**NEW YORK STATE DEPARTMENT OF HEALTH**
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**
**PUBLIC HEALTH COMMITTEE**
**July 11, 2024, 1:00 PM – 3:00PM**
**90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC**
**TRANSCRIPT**

**Dr. Boufford** I'm going to convene the meeting and do the usual advice around webcasting, and then we'll maybe do introductions as there are a number of folks that are new to the Public Health Committee and new colleagues at the health department. I'm Jo Boufford. I'm the Chair of the Public Health Committee. I'm happy to call the committee to order and welcome our members and participants and observers. For webcasting purposes, I'd like to remind council members, staff and audience that this meeting is subject to the Open Meeting Law and is being broadcast over the internet. Webcasts are accessed at the Department of Health and should be available within no later than seven days after the meeting for at least thirty days, and a copy will be retained. Because of the webcasting there is synchronized captioning, we are asking folks to please not talk over each other. The first time you speak please state your name and briefly identify yourself as either a council member or DOH staff person. All the mics are hot. Side discussion should be avoided. We have a few people in the audience down here. If you wish to speak, you're asked to actually whether your wish to speak or not I think you're asked to fill out a form that's on the table outside so that there's a record of your participation. I think that's it.

**Dr. Boufford** Let me welcome everyone again. I wanted to perhaps go around. We're a small group. We have the eight colleagues here in New York City and colleagues, most of our staff colleagues are online. Not everybody. Maybe just go around the table. Everybody just introduce themselves very briefly, you know, where you're from. I'm just looking at Stanfort perry, who is one of our new members.

**Mr. Perry** Good afternoon. I'm Stanfort J. Perry. I'm the CEO at AHRC Nassau on Long Island.

**Dr. Boufford** Great.

**Dr. Boufford** Denise.

**Dr. Soffel** Denise Soffel, a consumer representative to the council.

**Dr. Lim** Sabina Lim from New York City, Mount Sinai Health System.

**Dr. Boufford** We'll have our staff colleagues here since we're all in the circle.

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

**Dr. Boufford** Jo Boufford.

**Dr. Torres** Anderson Torres, President and CEO of Rain Total Care and Co-Chair of this wonderful committee.

**Dr. Yang** Patsy Yang, a member of the council and with New York City Health and Hospitals.

**Mr. Eisenstein** Larry Eisenstein, Vice President Community and Public Health for Catholic Health on Long Island and formerly Nassau County Commissioner of Health.

**Ms. Farrell** I'm Lindsay Farrell, President and CEO of Open-Door Family Medical Centers, member of the council. My facilities are in the Hudson Valley.

**Mr. Thomas** I am Hugh Thomas. I'm a member of the council.

**Dr. Boufford** Dr. Bauer, up to you and your colleagues.

**Dr. Bauer** Thank you so much, Dr. Boufford. Welcome to our new members. And of course, welcome to our long-standing members as well. I'm Ursula Bauer, Deputy Commissioner for Public Health.

**Dr. Bauer** I'll turn it to Doctor Whalen.

**Dr. Whalen** Hi. Eliza Whalen, Medical Director for the Office of Public Health and formerly Commissioner for Albany County.

**Ms. Trolio** Laura Trolio, Deputy Director for the Office of Public Health.

**Ms. Owens-Cody** Hi everyone! My name is Keshana Owens-Cody. I'm the Office of Public Health Workforce Director.

**Mr. Rosenberg** Eli Rosenberg, Deputy Director for Science in the office of Public health.

**Ms. Alaali** Good afternoon, everyone. Zahra Alaali, New York State Department of Health, Office of Public Health Practice and the Prevention Agenda Coordinator.

**Ms. Gazitano** Good afternoon, everyone. I'm Gina Gazitano from the Office of Public Health Practice.

**Mr. Davis** Hi. Good afternoon, everyone. Chris Davis, Population Health Data Manager in the Office of Science, and I took the lead on our state health assessment.

**Ms. Brown** Afternoon, everyone. I'm Dove Brown in the Office of Public Health. I am the regional office liaison for the Public Health Infrastructure Grant.

**Dr. Boufford** Do you have other people up there?

**Dr. Boufford** We have one other person who's been wandering around helping us get organized. You want to introduce yourself? Can you?

**Jacob** Yes.

**Jacob** My name's Jacob.

**Dr. Boufford** Anybody else up in Albany?

**Ms. Leonard** This is Colleen Leonard. I'm the Executive Secretary. I'm on Zoom today.

**Dr. Boufford** Oh, I see you're hiding. I don't see your picture.

**Dr. Boufford** There she is.

**Dr. Boufford** Thanks, Colleen.

**Dr. Boufford** I want to do a little bit of just... I'm not going to spend too much time, but a little bit of background on the Public Health Committee itself and our role for those that are joining us for the first time. I'm going to come back just before we do the second half of the meeting on the prevention agenda to provide some context for that before we move into it. The Public Health Committee is it plays really the lead role for the PHHPC to meet its statutory responsibilities to approve the prevention agenda, which is the term that it's being used for the state health improvement plan, which is required by state statute and also by the Obamacare, by the federal law for community benefit responsibilities of the hospital industry. Our practice has been to be involved in the shaping and oversight of that activity, but also each year or two, depending on the issue we pick another issue that with the department, in collaboration with the department that we think is of significant importance that we agree. We then try to use our, if you will, public platform, as well as the activities and the authority of the PHHPC to maybe move that issue along and give it more visibility than it might otherwise get. And in the past, we've done that on maternal mortality, which we think made a significant difference. It was a good year or two before the commission was developed. I think there's been a sustained interest. The issue that was selected for the next year or two was public health workforce, which we have all thought was a critical issue. Obviously, there is in the state budget issues there about the health care workforce, but not the public health workforce. That's the one we picked. We've had an initial briefing. We'll hear more today on the progress of that office. Today's meeting is we're going to pick up those two items. We'll hear first from Keshana Owens-Cody, who is the Workforce Director for the Office of Public Health. She's going to give us a sort of progress report on what she's been up to. She had a significant responsibility to stand up a significant office from a sort of standstill point early before the year. That was our first exposure to her work. She is going to have more to tell us today. I think our goal whether we can do it today or not is unclear is to identify the one or two issues where she thinks we could be the most helpful to her. We'll have that discussion today and then see where we end up. The second half of the meeting it's maybe going to be a little more than a half will be just having a presentation by the department on the proposed framework for the prevention agenda cycle 2025 to 2030. We have been asked, as you may recall, from the last activity, I think of the PHHPC meeting a week or ten days ago was that we are now charged to approve or raise concerns, but hopefully approve that proposal on behalf of the PHHPC today, because the next PHHPC meeting is not for a while and the department would like to get underway. We'll be operating more formally than we normally do because we do have a decision to make. That'll be our resolution at the end. We will have a time period for public comment before we close the meeting because of that.

**Dr. Boufford** I'd like to begin with Keshana Owens-Cody and ask her to present her progress report to us and her thoughts about how we can be most helpful.

**Dr. Boufford** I'm sorry. Ursula, please make your opening comments. I apologize.

**Dr. Bauer** Thanks so much, Dr. Boufford.

**Dr. Bauer** I'll just echo that we're at a very exciting point in our prevention agenda planning for the next cycle. I especially want to thank you, Dr. Boufford, for shepherding us, to this point and to thank our lead staff Zahra Alaali and also Shane Roberts, who

joined us for this meeting, even though he's left the Office of Public Health for their leadership in bringing us to this point. It's my pleasure to re-introduce Dr. Whalen. I mentioned at the full PHHPC meeting that she has joined us in the Office of Public Health as Medical Director. Importantly, she is taking over the leadership and support role for the prevention agenda and will be working closely with Zahra and her team to bring the prevention agenda to implementation. Thank you, Dr. Whalen for your leadership and guidance. I'll also note that I will be leaving my position here with the New York State Department of Health at the end of this month. I'm very proud to be leaving the Office of Public Health in a much stronger position than I found it three years ago. Really proud that we have such a strong and competent team in place moving forward. Really excited to see where the prevention agenda goes in the next cycle. So proud of the work that we've been doing with workforce.

**Dr. Bauer** With that, I will turn it over to Keshana Owens-Cody.

**Ms. Owens-Cody** Hello again. I'm going to advance or share my slides. Happy to be here to provide an update on where we are with the Public Health Infrastructure Grant. I did bring two of my staff members with us to give some updates as well. As you all may remember or from previous meetings I did share that the CDC Public Health Infrastructure Grant team. We were building a team, as you mentioned, Dr. Boufford, where I was the only one on staff. We've built a pretty robust team. Our hiring has kicked up quite a bit I would say not even just with the public health infrastructure implementation team, but we've hired over forty staff that are being placed across the Office of Public Health. Each one of these units. We do have a Public Health Continuing Education Director on staff now that is really heavily looking at training and development needs of the public health workforce, not only for department and regional office staff, but also our local health departments. We have our Community Engagement Director on staff. Our health, wealth and wellbeing unit. We've met Natasha in the past. We also have our liaisons that are on staff. One of the partnerships that I wanted to highlight today is we wouldn't be successful with all of these hires and recruitments without our human resource team. I wanted to share with you how we're working very collaborative with our human resource departments both for health researching as well as the department's human resource department or HRMG. Three areas that I would say we've really focused on in terms of collaboration and engagement have been around recruitment, workforce development and engagement. We've been able to dig into a lot of the job descriptions that we're writing. Being very creative on how we are reaching candidates and attracting candidates to apply for public health careers. We've developed new titles. We've also been kind of digging into the review of the recruitment cycle overall and how we can make adjustments and impact there. From a workforce development standpoint, we have been reviewing what current trainings are offered, and how we can provide a lot of the resources that we have within the grant to increase different training and development opportunities through many different partnerships. Some things are expanding on current training and development partners, such as the School of Public Health, working with Cornell University and expanding some of the activities we had there, but also exploring other training providers to bring in-house as well. We've also developed an internship program we've piloted inside of the regional offices initially. We hope to continue that growth there. We initially piloted and I will definitely let our regional office liaison share more about this too. We initially started with the regional offices because we know sometimes it's challenging for them to have paid internship opportunities. We plan to expand it and share more with having another liaison come at a future meeting. And then the last area, I would say in terms of engagement, just engaging the public a little bit more into what different careers exist in public health. We've been attending different academic institutions, community events,

career fairs just to educate the public on careers in public health. Something else that we've done is work with both HR departments, along with our academic liaison kind of in the middle to create what is our approach when we're collectively going out to recruit staff to come into public health careers? We've been very collaborative. One of the things I wanted to share or celebrate is just acknowledging we participated in a webinar that Dr. Heather Krasner facilitated, actually both for New York and New Jersey and HRMG, which is the Department of Health's Human Resources Department, as well as myself participated on a webinar where we were educating the public on how you apply for a job in public health. The local health departments also had their own day. Participated in that as well. I wanted to just acknowledge we're also strengthening our relationships with our human resource teams to be able to really be the backbone of our Public Health Infrastructure Grant. We'll continue to provide you updates on unique partnerships that we're bringing to the table, but I at least wanted to spend some time sharing, how that's going with our HR Department.

**Ms. Owens-Cody** I'm going to pass it to Deborah Brown, who will talk a little bit about regional office updates that she has.

**Ms. Brown** Thanks.

**Ms. Brown** Again, my name is Deb Brown. I'm the Regional Office Liaison for the grant. I'm just going to provide some high-level regional office updates.

**Ms. Brown** Next slide.

**Ms. Brown** I just wanted to briefly touch on the goals and outcomes of the grant activities, which is to overall strengthen the capacity of the Office of Public Health, the regional offices and the local health departments in New York State. The PHI grant focuses on three main strategies to achieve the goals and outcomes listed here, which is workforce, foundational capabilities, and data modernization. The priority short term outcomes we want to achieve include improved organizational systems and processes, increased hiring of diverse public health staff. We want to engage with communities across New York State in public health program development. A few more of those long-term goals and outcomes are to increase the size and proficiencies of the public health workforce, right? Having a stronger public health foundational capability, increasing the availability and the use of public health data, and being able to share those best practices to make informed decisions to reduce health disparities and inequities affecting our communities. I wanted to highlight the regional offices throughout New York State that I provide support for through our grant. For those of you who aren't familiar, if you look over to the left in the yellow and blue counties, we have the Western New York Regional Office, which has locations in both Buffalo and Rochester. In the middle of the map, we have the Central New York Regional office, which sits in Syracuse. Moving over to the right, orange counties, we have the Capital District Regional office, which is currently being reestablished. Last but not least, at the bottom we have the Metropolitan Area Regional Office, which encompasses a New York City office, a Central Office that serves Nassau and Suffolk counties, and then the New Rochelle Office. As I've mentioned earlier, one of the goals of the grant is to really build up the public health workforce, especially in our regional offices, and particularly for positions that might be harder to fill in more traditional ways. This chart reflects the positions that have been allocated to each of the regional offices through our grant based on their needs. I am supporting each one of them and actively recruiting these positions. What I really want to point out, and what you'll notice across all of the regions here is the need for public health nurses and public health representatives, which includes public

health sanitariums and emergency response reps to name a couple. What we found through recruitment is that these positions are the hardest to fill. A lot of our recent efforts have been focused around recruitment and retention strategies for these vital public health positions. As you saw on the previous slide, there's a lot of positions to be filled across the region. I just wanted to provide a quick update on the recruitments as of June. The Capital District has recruited three people and is actively working on that list as they're being reestablished. The Central New York Office has three. Western New York has two with one position in progress. The Metropolitan Area has four positions in progress. As Keshana mentioned earlier, you know, through the grant we've also created this Pathways to Public Health Internship Program, which is creating and offering internships in the Office of Public Health and in the regional offices. We're very excited about the opportunity to source and recruit individuals from various experience and education levels, including multidisciplinary fields of study. We want to establish these pathways into public health careers. We were able to pilot this for the Summer. We have three internship placements in Central New York and then one in Western New York, as well as a couple in Office of Public Health. We're looking forward to increasing that capacity for the Fall and expanding that into other areas in our department as well. Lastly, I just wanted to emphasize that the grant recognizes the importance of increasing public health job opportunities throughout New York State. By collaborating with the regional offices, we are embedding grant staff within the regional office locations. We have our local health department liaison in the Central New York Office. We're currently recruiting for several positions within the Community Engagement and Outreach Unit and the Public Health Continuing Ed unit that will also sit across the state as well. Through these activities, we're working to develop best practices for staffing across the state and how that can support building a more diverse and robust workforce.

**Ms. Brown** I will now turn it over to Meredith to share some LHD updates.

**Ms. Patterson** Thanks, Deb.

**Ms. Patterson** Good afternoon, everyone. My name is Meredith Patterson. I use she/her/hers pronouns. I'm the local health department liaison for the Public Health Infrastructure Grant. We'll switch gears here. Excuse me, and I'll provide an update on our LHDs.

**Ms. Patterson** 40% of grant funding has been dedicated to the fifty-seven LHDs located outside New York City. This investment in the local public health workforce and the foundational capabilities of our LHDs is intended to address weaknesses in the public health system and to strengthen the preparedness of our LHDs to address new challenges and future public health emergencies when they arise. The expected short-term outcomes of this funding among our LHDs include improvements to the LHD workforce, including hiring new public health positions and filling vacant public health positions, retaining public health staff through various workforce investments and services, and improving foundational public health capabilities within our LHDs. The expected long-term outcome of this funding among LHDs includes improvements in the public health of the jurisdictions that are LHD served, especially among our socially and economically marginalized communities. As I mentioned, 40% of grant funding has been dedicated to the fifty-seven LHD's outside New York City. This amounts to an investment of just over $43 million in our local public health workforce. As of June, we have contracts with fifty-six LHDs who've accepted this funding and have approved forty-seven LHD budgets. Those LHDs are approved to spend their grant funding to support their workforce in the ways that work best for those health departments. Our LHDs have many options when it comes to deploying

these funds with allowable expenditures falling within four broad categories, including hiring new public health staff, public health staff, retention and job satisfaction efforts, expenditures that increase foundational public health service capacity, and expenditures to strengthen the capacity of LHDs to address health inequities and disparities. Much of the work that I do in my role is centered around supporting our LHDs and using their funding in ways that achieve the outcomes of this grant and also fulfill each LHDs unique workforce needs which vary by LHD. To that end, we've worked to increase the support that we provide to our LHDs and the engagement that we have with our LHDs through various means, including quarterly email bulletins like the one you're seeing on this slide. I also offer monthly drop-in office hours for our LHDs to ask questions or to troubleshoot. Deb and I, along with our grant administration team are always available to meet with our LHDs by request as well, and we do so quite frequently. Additionally, in partnership with NYSACHO, we host quarterly meetings with our LHDs to provide high level grant updates and support. Finally, we provide a number of resource guides to assist our local health departments in using their funding and submitting their budgets to us. Just to provide an example of what that might look like. We've provided our LHDs with an expenditure resource guide, which helps to break down the kinds of expenditures that LHDs can pursue with their funding. So, for instance, what you're seeing on this slide here is just a snippet from that guide that outlines one allowable expenditure staff resiliency programming and resiliency resources. Those expenditures fall within the broad category of staff retention strategies. The intention of this document is to support LHDs in choosing expenditures that stay true to the intention of the grant and that also fulfill needs within each LHD workforce. At this point, we're about halfway through year two, a little over halfway through year two of this grant. I wanted to give you a sense of how LHDs have used their funding so far. You're seeing here a breakdown of some of the most frequent expenditures we've seen. Just to highlight a couple of things. The most frequent expenditure we've seen is conference attendance and training opportunities for LHD staff. Our LHDs have been able to provide those continuing education opportunities for their staff using this funding. Additionally, we've seen many of our LHDs fund new public health positions with this funding. We've also seen many of our LHDs retain public health staff who were funded through other expiring funding sources. These are staff who may not have otherwise been able to stay within the local public health workforce but were able to do so through this funding. We've also seen a number of investments in staff retention, staff retention payments, longevity payments, tuition reimbursement, just to name a few. Our LHDD have been able to do some really great things with their funding so far and there's certainly more to come on this front as well. I hope you appreciate these updates.

**Ms. Patterson** I'll pass it back to Keshana to close us out.

**Ms. Owens-Cody** Sure.

**Ms. Owens-Cody** I guess from here will open the floor to see if there's any questions that you may have of us. We hope that you've appreciated the updates that we're providing from both department and regional office staff, but also the support that we're also extending to local health departments.

**Dr. Boufford** Thanks very much.

**Dr. Boufford** I encourage questions but also some thoughts about what some of the issue areas are that we might want to work with you on, Keshana, you and your team.

**Dr. Boufford** Dr. Eisenstein.

**Dr. Eisenstein** Thank you.

**Dr. Eisenstein** Thank you for the presentation. I left the Health Department two years ago. The grant that I was waiting for twelve years finally came. But, to me, this is one of the biggest issues, one of the biggest dangers affecting public health in New York State. I was the Commissioner for almost twelve years, and for twelve straight years my staff was cut. The bottom line is when you're paying nurses because it's union contract. There's no debate about it. There's no negotiation. Maybe you can get a waiver literally a third of what the hospitals are paying. When inspectors have to have a bachelor's degree that science based. You start paying them the low $30,000 range. You can't expect good people to stay. Over the years, we saw a lot of different things. We saw the CDC apprentice program over a decade ago, which means of sending people and then various fellowship programs and interns. We had close relationships with universities on Long Island and had twenty, thirty, forty interns a year. The bottom line is there really the incentive for people to stay in local public health. That endangers the health of everybody in the community. My hope and one of the things that I'm most passionate about and I can't believe it's the first meeting that I get to comment on this, because this has been simmering with me for years is what can we do? This is not a direct question to anybody. It's just the thought out loud. What can we do to secure a sustained public health force? Not grants that come and go with the politics and initiatives that we're trying to get people to go. Public health programs, I teach it two of them are loaded with people getting master's degrees in public health. Now, entities like hospitals are hiring people with those degrees. They're not going to go to a local health department and make half what they can make at a hospital. Is there something we can do? Is there a strategy? I think some of it was said. I thought the presentation was great. This is certainly in no way a criticism of what the state's doing. I appreciate what they're doing, but I think it should be an important agenda item for us to try and find some kind of sustained way to protect our health department workforce, because we're not going to be prepared the next time we need them to keep us all alive. It's that simple.

**Dr. Boufford** Thanks very much.

**Dr. Boufford** Dr. Yang.

**Dr. Yang** Let me just ask one question, which is, and I don't... I may not be phrasing it in a way that doesn't sound disrespectful, but the outcome of the Public Health Infrastructure Grant is recruitment retention not tied to a service or a delivery or program area, right? Whether it's regional or local health department. I would be asking this if I were still my thirty/forty years in New York City or Westchester health departments, which is I think, you know. It's tied to the prevention agenda and our larger conversation, which is what is public health, right? I mean, MPH all over the place and hospitals hiring MPH is a good thing. It is a good thing. Public health is a good thing. We talk about health in all policies. We talk about the broad aims of prevention agendas. We have this little one thing. You know, we're talking about local health departments, state health department, hospitals. Lumped are community partners. Community partners are poverty, health, economic, business, environmental development, neighborhood education, all of those things. I think the grant is critical and infrastructure is critical. This struggle that we've been going through for decades has been, I think, integrally tied to the definition and the value that public health offers that argues for itself continued investment. It varies by locality. It's got to be responsive to local needs. I'm not saying that one health department is every health department. It's not. Every community is different. They have different needs for public

health nurses, stuff like that. What is the relationship for local public health and state health departments and state regional offices and state central office? What's the relationship with the health care providers with DTC and FQCS? What's the facilitating and supportive and wraparound, the glue that holds everything? Where is the soapbox for data that tells people if we're as a society in a community being honest about how healthy and resilient we are. Are we regulatory? Are we environment? You know, we are so many things. If we think that we're still everything and haven't updated it. We're health in all things and not. Public health is where? I think that's the struggle for resources. That's all I wanted to say.

**Dr. Boufford** Dr. Soffel.

**Dr. Soffel** It's not exactly piggybacking, but there was an item on Slide 14 about what the LHDs can use their money for. One of them is increasing foundational public health service capacity. And after listening to Dr. Yang, I'm wondering, for the purposes of this grant and this exercise, how is increasing foundational public health service capacity being defined and being measured? How will you know that you have, in fact increased foundation? What do we mean by foundational public health capacity? How will we know that we have increased it?

**Dr. Boufford** Why don't we ask colleagues to respond to that? I think we had some good context statements from our first two speakers, but I think it does link to, part of the presentation. Our colleague doing the local LHDs, I guess, or anybody actually.

**Dr. Bauer** I'll just jump in and then turn it over to my colleagues. The Public Health Infrastructure Grant actually has three components, one of which is foundational capabilities. That's well defined within the grant in terms of what are the foundational capabilities that really all public health organizations should have at the local, state, tribal, territorial, federal level. That's one component. The hiring component is by far the largest in terms of funding, the workforce recruitment and retention. That's where you saw quite a bit of the resources being, dedicated.

**Ms. Owens-Cody** Sure, I can add to that.

**Ms. Owens-Cody** Like you said, a big component or the second component of the grant does focus on our strengthening foundational capabilities. We do have a program evaluator that's also tied to this grant that. As mentioned, there's performance measures that we have through the CDC that we have to speak to make sure that we are strengthening those core areas. Our engagement with NYSACHO and the meetings that Meredith mentioned that she has with the local health departments help us to just make sure that we're also providing the right resources and supports so that they can strengthen those different areas as well. We do have performance measures that we have to answer to through the CDC. We do share that with the local health departments as well.

**Dr. Boufford** I think the question was what are the capacities that are designated in the grant? Perhaps we could see those, or somebody could outline them now. I think this may offer an opportunity for some cross fertilization or support. What are those? How does CDC define them? I think that's probably the question.

**Ms. Owens-Cody** Sure, I can share them. I can share them offline, like where you can see the actual breakdown if that helps. It is the core foundational, foundational capabilities. I can even pop it up on screen if we wanted.

**Dr. Bauer** Assessment and surveillance, community partnership development, equity, organizational competencies, policy development, performance management, emergency preparedness, communication, the foundational things that we do every day in public health.

**Dr. Boufford** It's sort of like a... The frame that I was familiar with is the essential public health functions, which CDC designed some while ago. It sounds like this is a maybe update or somewhat consolidated version of those functions, which I think would be really helpful to have the detail for the committee to have the detail.

**Dr. Bauer** As Keshana noted they're really aligned with the Public Health Accreditation Board and the framework.

**Dr. Boufford** Can't read them.

**Dr. Boufford** Maybe we can get this slide and follow up. That would be super helpful to have that. As my colleagues have raised. I mean, one of the real issues the sort of bottom-line issue is lack of investment period in public health. I think this ability with the initiative that you have and the grant that you've received. It might be an opportunity to really take a look at where can we get the most bang for the investment of time? In terms of maybe attracting resources, I have to say I apropos of both folks' comments. I mean, there was a significant line item in the Governor's budget this last year to address the shortages in the health care workforce. What would we want to think about how one might position us to get something going in the public health workforce, which I think touches on some of the issues people have raised. What would it be? What's the definition? How do you make the case? That's something for us to consider and think about.

**Dr. Boufford** Other questions or comments from other members?

**Dr. Boufford** Mr. Thomas.

**Mr. Thomas** Just a quick question. You know, I pulled up the one-page summary from the federal government. Maybe the Commissioner could answer this or one of her colleagues. There's a total of $4.35 billion countrywide. Anybody know how much was awarded to New York?

**Dr. Bauer** About $136 million over five years.

**Mr. Thomas** Over five years that's what I want. That really gets to the heart of the comments that in five years you will have probably used $106, and you'll have a great story to tell, but then we're back into the federal appropriations process in order to continue that work. The way the federal government frames this is have been a 15% reduction in workforce at the public health workforce over the last ten years. This is a Band-Aid. This isn't an advocacy group. Getting back to the comment it's not a sustainable... $106 million is a lot, but really it's not really that much for a state of this size over five years. Anyway, it's just a comment.

**Dr. Boufford** I mean, two points you raised. One of them is I was going to ask the period of the grant because I couldn't remember exactly. If it is over five years, it gives maybe a glide path for thinking about how might we work with the state of New York relative to sustainability? Because you're absolutely right. Otherwise, it's one-off fellowships and

internships and other things. It's hard to build capacity in a short term if you're serious about it. I think that's really important.

**Dr. Boufford** Dr. Lim.

**Dr. Lim** I just have a related question. At the end of the five years, are there any sort of quantitative measures of success? Are they looking for whatever ex improvement in percentage of positions filled? Is it more sort of qualitative and literally setting the foundations?

**Dr. Bauer** Certainly, we had to specify our hiring target that we would meet over the five years. There are also operational targets, which I think are very important in terms of how we go about hiring in state health departments and state agencies. Overall, it can be a very long and bureaucratic process. What can we do in terms of quality improvement to make that process more efficient? CDC is actually asking us to look every six months at what's the time from position posting to onboarding? Doing something similar with procurements and contracts. What's the time period between releasing a request for proposals and actually getting a contract in place? We want to really shorten those processes and make them more efficient. There are clear hiring and retention outcome metrics. There are also these kinds of operational improvements that we hope to make, which really are kind of the bread and butter of what we need to do to be effective in our public health work.

**Dr. Boufford** Mr. Perry.

**Mr. Perry** My question relates to strengthening capacity to address and improve health inequities and disparities. What's the crosswalk to those communities that have been most disenfranchised in terms of access to high quality healthcare, especially those with intellectual and developmental disabilities? How do we make that connection through this funding?

**Dr. Bauer** This funding is really on the public health side. We don't actually address health care through this funding. What we would hope to do is increase our state capability, local health department capability to engage with communities to reach deeply into communities. I see Natasha put her video on. She's working on an innovative, program to look at wealth building and communities. How do we instigate economic improvements that we know will have health improvements over time? It's looking at the population health component rather than the health care component.

**Dr. Boufford** That question may come up later in the discussion of the new framework approach for the prevention agenda.

**Mr. Perry** Very good.

**Dr. Boufford** In terms of the access and quality question you raised.

**Dr. Whalen** There's ability within this grant. When we look at the workforce that we have traditionally used to see how we can advance strategies within the workforce to build equity and reduce health disparities. Particularly, looking at the workforce, utilizing community health workers, which has been very important for local health departments. Not all of them utilize community health workers who are members of the community that they are serving serve as trusted messengers and really have been found through a lot of

evidence to be able to affect a lot more change. I think that there is a strategy within looking at the workforce to see how the workforce can be used to reduce health disparities and build health equity.

**Dr. Boufford** Well, and also including disabilities around hiring issues. Just looking at that as a potential group that could be tapped for the positions the efforts are being made to fill those positions.

**Mr. Perry** I would agree and targeting those groups that have been most disenfranchised. There are populations that are deeply entrenched who are not receiving the level of access and support that they need to do well. Without those targets, how do you know then that those people are even being reached?

**Dr. Boufford** There would be sort of more information about that if some of the workforce had representation from disability populations.

**Ms. Farrell** This is a comment and then I think it's a question. There's nothing more frustrating than having duplication of services at the local level, specifically focusing on maternal and child health. In my experience working with several health departments, you know, there's personal care services being provided when there are well-established FQHCs, for example, in the delivery system in that particular county. Sometimes it almost feels like they're these sorts of legacy approaches that haven't evolved with new capacity that's created in communities. Is there any way that this grant might be able to consider duplication of resources at the local level, either through community partnerships or through the delivery of maternal and child health services, for example? It's frustrating when we're not working collaboratively and sometimes even competing.

**Dr. Boufford** I think one of the notions a few years ago was for the public health to get out of the services business. However, unfortunately, that was a source of revenue to deal with the issue we've been talking about. I think it's been in that notion sort of in the pipeline for some time. It's a reasonable question.

**Dr. Boufford** Dr. Bauer, do you want to take that on?

**Dr. Bauer** I'm actually not sure I understand the question. Local health departments are providing for example, maternal and child health services. I agree with Dr. Boufford that most health departments have gotten out of that business.

**Ms. Farrell** It's interesting. I mean, sometimes it's political, their jobs. Whereas, you know, a non-governmental provider can hire staff much more cost, effectively allowing those dollars to go to the essential public health functions that are lacking in the community.

**Dr. Boufford** It might be an item to think about in the work, especially with the local health departments taking a look at that because obviously it's going to be location by location in some ways, I think.

**Dr. Yang** I agree. Again, look, depending on the locality, it may be that the local health department is it. They're in a rural area. A health care facility within reach. That public health nurse is the lifeline. In other places there is that it may be legacy. It is duplication. There's so much to do that there's no reason for overlap or competition. I think that kind of that not letting go and moving forward is to the detriment of identifying what value public

health brings to the table. That argues again for investment for continued infrastructure support, not just a grant that's going to come and go. It is core stuff that we can offer.

**Dr. Whalen** I think these are really important points. You know, from the perspective and I'm sure Larry can share a lot of these thoughts as well of having operated a local health department for eight and a half years. In New York if you know one local health department you know, one local health department. The situation of being within a community that has almost an embarrassment of riches, where you have competing people competing for public health programs is not common. It's not common. I think in most counties it is clearly delineated. There is that collaborative work that occurs between the community-based organizations, between the hospitals, between the federally qualified health centers, so that the work is more synergistic then competitive. I do agree that all of us in public health want to be able to do the most with the least resources. Therefore, it does not make sense to do duplicative, programs. I think when I look at that and how that could be addressed, I tend to look a little bit more to the third arm of the Public Health Infrastructure Grant, which is a huge thing called data modernization. How do we know when we look at programs and services where these programs and services exist in particular counties? There are many counties that utilize the 211 services to figure out how to access specific services in their counties. There are other counties that are not organized and there are other counties, as I said before, who have so many different health systems within the county that it's difficult to discern who is doing what. It is much more likely that there are multiple people trying to do the same things. These are really good questions and good thoughts for public health going forward. I think that from the perspective of the grant this is why we put so much emphasis on the local health departments doing what is best for them because they are best positioned to understand the landscape in their communities and how to utilize these resources.

**Dr. Whalen** I'm sorry. I just want to add to it or acknowledge that we do have a community engagement unit too. It might be great for like in future meetings for them as well as the Health, Wealth and Well-Being Unit to speak to community engagement because we are looking at that even in terms of hiring like that was mentioned, I believe, by Dr. Perry that we're looking at how do we also in terms of like aligning with the eliminating health disparities. How do we also attract different non-traditional roles? We talk about non-traditional pathways into public health quite a bit within the team and how to bring in community, lived experience, community voice into our activities as well. Our Community Engagement Unit will be boots on the ground, as Deb mentioned, that they will also be placed in the regional offices. That will add also strengthen as it relates to community engagement as well. Recognizing all those different partners that are doing public health on the ground as well and seeing how we can provide resources, education and training to them as well.

**Dr. Boufford** Thank you.

**Dr. Boufford** Five more minutes on this one because I want to honor, give ourselves enough time for the second item.

**Dr. Eisenstein** Dr. Whalen's comments were right on. You know, one of the challenges with this is as staff gets cut at local health departments and even at the state, more and more you're limited to what the law requires you to do. There's no discretionary money left in public health. I'm hoping that the grant can help us achieve some discretionary results, because literally of the staff that was left when my time there was over in Nassau all of them were basically doing what the law said. The bare minimum we had to do. The only

thing we had that was not mandate is we opened a Health Equity Unit, which should have been mandated by the way. That was the one thing that wasn't that we did. But as far as things like competing, the last thing I think in the world the health department wants to do is compete with a provider who could do it more efficiently and better. When I started, we had five sites. One of the federally qualified health centers finally applied and won three of them away from us. We were sad for losing it, but we weren't because a better equipped provider won it. These are competitive grants. Part of the problem is the community clinical partners have to know about these things and be willing to go get them. The only two left, the only two sites left in Nassau are literally run by Nassau's Health Department because nobody else has ever applied for them. Nobody else wants them. Local health departments that are not clinical. If you look, for example, at the grant since it came up. There's a criteria as to who should win the grant. A non-clinical health department is like dead last. Anybody else who applies that's competent should win that award before that clinical health department. Maybe part of the strategy is to say to our clinical partners and community partners, hey, why aren't you guys applying for this? It's good for the community. It's good for your infrastructure. It's good for public health of everybody.

**Dr. Boufford** I mean, maybe I think the notion of this community engagement group perhaps focusing on us understanding more what the thinking is there would link to a lot of these issues that are being brought up.

**Dr. Boufford** Dr. Torres has the final comment. I'm going to ask a couple of questions and then we'll close.

**Dr. Torres** You know, in listening to the contributions of all that have spoken I'm thinking being within a very local neighborhood. How do we demystify service delivery? How do we honor and acknowledge? Not so much necessarily feel that we're competing with the community resources. We're challenge also some of us more than others with population shifts. They've been major. Taxing our resources in such a way that we may not be able to be efficient in our delivery. How do we create the partnerships? How do we look at the restructure without eliminating vital services and working closer together? I mean, those are my reflective thoughts because of my dealings with the local health department. I mean, it's great when you know the people you need to reach out to, but that information is not readily available or visible in the community.

**Dr. Boufford** A community partnership issue, I think it's definitely a theme we want to hear more about from the Community Engagement Unit and in general. I was thinking earlier around the sort of public health practice question that I think Patsy opened up. The issue of Public Health 3.0 really is about public health being, if you will, the coach or the convener to assure the health of the community and that inter sectoral partnership development is not necessarily something like sitting in a school of public health that we are teaching, even at a master's level. It's new. I think a lot of the faculty and others that have been involved in practice. It's a new undertaking. That would be something that would be really important, I think to emphasize here. Two other just observations I wanted to make. One of them is that this is in the connect the dots category. CDC also has a very significant grant to the National Hispanic Health Foundation to focus nationally on increasing the diversity in the public health workforce. I can connect whoever's involved there. I think it's a really serious undertaking. It's a longer term looking, especially at Hispanic, African American, American Indian opportunities for getting public health publicized in those communities, getting people interested in it so they even know about it, which is one of the issues that's certainly surfaced from discussions on that grant and with the Hispanic community is a lot of young people don't even know that there is an

opportunity in something called public health. They're thinking about medical school or nursing school or some other health care providers. That's one thing. The other thing, and this is not your responsibility, but I just want to plant the seed for it. There is no statewide organization of deans of public schools of public health, which has always been an issue and an interesting thing. I mean, they sort of made a run at it. I guess it was the year before COVID. I only raise it as an opportunity. There is a statewide group for medical deans and nursing deans. I think the dentists go to that occasionally. It's based out of New York City. I don't think it's terribly active. I just sort of put that out there as a challenge to think about in this process. Because I think there would be... It would make it maybe easier for the department to tap into some of the expertise across the schools of public health across the state, not just some of the ones that are more convenient or easier anyway. I think what I'm hearing as, as areas of interest A, congratulations on this. Everybody's very excited about it. Maybe the two themes we want to think about is for you all to consider and come back to us and let us know whether you think this would be useful. One would be could we use this committee and its meetings as a sort of glide path looking towards budgetary issues, increasing funding for public health as the grant goes through its finishing stages? The second one would be this area of community engagement, partnership development. We're done avoiding redundancy, making sure that public health dollars are able to be used where they're badly needed. Does that make sense?

**Dr. Boufford** Anything else people want to flag for maybe next steps consideration? Maybe next time we bring you all in. If it's a September conversation or in between maybe Keshana you could sort of indicate which ones seem of interest to your team and then we could start to maybe think about focusing a discussion at our next meeting there.

**Dr. Yang** Maybe talk about a little bit more. Sorry. Not just that we funded or hired or retained that many people, but what they did.

**Dr. Boufford** I think this is one of the elements of this capacity building. You've heard. I mean, the slide you showed. What are the elements of the capacity building agenda? You're going to be evaluating progress on those as well. That would be an element I think we want to hear more about, because there may be something there that we can.

**Dr. Yang** We want to make that case.

**Dr. Boufford** Making the case that's the issue. Thank you for adding that.

**Dr. Boufford** Thank you very much.

**Dr. Boufford** This is great. I think it really gets us started on thinking about how we might collaborate going forward in this important area.

**Dr. Boufford** Let me try to... Again, because we have so many members that are new to the committee. I have to say, in my experience, and I appreciate Dr. Bauer's commitment to this too. I want to thank you. I wasn't sure. We've been hearing that you might or might not be leaving. I wasn't sure when it was. I just want to again, thank you for your leadership in this area. We're delighted that Dr. Whalen. You're passing the torch to someone who's also lived it, I guess, in the community on the prevention agenda, which is really, really great. I think one of these we discovered ourselves is because of COVID and sort of the burnout, retirements and others. There was literally no one or very almost no one in the leadership of the health department who had had any direct experience with the prevention agenda. I think the last twelve to eighteen months has been a really important

collaborative process and has been a lot of work. I want to thank Ursula and her team for that effort. I do want to show this slide just by way of background is orientation. I will not go into it in any detail. I want to mention the fact that the Public Health Committee and it's I would say it's Ad Hoc Committee for the prevention agenda. You're going to hear this. These are the two items that are mentioned in the accrediting body language and the Ad Hoc Committee is for the prevention agenda. A sort of an instrument of this committee on behalf of the PHHPC. The Ad Hoc Committee is advisory. We are, in a sense, the take their input, work with the department. Obviously, the PHHPC has the statutory responsibility, as I mentioned. Again, we use the term prevention agenda, but it is the state health improvement plan, which is also a statutorily required activity that's reinforced by the federal government. I said that, but I wanted to say it again, so you know why we're spending as much time on this as we are. This, slide, which I think has been presented in the past, but we might also share it as a record of this meeting sort of tells you that we are moving in the 2025 to 2030 proposal that you're here about today. This is, in a sense, the fourth revision. It was sort of the fifth round of the prevention agenda. It isn't like the only time we've been talking about it. It has been going on. This slide on the far left which is the pre prevention agenda slide really stipulates what the local health departments are obliged to do under Article 6 of the Public Health Law. Similarly, what the nonprofit hospitals are asked to do in relation to the State Health Improvement Plan. That has been going on. As Elizabeth or Eliza Whalen said earlier, if you've seen one health department or one partnership you've seen one health department. Part of what the efforts were in the 2008/2012, 2013/2018 and then the 2019 to 2023, which we're just coming to the end of was to see how there could be more alignment and more, I guess of the tools that the health department might have at its disposal to increase the collaboration between hospitals and local health departments, bring more stakeholders to the table at the local level. I dare say align with the waiver, the district waiver. There was an effort there in sort of the fourth bucket of the waiver to sort of look at you're picking an area. Could you pick one that's part of our prevention agenda that you've signed on to? Just try to get more alignment and more collaboration in that area. That's been our goal in these different iterations. I think the PHHPC has been very interested in and cooperative. What you will see on the slide on the right is there is now language, which you may have noticed in the hospital acute care CON process where they are, they have to address how they are collaborating with the prevention agenda. Now, that language we've talked about revising it. It will need to be revised again based on the revision that the department is proposing, which is fine. We need to do that so that we can see how that be helpful. I would say the PHHPC had also indicated that they felt that conditionality on the CON might be extended, to community health centers, to even ambulatory surgery, even into long term care areas and thinking about that relative to healthy aging. That's something that's also, in a sense on the plate of the PHHPC in terms of trying to align the various areas that we are involved in with the work. I think it's fair to say that, obviously not much 2019 to 2023, which was the last round 2024, if you will. Slight interruption there with COVID. People had other things on their plate, but their dashboard has to be created. It was continued, the reporting was continued, but there was not really an effort to do any significant revision. The same five goals were continued. As we began this revision planning for 2025-2030. Again, I would say over the last year plus what we've been doing is reviewing the progress of the prevention agenda during these different cycles. But of course, most recently the 2019 to 2024 cycle. There have been multiple meetings. I think I've summarized previously. Public Health Committee meetings, Ad Hoc Committee meetings, bringing in all the different players, the hospital associations, the local health departments, some of our state agency partners, mental health, OASAS, NYSOFA, who were the sort of core group that we've been working with along with the Department of State, which has been really helpful on the economic development side, asking them to sort of how was the prevention data

structure? How did you use it? How did they help you with your members in your agency work? What were your critiques of it? How can we make it better? What would your recommendations be going forward? All of that has been going on off and on for the last twelve months or so. It's in the notes of this meeting and multiple Power Points. We're at the point now, I think, with the recommendation at the February meeting, the latest meeting that the Public Health Committee and the Ad Hoc Committee had was to move forward with a model that in a said shifted from what had been perhaps more traditional sort of health problems representing the sort of major sources of preventable morbidity and mortality in the state of New York to really taking on board the sort of priority areas being the social determinants of health and the ones that the state has adopted are, in fact, those same five that have felt to have an adequate evidence base for intervention and activity from the Healthy People 2030 process. First time the federal Healthy People 2030 has included social determinants in its ability to work with. We're in good company relative to moving in that direction. I think the last meeting we had just in terms of teeing up this presentation. Again, thanks for a lot of work by the staff. There were about seven or eight questions that the Public Health Committee asked when the most recent presentation. I think the focus of our concerns had been asking for a little more detail on an implementation plan if we are going in the direction to which we are, this is clearly the preference of the Commissioner and of, I would say, well, of NYSACHO and various other parties that have been involved that this is a really good idea to make this shift. What about implementation? What about the issues of leverage and influence that one might have to get things to work? I mean, that was kind of if I can put those two things in a nutshell. I want to again thank Dr. Bauer and her team for putting a lot of time in. I think you will see one of the slides is, in fact, those questions. Focus to present these is to present us with what is really a framework to say this is how we're going to be going forward on the new prevention agenda 2025 to 2030. Here's, in a sense, our plan, our action plan at this point with some timetables on it. Because our concern also about how are we going to track what you're doing and sort of monitor that it's being done. Because that's our job is oversight. The only other thing I'd say, for those of you new to the process, because I did get this question from one of you. There never has been sort of a narrative plan that we approve. What we have always approved is a framework for developing the plan. Details of the plan are laid out in the guidance that the department issued to local health departments and the Commissioner share shares with local hospitals. Again, what you are seeing in this Power Point today is pretty much what we have been getting historically as the vehicle for explaining how the department plans to go forward. We welcome questions, additions you have. At the end of this conversation, hopefully we will be able to move ahead with a resolution on behalf of our colleagues.

**Dr. Boufford** With that, let me turn it over to Dr. Bauer.

**Dr. Bauer** Dr. Boufford, thanks so much for that very helpful background and introduction.

**Dr. Bauer** I am just going to ask Zahra to jump in with the presentation of the framework.

**Ms. Alaali** Thank you.

**Ms. Alaali** I will start with an overview of the processes we took for the planning of this state health improvement plan or the prevention agenda. Before doing this, I will try my best not to use any acronyms during the presentation, but if I do so this is your reference slide for the acronyms here.

**Ms. Alaali** The timeline on the screen illustrates the process and the key milestones for the development of the prevention agenda and the implementation as well. The process begins with the convening the Ad Hoc Committee. In March 2023 last year, the Ad Hoc Committee members were invited to lead the State Health Improvement Plan, or what we call here Prevention Agenda. Data collection for the state health assessment took place in July 2023. In December, our team provided a comprehensive description of New York State population, demographics and general health status to identify the needs for the state. In February, this year, our team identified a list of health issues and started the prioritization processes. We will basically provide an overview of the theoretical framework selected and the selected priorities. There are more details to come on the next few slides. By December 2024, our team is planning to finalize this prevention agenda action plan. The implementation will start from January 2025 through December 2030. You will see summary of the development who was involved. The New York State Department of Health developed the priorities through an extensive data analysis, assessment and feedback from Department of Health staff and critical partners. There were around thirty-one in both meetings that included priority identification as part of their agenda. Six of those meetings were convened exclusively to discuss and identify health priorities for the 2025-2030 prevention agenda. Our team identified cross-cutting themes from the state health assessment and presenting them to partners for feedback. A total of forty-four health issues has been identified. The identified health issues include health outcome priorities and social determinants of health. As I mentioned in February 2024, our team started the prioritization process. We disseminated a health prioritization survey to identify the highest priorities for the state and the new cycle. We used a weighted voting tool.

**Ms. Alaali** I'm going to move to the result of the survey. We have a total of 230 participants in the survey. The response rate was, 57%. We have approximately 31% of the participants affiliated with the hospital, followed by 28% affiliated with local health departments and approximately 27% with other organizations. Other organizations include community-based organizations, professional medical associations, school-based health center programs, non-governmental organization and private organizations, legal services, and others. Additionally, we have 80% of the participants were from New York State Department of Health and 6% from other governmental agencies. For the new sector of the prevention agenda, we decided to go with the top twenty-three highest ranking issues.

**Ms. Alaali** In this slide, you can see the key findings here. We grouped the top selected issues into six main themes. Number one is economic well-being. Number two is maternal and child health. Number three is mental health and substance use. Number four health care access and quality. Five, safe and healthy communities. Last, education access and quality.

**Ms. Alaali** In the next slide we will see tables with the top-rated health issues. For the top-rated health issues, we see that poverty was ranked number one followed by prenatal care and maternal mortality, nutrition, security, drug overdose, death, health insurance access, housing stability and affordability, and infant mortality. Number eight is healthy eating. Number nine is resided. Number ten is preventive services for children, followed by depression, early intervention and employment. Preventive services for adults and physical access and proximity to health care. Number sixteen is anxiety and stress, followed by adverse childhood experiences, oral health, injuries and violence, education access, safe communities, tobacco and e-cigarette use. Last, lead poisoning.

**Ms. Alaali** Here in this table, we see the least ten selected health issues. We have tick borne diseases, compulsive gambling, foodborne illnesses, cannabis use, end of life care

and planning, health care associated infections, outdoor quality, air quality, climate change and social cohesion.

**Ms. Alaali** The survey results show that social determinants of health are recognized as a key area requiring attention in New York. To address this, we commend integrating social determinants of health into the 2025-2030 prevention agendas priority. The integration will address direct and indirect factors influencing health. It will reflect the needs of the communities in New York. Also, by integrating the social determinants of health, the new prevention agenda will be consistent with the Healthy People 2030 approach. The goals for each health priority, however, are relevant to New York State context. It will be selected through a partner engagement process.

**Ms. Alaali** In this slide, you can see the current domains of the prevention agenda for the, 2019-2024 in the left side. On the right side, you will see the new domain of the 2025-2030 framework. Looking at the left side, we have five domains. For the current cycle of the prevention agenda. We have prevented chronic diseases. Number two is promoting healthy and safe environment. Number three is promoting healthy woman, infant and children. Number four, promote well-being and prevent mental, substance use disorder. The last priority area or domain here is prevent communicable diseases. The right is the 2025-2030 prevention agenda, which is center around Healthy People 2030 social determinants of health five domains. Domain number one is economic stability. Domain number two is social and community context. Domain number three is neighborhood and built environment. Domain number four is health care access and quality. The last domain is education access inequality. One of the key questions here is why the shift? What are the reasons behind restructuring or organizing the prevention agenda around the social determinants of health? Well, during our health assessment, we noted that New York's overall state health ranking significantly declined from 2016 to 2021. Basically, declined from or drop from the 11th healthiest state in 2019 to 23rd healthiest data in 2022. Most of this stems from the latest ranking algorithms, including social and economic factors that public health has largely not focused on. These include poor rankings for poverty measures, food insecurity and lower education level. You can see a summary at the left of this slide.

**Ms. Alaali** This table will show some income and poverty related metrics by race and ethnicity in New York State. Non-Hispanic White and Asian Pacific Islanders have the highest median annual gross income, whereas Black non-Hispanic have the lowest. Looking at the percentage of families below the poverty line, Hispanic and non-Hispanic Blacks have the highest at 17.6% and 16.5%, respectively, living below the poverty. 18.4% of children in New York State live below poverty with 28% of Black, non-Hispanic children living in poverty versus 12% of white non-Hispanic. Unemployment among Black non-Hispanic was 9.2%, while 8.3 of the Hispanic were unemployed. You can see there is disparities here. These numbers are concerning. On the America's health ranking New York State also was ranked number 34 out of 50 for New Yorkers graduating with a regular high school diploma within four years of starting ninth grade. For a school year of 2019-2020, the high school graduation rate was 83%, which is below the national rate of 86.5%.

**Ms. Alaali** I will skip this slide.

**Ms. Alaali** The shift to social determinants of health provides a comprehensive view of health by considering various factors that influence well-being. This framework basically enhanced the existing prevention agenda by adding more dimensions, making the prevention agenda more robust and inclusive. Also incorporating the social determinants

of health strengthen the old framework by targeting the fundamental causes of health inequities, leading to more effective and equitable health outcomes. Lastly, the social determinants of health framework is more aligned with the new York State Department of Health vision.

**Ms. Alaali** Here in the next slide, you will see the new vision of the Department of Health, which focus on health equity and thriving communities.

**Ms. Alaali** Moving to the most important slide here, which covers the details of the new framework. We see the new vision of the prevention agenda. Every individual in New York state has the opportunity, regardless of background or circumstances to attain their highest level of health across their lifespan. The new vision statement shifts the focus from being the healthiest state in the nation to achieving health equity. The 2019-2024 vision for the prevention agenda is to be the healthiest state in the nation. We are shifting this to health equity in the new cycle. Next is the foundations. This prevention agenda center on these four foundations; health equity, prevention across the lifespan, health across all policies and local collaboration building. To improve the health outcome, to enable wellbeing and promote equity across the lifespan, the prevention agenda employs the following cross-cutting principles; addressing social determinants of health and reducing health disparities, advocating for increased investment in primary and secondary prevention at every stage of life, incorporating a health across all, which promotes interdisciplinary, multi-sector collaboration. For example, currently we are working to improve the alignment of the prevention agenda and the Master Plan for Aging with New York State of Aging and the Office of Aging and Long-Term Care. Another foundation here is Local Collaboration Building, which focuses on promoting community engagement and cross-sector collaboration in developing and implementing local plans. Last, we will continue to maximize the impact with evidence-based interventions for state and local action.

**Ms. Alaali** Now, moving to the domains and priorities. This cycle of the prevention agenda will utilize the five domains of Healthy People 2030. You will see the domains at the left and the priorities on the center. There are a total of twenty-one priorities. The priorities are in blue and the text in purple are just the label of the category. We have four identified priorities which include poverty, unemployment, nutrition, security and housing status.

**Dr. Boufford** We can see these. I think we don't want to spend too much time. I just want to be sure you finish the proposal. You need to read all the details under each of these detailed ones if you will. That's okay. Just keep going. I'm sorry. I didn't want to interrupt you. This is legible, I think. Everybody's got the slides in front of them.

**Ms. Alaali** I will skip to the next.

**Ms. Alaali** I already covered those.

**Ms. Alaali** Each domain has an overarching goal. You can see the goals listed here. These are the visionary goals we want to accomplish with each domain. So, for example, economic stability, the goal is that all people in New York have the financial security and support needed to thrive.

**Ms. Alaali** Since you have the slides also I can skip the list here.

**Ms. Alaali** In general, each domain in this framework will have overarching goal, one to three objectives for each priority, indicators to track progress. Some priorities will have more than one objective and possibly more than one indicator. We are aiming for fewer objectives and indicators than the last cycle of the prevention agenda. Also, each priority will have evidence-based intervention at different level, health department level and other organization level. We will provide also resources for implementation. The action plan will have identification of population and age groups affected by the priority and a list of partners and organizations that play a leading or supporting role. For the next step, since we already have identified the priorities, identifying the goals, objectives or finalizing the goals, objectives and indicators, and identifying evidence-based intervention is what is next. We are planning to establish workgroups compromised of organizations and members from the Ad Hoc Committee. This includes staff from New York State Department of Health, local health departments, hospitals, subject matter experts, and community members. The workgroup basically will be established by the end of July, beginning of August, and activities estimated to be completed by October 2024. For the objectives, we will use the framework to ensure the objectives are precise. In 2019-2024 cycle, we use an objective which stands for specific, measurable, achievable, realistic, and time bound. These two additions incorporate input from community partners, especially those most impacted into the process, activities and policy decision making in a way that share power to address the systematic, inequity and oppression. Bottom line here is we are switching from framework for the objective to smarty. That includes inclusivity and equitable objectives.

**Ms. Alaali** Here is some of the questions Dr. Boufford mentioned earlier. These questions were raised by the Ad Hoc Committee members and the PHHPC members. We will provide some examples of successful collaboration between hospitals and local health departments and other local partners to address social determinants of health in the next few slides. We will also discuss cross-sector partnerships and strategies for strengthening collaboration.

**Ms. Alaali** Here are some examples for successful collaboration. All the examples it's worth mentioning that they are from New York State. The first one is we live well Erie Initiative by Erie County Health and Human Services Department. The initiative goal is to improve the quality of life for Erie County residents. This initiative basically has a clear focus on the social determinants of health and racial equity. Erie County Health Department partnered with over sixty community organizations, private nonprofits, and academic organization to accomplish three demographic goals. Number one is every child deserve a chance to succeed. Concentrating on the well-being and opportunities for children. Number two is empowering working families aiming to enhance economic stability and support system for families. The last goal is support for our seniors, which focus on improving services and resources for the elderly population. Data indicators to monitor progress toward those goals and adopt what is called results-based accountability framework to guide their efforts. This initiative basically focuses on cross-sector partnership. Another example here is the of integrating social services with public health services as the Seventh Valley Health Coalition. This coalition focuses on improving the health and well-being of the Cortland community through collaborative action. This initiative basically focuses on identifying needs and address local health issues at the local level. They provide multiple services and projects. This include helping people navigate and obtain health care services. They offer also prevention and management education for chronic health condition, food waste and other services. They provide or offer a 24/7 helpline in which they provide information and referrals to human services agencies and program. Some of the services they provide is basic human needs resources such as

access to food, clothing, shelters, and rent. Physical and mental health resources such as health insurance program, crisis intervention and others, and work supports such as financial assistance, job training, transportation, and educational programming.

**Dr. Boufford** Can you sort of to summarize the top lines for these other case studies? Because I think they're really glad you put them in. They're really helpful because there have been questions about what local health departments and hospitals can do in these areas. These are great examples of those. Maybe just give us the top line because I want to get to your later slides.

**Ms. Alaali** Sure.

**Ms. Alaali** The bottom line all those examples are from local hospitals or local Department of health. They focus on the cross partnership between health departments and social services or other partners at community level or they focus on improving the data and data collection on social determinants of health to better allocate their resources. I believe I can skip the examples. You have a copy of them. Feel free to reach out to me if you have any question about them.

**Ms. Alaali** Now, moving to the comparison between the current prevention agenda and the new prevention agenda framework. The prevention agenda, many of goals, objectives, interventions provide a tool for all communities to improve outcome for New York of all ages. You can see here whether in the previous cycle or the current cycle. The key is collaboration. We have multiple partners who utilize the prevention agenda framework. This includes local health departments, hospitals, state agencies, local agencies, among others. The strategy is basically for the 2025 and 2030. Will be carried out through these channels. The first one is community health improvement effort led by local health departments. We talk about the community health assessments and community health improvement plans. Another channel is hospitals, activities, investments and community benefit expenditure. Another channel is actions and investment by other community partners. You can see here this is local collaborative effort. There are always community partners involved in the implementation. The last channel is the New York State Certification of Need. Dr. Boufford already mentioned that health care facilities are required to submit when they submit their Certificate of Need they’re being required to address or report out how would this project advance prevention agenda goals? In New York State, also health care facilities are required to submit to health equity impact assessment. This is another channel to advance and address social determinants of health. In the next cycle, we are looking for opportunities to strengthen nonprofit hospital collaboration with local health departments and ensure a stronger alignment of hospital community investments and local health departments priorities. I will get to this in more details in the next slide. Lastly, we are looking for establishing cross-sector partnership. We have cross-sector of black initiative at the moment, but I will get into this in more details in the next slide. This partnership basically will help with identifying assets and resources, interventions, whether events based on best practices and strategies that our partner will implement to advance the prevention agenda. This is another slide here. This is a summary that highlight the differences or incoming between the current cycle and the future cycle of the prevention agenda. Both cycles are for six years. 2019 2024 cycle focus were on major areas of public health with emphasis on health disparities and determinants of health outcomes ranging from individual behavior, social economic status, and health coordination. However, at the 2025-2030 shift, they focus to health equity and social determinants of health. For the objective, we are more moving from Smart to Smarty. The new prevention agenda cycle, we are moving to six-year community health assessments

and community health improving plan submission instead of the current three-year cycle for local health departments. However, our hospitals will continue to submit their community service plans every three years to meet the federal requirements for tax exempt status. Priority selection and the current prevention agenda cycle hospitals and local health departments were asked to select either two priorities with one focus area under each or one priority with two focus areas. One of those priorities, needs to address disparity and promote health equity. The new cycle of the prevention agenda hospitals and local health departments will be asked to select three priorities. The three priorities can be selected from one social determinant of health domain or more than one domain. Here's an example. This is an example of three priorities and their one social determinants of health domain. They can select tobacco, adverse childhood experiences and healthy eating. Here's another example for the other option which is three to priorities under different domains. For collaboration and the next prevention agenda cycle, we aim to continue strengthening the collaborative efforts by aligning priorities and working with community-based organizations. We are also arranging for a meeting with the hospital associations and hospitals next month to explore ways to ensure priorities, alignment and continuation of the planning and implementation between hospitals and local health departments. The reason why the shift from six years submission cycle for local health departments. We are trying to make sure or ensure that the collaboration continue with this shift from three to six years submission cycle for local health departments. For the interagency collaboration both cycles had an Ad Hoc Committee to lead the planning for the prevention agenda. However, in 2025-2030 cycle, we are exploring the development of a new interagency working group to advance social determinants of health. I will provide more details in the next slide. The Social Determinants of health interagency working group, basically. This is something we are exploring. We are exploring opportunities for existing interagency councils to create the working group to perform this function. The working group will basically provide a forum for agencies to identify shared goals and opportunities to address social determinants of health through collaboration. It will also promote a government culture that prioritize health and equity for New Yorkers across policy areas. Last, it will incorporate health and equity into the state agency practices. This is a proposed timeline for the establishment of this interagency working group. By October 2024, we will define the mission roles and responsibilities of the working group. By January 2025, we will establish the task force and recruit members. In March 2025, we will hold the first initial meeting to introduce members, outline objectives, and review the prevention agenda framework. After the initial meeting, the working group will start meeting to review the progress against prevention agenda, goals and milestones. This leads to the end of the presentation here.

**Dr. Boufford** Thank you very much.

**Dr. Boufford** Let me just add a couple of, just to re for the committee itself. I think if we look at the Slide Number 23, which sort of laid out the domains which are the new social determinants on the left and then these priority areas that are identified with each domain. The idea as was said, but I just want to emphasize this relative to the accountability question. The options that are being given to the local health departments will relate to these priority areas under each of the domains. There will in a sense be local accountability between the department and the local health department, ideally local health department and hospital partnership. When they say what they plan to work on, they will then need to report that and that will be tracked by the State Department. What this does not do is sort of align all the interventions across, ideally across the local health departments by having people go into a particular channel. I think I would say that this approach is very much favored by the local health departments at this point in time. Again,

I think what in my mind and I think it's helpful for the committee, the prevention agenda becomes more of a... I won't say heuristic device, but it becomes more like what Healthy People is, which is basically saying, here are the goals we want to achieve. These are the objectives underneath. Here's data to help you think about it. We will come back and focus on how far we got on the area. I think over time, the interagency collaboration would focus on enriching perhaps the area of work that could happen under these priority areas and the interagency might begin to... This was another concern is what leverage do the hospitals and local health departments have over the other agencies to come in? The idea is that leadership of the department would then reach out to colleagues in the other agencies and bring them to the table to start talking about more of a health and all approach to their work that starts next year. We would be able to track that process. The other issue that it's a bit outstanding. I've raised this with colleagues as we've gone through this is the degree to which the department may have levers that have not yet been used relative to having the hospitals and local health departments collaborate in more of a thou shall rather than wouldn't it be nice if. I think it's an area that's sensitive. We talked about it a good bit in the reviews. I think there's a commitment of looking at this and seeing how that might go forward. As mentioned, the initial steps would be approaching the hospital associations to bring this new model to their attention, getting them engaged. There are these other tools that could be used later on. Sort of part of it is we know that in New York State when people start looking at things people start thinking about how do we do this? I just want to raise those issues around the issues of implementation, tracking accountability, and obviously the touchstones that are in the final timetable would at our September/October meetings track where they're going, December meeting, track how it's going. I'll stop there.

**Dr. Boufford** Let me open it to questions.

**Dr. Torres** I appreciate, I'm intrigued by the key findings. I'm glad that safe and healthy communities made it up there. It will be interesting to see how the trend continues to float and how it changes in communities. Because I'm looking at the weighted voting survey and as we look at safety and healthy communities are impacted that might change and might change also the request for resources, especially with local hospitals and providers nearby.

**Dr. Boufford** Dr. Yang.

**Dr. Yang** Sorry. I keep apologizing. One thing when we're looking at these areas. Thanks for raising them again. This is going back a little bit to what's public health anyway. What's our role? I think in an earlier committee meeting talked about sort of what the metrics for performance? What the metrics would be for success or performance? Poverty, unemployment, world peace. It's big stuff. It's absolutely critical. It's all the way upstream. It is definitely social determinants. It's not something a local health department necessarily does or even a hospital or anything. It takes the village kind of a thing. To move here in terms of metrics, if public health, the health department. Not public health is too big. A health department's role, at least for this commonly is to help measure at a local and a state and a regional level how a community, a state, a county or region is doing by these things, which at least gives a platform for informed action should those broader coalitions want to do something. That is definitely a role. It's not that Westchester Health Department's going to solve poverty in Yonkers, but it's going to help measure that and help measure progress. That wasn't a question. That was just a clarification for myself. The thing that I was looking at the questions raised slide and the how will the 2025-2030 ship be implemented? A couple of things just struck me, which is we have all these

examples. Are there examples that are carrying forward or lessons that we learned from that or PPS that were good nuggets for collaboration that can be taken and learned? I also noticed that on the prevention agenda that expired in 2018 that hospitals were acquired and their CONs to demonstrate and talk about how they contributed to the prevention agenda.

**Dr. Boufford** It didn't really expire. It continued without change because of COVID. It's still underway at this point.

**Dr. Yang** I think that's an opportunity as PHHPC to see what we can help move along. I'm fascinated by the state interagency workgroup. Like who is on it? There was a meeting of the Prevention and the Public Health committee last year some time. There was one moment where the Office of Health Insurance came. Money does make the world go round. We talk about funding and supportive. It's the softer services, traditionally the wraparound, the facilitative, the glue. I think there are between 1115 waivers and opportunities for Medicaid and Department of Finance and OHIS to start more broadly envisioning what is health and what is supportive and reimbursable as health. I mean, that would be an amazing thing for a state interagency work group to start trying to do, not even statewide, at least on a pilot basis to start making a dent. That was it.

**Dr. Boufford** It's really important.

**Dr. Boufford** Let me get some responses on these because I know these questions are going to be complex.

**Dr. Boufford** Dr. Bauer, do you want to take on maybe a little bit more discussion on the interagency workgroup while you're imagining it. As we talked about before, I think I wanted to emphasize the fact that there would be local accountability at this point with local health departments and their hospital partners and maybe other partners. The point of how we begin to move the needle on the bigger issues, this sort of needs to be... We'll be part of this but thinking out going forward a little bit further out.

**Dr. Bauer** I'll speak quickly and then defer to Dr. Whalen. You know, I think we envision this interagency group as really bringing all of the social determinants of health agencies together. It's really focusing them on getting their work done, whether it's economic development, whether it's housing, whether it's transportation, and how we can support each other in addressing the needs across the state lifting the whole state up. The health across our policies working group focused more inward to each agency in terms of what can I do with my contracting, with my procurements, with my federal reporting? This is more outward focused. I think, in terms of how do we each do our jobs better so that we are addressing the social determinants of health?

**Dr. Whalen** I would just add to that when we look at convening these groups together and when we look at doing something new that really has been talked about but hasn't really been done before. It's often you look at your short-term goal. You look at your long-term goal. I think we're all understanding of what the long-term goal is, which is really to establish a collaboration that is unified to work towards the common good and work towards addressing the social determinants of health. Now, if you bring a group together and say that's what you want to do it's very broad. It's very nebulous. It sounds like a lot. I would think to start a group off like that we could concentrate on where these synergies already are happening and how can we amplify those. As a small example, if you look at the Complete Streets Project, which is so important for the concept of built environment,

bringing people into place where they can be safe, where they can exercise, where they can commute by ways other than cars. A lot of non-traditional partners. You might have the Department of Transportation. You might have municipalities. You have a health department. There's a lot of ways that previously these can be viewed as non-traditional partnerships. To highlight what are things like that. Some of those would be examples that Zahra had in her presentation as well of what's already being done. Amplifying those and then looking at hey, that those things are all really cool. What can we do that similar to advance and get us to the long-term goal? I think that's a good way of kind of building a coalition is to start with the low hanging fruit and then work slowly towards a unified mission. That is what I think I would be looking at going forward with these very partners.

**Dr. Boufford** Dr. Soffel.

**Dr. Soffel** Really quickly. I just want to respond to that directly. Beyond an interagency working group, it seems to me really important that the Department of Health look internally within its own in an intra agency way. Because there are lots of folks within the department who spent a lot of time thinking about social determinants of health and health care provider community or collaborations and how to make those work. Some of them worked and a lot of them didn't. I think that there's a real lot of knowledge that needs to be brought into this conversation so that we at least learn from the bazillions of dollars that we spent and don't make the same mistakes all over again. I really believe that this prevention agenda needs to be very, very closely allied with the 1115 waiver and with all of the work that's going on there. Although it's Medicaid, Medicaid is half the New York State population right now. There's a lot to be collaborated with internally.

**Dr. Whalen** I agree with you so much on the points that you just made. I do think there is a lot of strength within the Department of Health. Those kinds of collaborations are essential. I was part of our local initiative and was very unhappy with the way that it played out. I thought it was a phenomenal opportunity, which I was really enthusiastic to get involved in. I really wasn't asked to be involved in it, other than to kind of sit on committees that I was told with the hospital was going to do was tough. I think all of us are mindful about how we don't want that to happen the second time around. In order to do that, there has to be, as you point out, wonderful opportunities to look between Medicaid, between the office of Primary Care and practice and how we move metrics within the medical care system, which is incredibly stressed now and needs a lot of work within and with community partners. I agree with those comments. Thank you very much.

**Ms. Farrell** You know, I'm just recalling my days and sort of who was there and what we were talking about and sort of where we're doing the work now. I just want to make sure that OCFS is involved. I want to make sure the cops, the police, the Police Department. I want to make sure that OMH is there. I want to make sure that OASAS is there. I want to make sure that everyone is focused on this agenda because traditionally it's so darn siloed. You're trying to do good and important work in childcare, for example, and you just can't get it done. Can’t get it done.

**Dr. Boufford** I think the challenge is really how can an engagement like this at the state level support work at the local level? Where is where the action is? Patsy asked the question earlier and I think there are examples probably that. I mean, these examples here and others that we heard about during the time the prevention agenda. It really has to do with the degree to which the local health director and the local hospital system leadership work together and bring people to the table to get it done. That there's a will there at the

local level. The issue is what are the support systems we can do to make sure something happens this time?

**Ms. Farrell** Sometimes in health care we're so focused on the medical care, it doesn't even occur to us that we should involve the police in the first responders, for example.

**Dr. Boufford** That's where public health comes in. Hopefully, that's the 3.0 parts of it that's bringing those in.

**Dr. Lim** I may be saying a lot of what other people are saying, but in a slightly different framework. First, I want to talk about the framework because I think it's a very bold framework. I applaud you for taking a very bold step. You know, I certainly can't speak for all hospitals, but I think because it is such conceptually a different framework. I mean, if you just compare the 2019 versus 2025 and forward. I think it would be very helpful. Because sometimes the first thing you see if you see the framework, it'll be like, oh my. This is not necessarily what hospitals do, right? Part of I think sort of not just packaging, but in sort of helping hospitals and other health care providers to get on board with this is, I think, in part what many people are saying is that how do we make sure that hospitals understand sort of globally, I think they globally understand their role in SDOH. What can they meaningfully drive within any of these priority areas? that's where I think where a lot of people are already saying is it's not just even dependent on the health care system. We need the structure of other agencies, other domains of society and economics and etc. to help hospitals and local health departments actually implement it. Because I think if hospitals feel like they have to drive this we might end up having some difficulty and sort of having people buy into this. moreover, I worry that it might end up where there's like individual success stories or individual pilots that work. What is the sum of the parts, right? What are the actual streams of work? I think I'm saying essentially what other people are already saying too, but I think it would really be important to make sure that the Interagency Work Group, for example, isn't just sort of a like a think tank, but really helps outline clear partnerships, pathways, really outline a structure so that it incentivizes other agencies to sort of get on board with this. That's all I'll say for now.

**Dr. Boufford** Thank you.

**Dr. Boufford** Well, we have a limited amount of time. I think we'll go over a little bit because we want to get this discussed and we want to get our resolution but ask people to sort of be pointed and terse in your questions so that people know what the concerns and questions are that they can be addressed and then give everybody a chance.

**Dr. Eisenstein** I'm bad at pointed and terse.

(Laughing)

**Dr. Eisenstein** We talked about --- and the Medicaid waiver. That is one of almost a dozen different social determinant initiatives that hospitals have gotten placed on them in the last year. ACO, reach requirements, CMS, IQR bonus requirements, Joint Commission requirements, leapfrog requirements, and now this. I see that as an opportunity, not as a bad thing if it's aligned and not competing. I don't think hospitals are going to have a hard time with this. I love this because we're doing it anyway for the other things that we have to do. CMS is 70% of Catholic Health's revenue. If those funds are at stake based on us performing with social determinants, we have to implement programming and self-serving full disclosure. That's my responsibility for the system. The one thing I would ask, though,

is that the data collection and the operations are not conflicting Where CMS is giving us one set of things, Medicaid waiver, --- 2.0, which is nothing like 1.0. I fully agree with Dr. Whalen on my visceral reaction to that. Please, even now, the Medicaid waiver in New York State went live in April and we still don't have any kind of... And this is not a criticism of any people from the Health Department. You know this. We don't have our procedure manual. We don't know what we can do or what we can't do yet. I just hope that we align all of this so that we have one data set, one data source.

**Dr. Boufford** This is going way beyond the prevention agenda.

**Dr. Eisenstein** This is all what's going on with the waiver and other things. My point simply is let's align it so that when we bring all the partners to the table, whether it's police or social services, whoever, that there's a common-sense practical approach that's achievable. One other quick thing. Did you say that the survey was based on 230 people responses?

**Ms. Alaali** Yes.

**Dr. Eisenstein** Look, I know how hard it is to do survey data, but we're a state of more than 20 million people. If we're going to get other agencies to buy in, I think we have to Dr. Torres this point, like to see how the priorities change. The priorities can't be based on 230 people of which a third are health department employees in New York State. We all get it. We understand how hard it's going to be. I think that when we do a data set there's got to be a more how shall we say, statistically significant baseline.

**Mr. Perry** It's critically important that entities that are supporting people with disabilities are at the table and invited to be serious parts of the decision-making groups as it relates to this domain. I don't know who the subject matter experts are. It would be good to outline that so that we know who's missing. In a survey of 200 and something folks' families with children with autism are often not at the table at all. 1 in 36 are born in this country with autism. 1 in 36. That's tremendous. Yet there is no sustainable infrastructure to meet those needs. It's very important that as we develop this domain workgroup, and we look at the folks who should be at the table that we include a large and growing community of folks who have been traditionally left out. I also would like to add that annually the number of children born with autism grows. It is not going down.

**Dr. Boufford** Thanks.

**Dr. Soffel** This is very exciting. I have concerns. All of those things are true. My single biggest concern is how you measure the impact of any given intervention on moving the needle on something as large as poverty or unemployment. I don't know that any social scientist has been able to figure this out. How do we measure progress on the prevention agenda if we don't have metrics that we can tie to it? That's sort of my concern. A question and I don't know the answer to this, but I'm sure that somebody around the table does. Are there going to be metrics on each of these objectives? If we don't meet them, what are the consequences of not meeting them? Are there consequences if we don't meet our objectives? Because that troubles me. I mean, if there are, then we need to make sure that we are not talking about how a hospital neighborhood collaboration is going to change poverty in the South Bronx.

**Dr. Boufford** Well, I think it's fair to say that there have not been consequences. I think the question would be unless it's pure embarrassment in reporting. What are the

consequences? I think that it's a legitimate question to ask going forward. I think your point about the metrics is that will, in fact, happen at this point on these particular priority areas under the domains. The challenge of the interagency group is how much can those activities be expanded with the knowledge and the horsepower of transportation or housing or other agencies?

**Dr. Soffel** The social scientist in me is very troubled with the idea that we're going to take a narrow community-based intervention and try to evaluate its impact.

**Dr. Boufford** We aren't going to do that. I mean, we aren't doing that in the outset. I think this is the thing we've been struggling with as a committee from the beginning is when we move to saying that the domains are these broader determinants they're very complex. Even if you look on the Healthy People 2030 website, there are a number of goals there, number of objectives there that are evidence-based objectives bringing in other agencies. I think the issue here is we're starting with things, and this is what's on this Slide 23, which is why it's important. I've had these discussions. I can ask Dr. Bauer or Dr. Whalen to expand, but we're starting with things. This is something that is within the domain of what the health department can do with hospital partners. That's where we're starting. The proposal, which is more fleshed out than it had been before is to have a mechanism for trying to bring in other agencies specifically and to have a mechanism for trying to enhance the collaboration between hospitals and health departments that are in this first bucket. That's what this is all right now. It's a reasonable point. I mean, ultimately, as one knows, this is not specific to this agenda at all. I mean, the ultimate where you get needles to move on things like poverty and education is political officials running cities and states and governments decide to bring everybody together and say, I want you to do this. I mean, I think that's the ultimate challenge. Realistically, we have a better roadmap, I think, than we've had before about where we're starting, what we want to bring in, and then how we can begin to ask the questions, perhaps in a year or so, I'll begin to ask the questions that you're asking, which are the right questions.

**Dr. Wilcox** I think it's really amazing. I agree with other points that have been made. Mainly, that it's going to be really important to bring a broad swath of agencies and other community groups to the table to help drive this so that the onus isn't just on the hospitals. This is already an improvement on 1.0 because, as I'm sure everyone is aware that maternal health was completely excluded from 1.0. I'm really happy to see that included here. Just one question or point of clarification is that I'm seeing maternal health care and prevention of maternal mortality in health care access and quality. I would almost argue that it could really be under any of these domains. When we're looking at economic stability that we would want to include pregnancy and childcare in that domain as well, because we know that one pregnancy can absolutely lead to economic instability, and that can cause a cascade that can then further affect someone's health. Just wondering about the integration and crosswalk of kind of different priorities matching to different domains other than where they're listed.

**Dr. Boufford** Important question.

**Dr. Boufford** Any other questions?

**Dr. Boufford** I want to have Dr. Bauer, Dr. Whalen and other colleagues. Jump in wherever you wish relative to this. These are just concerns that have been raised and I think appropriate statements about what do we want to watch going forward? What do we

want to keep our eyes on? How do we want to help you be as effective as possible in moving this new model forward?

**Dr. Whalen** I just want to thank everyone for these comments. I think that they raise a lot of issues. A lot of them are very big. In terms of the metrics and in terms of this moving something like poverty that, of course, is aspirational. It's going to be very difficult for us to have the goal of eradicating poverty in the State of New York. I think when we're looking at how we are working within the partners that we have to create these opportunities. You know, you can use intermediate metrics. Say, you know, this is something that we know is evidence based. We want to bring it to our community. Our goal is to do two or three of these things. That is a way of achieving success. When that success is achieved that hopefully amplifies the efforts and this is what we're trying to create is this movement across the state to align multiple different organizations with these similar goals to ultimately create better health. Address the root causes of health, which are the social determinants of health. I'll say that. Please know that I'm not saying this in a kind of nebulous way to get around the question. I think that the question is very important. When I started in those meetings and started to kind of voice some concerns that I had around that. I was told flat out by the person that was heading up in our region this isn't going to cure poverty. That is exactly what he said. And for me, that has always stuck as it should. That's what the aspiration should be. I think that that's something we're all in agreement on. You have to kind of chunk away at this bit by bit and create either innovations or evidence-based strategies that are going to make this difference and elevate these by involving multiple partners, sharing these successes over a long period of time. For that question, you know, I want to say that I think that this is going to be a long-term approach. You know, in how we identify metrics of success will often be intermediate metrics of success.

**Dr. Boufford** But if you think about a six-year horizon, which is sort of what you're proposing, I think that also sort of provides at least some sense of opportunity. I would comment on having been on it as well. I sort of share a lot of my colleague’s concerns. I think the other... One of the just two pieces I wanted to say here. I think taking on this health care access and quality issue as a social determinant of health, which is quite relevant... Is and I just for the new folks that have not been involved in this before. The prevention agenda historically has stopped at the door of the clinical facility. I mean, we've wanted the hospitals to bring the clinical piece together with the public health folks. This is going beyond that at this point. I think it opens up an area that needs to be more fully fleshed out and offers a lot of great opportunities. We've not really, put our toe into the service delivery model. I think it raises the question about the current waiver, because the current waiver is very focused on individual health and social services integration. There may be stuff that can go on there that would not have gone on before. We could keep an eye out. I think that's a great the notion people had about looked within and across the department for connections. I mean, Zahra mentioned the Master Plan on Aging. The jury's still out about where there's a lot of work that has been done on prevention there that could be moved over here over the next few weeks and months. I think we'll hear hopefully more about that before we touch base again.

**Dr. Boufford** Please, Dr. Bauer.

**Dr. Bauer** I'll just add coming to the end of my thirty-five-year public health career much of what we've done in public health, unfortunately is mitigate the adverse health impacts of these social determinants, poverty and housing and so forth. What's exciting to me is I kind of look to the next generation is taking on those determinants. You know, yes, we're not

going to solve poverty in New York State, but we're going to tackle it, right? We can't just mitigate the ill effects. We need to get to the root cause. That's what's exciting to me about the next cycle of the prevention agenda.

**Dr. Whalen** I just wanted to make the additional point that when we talk about partners and organizations and how we partner with health care. A big opportunity is also through the managed care systems. We know we're living in an area where there is tremendous. Well, across the United States. I mean, the burden of chronic disease and the cost on the health care system is breaking the health care system. That's nothing that's new to any of us. This is the prevention agenda. This is where public health really should be convening the partners to talk about how we prevent chronic disease, how we work together to mitigate this tremendous cliff that we are on the verge of falling off. I think that's where health care comes into this. How do we adapt and move away from our reactive health care system where you only come see your provider if you have a problem to prevention. These are tremendous opportunities that exist when you give the landscape of the 1115 waiver at the same time as the prevention agenda and the network of resources within the state Department of Health.

**Dr. Yang** Just because I feel so self-conscious I was sounding really negative. Ursula, I mean, we've worked together, or our paths have crossed for decades. Elizabeth, ours didn't. I'm sorry about that. When I was 20, I was asked what why I was going into public health and what it was. I just said, it's poverty. I totally believe that we should be arguing for it and fighting and aspiring to combat that and unemployment and housing and world peace. I think we just have to be very truthful and honest and take a really hard look at where we are now, not where we've been so much. I think it doesn't do anybody any justice to talk in vague terms and purely aspirational. We're not going to get that far. I think this is really helpful. I just wanted to swear my allegiance to this and not say otherwise.

**Dr. Boufford** I think the other thing, to that end, I think it came up when Zahra was presenting. If we look at the domains. I mean, one of the notions, I think of the data piece that you mentioned, Eliza. If there is local data in terms of poverty. I mean, the county health rankings provide a lot of relatively local data on a lot of these things. I know that has been used actively by a lot of local health departments and others. This idea that we might keep the local data available on these bigger domain areas as a benchmark to see what's going on locally. If we get a real something fantastic in Syracuse or Schenectady or Albany or Buffalo, we can tout it because it'll be more visible at that level in addition to these sorts of smaller activities that would be going on. I don't want to leave the discussion by saying the money is not in my historical experience in the same number of decades that Patsy has been at this. The money we're going to get is not... I mean, it may be in community benefit in either sort of health improvement category, not the rest of it, but it's really on these other agencies because they have to do things to improve housing. They have the money to do transportation infrastructure. They have these huge hundreds of millions of dollars. Our job is to really influence them to make decisions to promote health. I think that's the exciting opportunity here, potentially going forward.

**Dr. Boufford** Denise, last word.

**Dr. Soffel** I would be amazed if any county in the State of New York picked poverty or unemployment or as their metric. I just don't think. Therefore, I think it's important for us to think about how are we going to maintain focus on those if no county has said that that's my goal for the next six years? I would be astonished. I would eat my hat if any county said we're picking poverty reduction as our 2026 goal.

**Dr. Boufford** I don't think they're going to be asked to do that. They're going to be asked to do it as a category and underneath it would be a set of activities. It's a little bit smaller. It's a domain, but they're not being asked to fix the domain. They will be asked to identify activities within the domain, priority activities within the domain. I mean, if they want to take on the whole domain that's fabulous.

**Dr. Boufford** Job creation could be addressing local purchasing by hospitals I mean, these are smaller. These are micro interventions. We'll keep an eye on it. That's really a good caveat. You can see the committee is going to be working closely with you going forward.

**Dr. Boufford** Anyway, I need a resolution on behalf of the PHHPC accept this overall framework and approach to the prevention agenda for 2025-2030. We have notes of questions, issues, answers. I want to thank Dr. Bauer for her work up to date and passing the torch to Dr. Whalen who will be our lead here.

**Dr. Boufford** If that's acceptable to everyone I'll move adoption of this approach.

**Dr. Boufford** Second by Dr. Yang.

**Dr. Boufford** All in favor?

**Dr. Boufford** Aye.

**Dr. Boufford** Any opposed?

**Dr. Boufford** We'll see you at the next meeting. I think we'll have to talk offline relative to the monitoring. Again, thank you all very much for really important work.

**Dr. Whalen** Thank you for the great discussion. Much appreciated.