amazing. Just tying those pieces together would be terrific. Thank you.

Dr. Boufford Anyone else, Dr. Bauer?

Dr. Bauer Not here in Albany.

Dr. Bauer Thanks.

Dr. Boufford You want to make any final remarks?

Dr. Boufford I'll just wrap up down here and we'll be right at time.

Dr. Bauer Terrific.

Dr. Bauer Thank you.

Dr. Bauer This has been really just a wonderful set of conversations. I really appreciate the little bit of wrap up, Dr. Greene. You know, one theme that I may be heard across the three hours is all roads lead to health. If we're talking about community development we're affecting health, mental and physical health, if we're talking about climate change, we're affecting health, mental and physical health. If we're talking about environmental justice. We can, in the prevention agenda, kind of frame these very broad and important issues. What I also heard is we need some specificity. We need to know how do we actually implement this? If we're looking at at health equity, we can... I don't know if we want to make a leap of faith or if we actually want to draw out the logic model. We can say if we

improve health equity we will improve X, Y and Z health outcomes. This is how we do it. This is what hospitals can do. This is what local health departments can do. This is how to engage your community organizations and what that variety and richness of community organizations can bring to the table. We can provide that kind of specificity, but not across 99 indicators of the prevention agenda, right? Not across 10 or 15 focus areas. As we look to the next iteration of the prevention agenda, there are some very tough decisions to make about what those broad priority areas are. There's a lot of specificity to put in there about what each of our stakeholders and partners can do, but the return is that we probably have a chance of affecting many, many, many of those 99 indicators over the very long term, which I also heard two or three years isn't going to cut it. Six years is probably just going to get us started. We can create a framework that will move a whole bunch of agendas here in New York Forward to borrow your program and bring more people, more organizations more effectively to the table. Thanks.

Dr. Boufford Thank you,.

Dr. Boufford Just to add a couple of things to Dr. Bauer's really, really important summary. I think we've heard this morning and early afternoon about the importance and the challenge, frankly, if we want to really move to address the currently much improved set of evidence and experience and informed basis of what we know about addressing social determinants of health in communities, I think is new relative to the last realm in which the provincial agenda was developed. The challenge of that has been loud and clear in the importance of interagency collaboration, as well as work with the public/private sector and the CBO sector. We have a lot of things going on. Part of the challenge of initiatives like the provincial agenda is connecting the dots. I think we've got a lot of ideas here. Over the next few weeks before we get back together again, we'll be doing that. I know the department will be doing that to inform some of their thinking about some of the proposals really for the next round of the prevention agenda to present. I think the other theme we look forward to working with Tina Kim and her colleagues on the equity disparities question and how that can be addressed as robustly as possible. The degree to which resources are really needed, resources and expertise to design metrics that work, metrics that link to the things communities are being asked to do, the role clarifying the roles of various actors and then trying to really get a good handle on results. Al of those things is very much in the conversation. I want to thank Paul and other agency colleagues. We look forward to continuing to work with you. Let me also thank Shane Roberts and Zara for their helping put this meeting together under Dr. Bauer's leadership. Our plan for next steps, we will have another meeting of the committee on December 5th. We'll announce the exact time that will be in New York City. It would be great if as many people as possible can come in person. We've had some I.T. telecommunication issues in the city. We're sure they're going to be fixed by the time that meeting is scheduled. Hopefully, for my colleagues on the state Public Health and Health Planning Council, especially the Public Health Committee, thank you for being as involved and committed as you have, Dr. Rugge, on the Planning Committee. We are working on scheduling. We'll be able to announce the next 24, 48 hours literally dates for what we hope would be two Public Health Committee meetings between now and December meeting of the Ad Hoc Committee to sort of take up many of these issues and get guidance from the council working with the department on priority setting. Again, thanks to all of you who prepared our first panel. Really appreciate it. Isaac, good luck on your thesis. You've got a great start. We'll all be there at your defense when you get ready to do it sort of publicly. All of you commented and stayed involved. We look forward to your ongoing engagement. We'll be back in touch with you shortly. Thanks very much.

Dr. Boufford I declare the meeting adjourned.