NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
AD HOC COMMITTEE MEETING
July 24, 2024, 10:15 AM-1:15 PM
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
TRANSCRIPT

Dr. Bauer Good morning. Good morning, Dr. Boufford. I think we're set here in the room in Albany and ready to get started when you are.

Dr. Bauer Dr. Boufford, it looks like you are on mute.

Dr. Boufford After all this time.

Dr. Boufford Thanks very much, Ursula.

Dr. Boufford I'm Jo Boufford. I'm the Chair of the Public Health Committee. I have the privilege of calling to order the Ad Hoc Committee to support the prevention agenda. I want to welcome members of the Public Health Committee on the council, the Public Health and Health Planning Council, and participants and observers. I want to give you the webcasting guidance for everybody to recall. We are subject to the Open Meetings Law, and this meeting is being broadcast over the internet. It can be accessed by the Department of Health's website NewYorkHealth.Gov. The webcast will be available no later than seven days after this meeting and for thirty days. A copy will be retained for four months. Some suggestions and ground rules, especially because this is a hybrid meeting. We have people in person in Albany and a lot of folks online. There is synchronized captioning being conducted. It's important that people not talk over each other. The first time you speak, we're asking you to please state your name and identify yourself as a council member or DOH staff. Finally, I guess the mics in Albany are hot. The ones here are up to whether we put them on or not on our virtual line. Again, to be careful. Certainly, avoid side conversations. If you are online, please keep yourself on mute unless you want to speak or make comments. For the in-person audience, there is a forum to be filled out. I think should have been available when you entered the room. It is also available on the NewYorkHealth.Gov under Certificate of Need website. I'd like you to fill it out to as a record of your participation. As I mentioned earlier, this is a hybrid meeting. I'm online. Dr. Bauer is in Albany, so we'll sort of co-chair this. We are asking that those of you online. There will be sort of two discussion periods. Please raise your hand and we'll do our best to call on you. When we get into the discussion period Ursula will manage the group in Albany. They'll go first, and then I'll follow with the folks that are online. Brief overview of the agenda. We after this sort of opening we do Dr. Bauer will have her opening remarks, and then we will introduce everyone who's here, because that's part of the idea of the Ad Hoc Committee is knowing who's involved in the conversation. We'll then have a presentation from colleagues at New York Presbyterian, New York Columbia, University Medical Center on some work they're doing on community partnerships. Following that will be the sort of main presentation of the meeting of the new proposed prevention agenda framework by

Zahra Alaali, and then that will be sort of half of that time slot will be presentation, half will be discussion. I'll come back to the intro introducing that part later. We'll have closing remarks. We will not have public comment as listed on the agenda because it's not a decision-making meeting. It's an effective Ad Hoc meeting, which is the public involvement in the prevention agenda by definition. That part of it we should be able to end at 1:00pm.

Dr. Boufford Before introductions, let me turn it over to Dr. Bauer for welcoming remarks. And then Dr. Bauer, perhaps you could start with the introductions of colleagues that are in Albany; name and organizational affiliation, if you will.

Dr. Boufford Thank you.

Dr. Bauer Excellent.

Dr. Bauer Thanks so much, Dr. Boufford

Dr. Bauer Thanks all of you for joining us today in the room and online. I'm Ursula Bauer, Deputy Commissioner for Public Health. I'm really thrilled with where we have gotten in planning the framework for the 2025 to 2030 prevention agenda. Thanks go out to Dr. Boufford and the Public Health Committee for their leadership in bringing us to this point, to our staff at the Department of Health, and to all of you, our subject matter experts and partners and stakeholders around the table and around the state. Thank you. It's very exciting to be poised to plan the launch of the next cycle. I will note this is my last PHHPC meeting and my last engagement with the prevention agenda as I am stepping down from the Deputy Commissioner for Public Health position at the end of this month. I am thrilled to have my Deputy Director for the Office of Public Health, Laura Trolio, who will be stepping into the Acting Deputy Commissioner for Public Health role until a new individual is onboarded into that position. Dr. Liza Whalen, who I think many of you have met at the Public Health Committee, who is the Medical Director for the Office of Public Health and who will be stepping into the leadership role over the prevention agenda as well as serve as the Office of Public Health liaison to the Public Health and Health Planning Council.

Dr. Bauer With that, we will go around the room and introduce who is here.

Dr. Bauer Let me start to my right with Laura Trolio.

Ms. Trolio Thank you, Ursula.

Ms. Trolio Good morning, everyone. Laura Trolio, Deputy Director for the Office of Public Health.

Dr. Whalen Good morning, everybody. I'm Liza Whalen. I'm the Medical Director for the Office of Public Health. I just want to echo Ursula's sentiments of gratitude for all the

work that's been done so far. I'm very excited, to continue this work going forward. Thanks.

Ms. Alaali Good morning. Zahra Alaali, the Prevention Agenda Coordinator.

Ms. Gazitano Good morning. Gina Gazitano from the Office of Public Health Practice on the prevention agenda team.

Ms. Mazzetti Hello. I'm Bella Mazzetti. I'm also from the Office of Public Health Practice, supporting the prevention agenda team.

Mr. Bishop Hi. Lloyd Bishop, Senior Vice President for Community Health Equity at the Greater New York Hospital Association.

Mr. Williams Good morning. Charles Williams, Assistant Director for Healthy Aging and Longevity at the State Office for Aging.

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

Ms. Battaglia Good morning. Lynda Battaglia. I'm the Director of Mental Health and Community Services for Genesee County and a member of the Conference of Local Mental Hygiene Directors.

Mr. Lebwohl Good morning. I'm Andy Lebwohl. I am the Director of the Center for the Master Plan for Aging at DOH.

Ms. Ashley Good morning. Lauren Ashley, Senior Director at the Health Care Association for New York State.

Mr. Friedrich Good morning. Marcus Friedrich, CMO of the Empire Plan.

Dr. Heslin Good morning. Eugene Heslin, First Deputy Commissioner and Chief Medical Officer, New York State Department of Health.

Ms. Leonard Colleen Leonard, Executive Secretary to the Public Health and Planning Council.

Mr. Stelluti Good morning, Mike Stelluti, Department of Health.

Mr. Bintz Good morning, Jacob Bintz, Department Health.

Dr. Bauer Dr. Boufford, that concludes around the table here in Albany.

Dr. Boufford Let me know if there's any way to get any more light on people when they're speaking. Everybody's, at least for me, a little bit in the dark, but maybe we can deal with that.

Dr. Boufford Let me start on this screen. This is very risky because once your change screens, everybody moves around.

Dr. Boufford I'm going to start with, John Rugge.

Dr. Boufford I'm going to go in the order on my screen.

Dr. Rugge John Rugge, member of PHHPC. Thank you.

Dr. Boufford Nora O'Brien-Suric.

Ms. O'Brien-Suric Thank you.

Ms. O'Brien-Suric Nora O'Brien-Suric with the Health Foundation for Western and Central New York.

Dr. Boufford Trang Nguyen.

Ms. Nguyen Good morning. Trang Nguyen, State Department of Health. Thank you.

Dr. Boufford Nilda Soto.

Ms. Soto Good morning. Nilda Soto, member of PHHPC.

Dr. Boufford Dr. Eisenstein new PHHPC member.

Dr. Eisenstein Thank you.

Dr. Eisenstein Larry Eisenstein, Planning Council member. Thank you.

Dr. Boufford Dr. Lim.

Dr. Lim Good morning. Sabina Lim, PHHPC member.

Dr. Boufford I have two disadvantages here. I have bifocals that I'm looking up and down at the same time.

Dr. Boufford Terry Fulmer.

Ms. Fulmer Terry Fulmer, PHHPC member and at the Johnny Hartford Foundation in New York City.

Dr. Boufford Amy Lyn Clarke.

Ms. Clarke Amy Lyn Clarke, Western Region, New York State Department of Health.

Dr. Boufford Diane Oyler.

Ms. Oyler Hi. Diane Oyler, Health Foundation for Western and Central New York.

Dr. Boufford Thanks.

Dr. Boufford Anthony Feliciano.

Dr. Boufford I'll come back to Anthony.

Mr. Klein Good morning. Daniel Klein, New York State Medical Association and the New York College of Medicine.

Dr. Boufford Cristina Dyer-Drobnack.

Ms. Dyer-Drobnack Cristina Dyer-Drobnack, New York State Association of County Health Officials.

Dr. Boufford Lauren Wetterhahn.

Ms. Wetterhahn Lauren Wetterhahn. I'm an Ad Hoc Committee member, and I work for Inclusive Alliance.

Dr. Boufford Great.

Dr. Boufford Maya Scherer.

Ms. Scherer Hi. I'm Maya Scherer. I'm also at the New York Academy of Medicine.

Dr. Boufford Beth.

Ms. Finkel Beth Finkel, AARP New York.

Dr. Boufford Denise Soffel.

Dr. Soffel Good morning. Denise Soffel, Consumer Representative to the PHHPC.

Dr. Boufford Kevin Watkins.

Dr. Watkins. Good morning. Kevin Watkins, Public Health Planning Council member.

Dr. Boufford My esteemed Vice Chair of the Public Health Committee, Andy Torres.

Dr. Torres Good morning. Anderson Torres, PHHPC member and Vice Chair of this wonderful committee.

Dr. Boufford Dr. Ortiz.

Dr. Ortiz Hi, everyone. I'm Mario Ortiz. I'm a PHHPC member.

Dr. Boufford Let me see if I can just move things over.

Dr. Boufford I've got a bunch of other staff.

Ms. Farrell Hi. Lindsay Farrell, PHHPC member. I'm from Open Door Family Medical Center and FQHC.

Dr. Boufford Stanfort Perry.

Mr. Perry Good morning. Stanfort Perry. I'm a PHHPC member and I'm with AHRC Nassau.

Dr. Boufford Dr. Wilcox, Wendy Wilcox.

Dr. Boufford Good morning, everyone. I'm Wendy Wilcox, PHHPC member and member New York City Health and Hospitals.

Dr. Boufford Joan Guzik.

Ms. Guzik Joan Guzik from United Hospital Fund.

Dr. Boufford Jordan Goldberg.

Ms. Goldberg Jordan Goldberg, Primary Care Development Corporation

Mr. Dorvil Morning. My name is Alan Dorvil. I work with the Department of Health and Mental Hygiene. I'm a wellness advocate in the initiative.

Dr. Boufford We're going to be hearing from you, I think.

Ms. Hidalgo Good morning, everyone. Monica Hidalgo with New York Presbyterian Hospital.

Dr. Boufford Cheryl.

Ms. Geiler Hi. I'm Cheryl Geiler. I'm from the New York State Department of Health. I'm in the Central New York Regional Office.

Dr. Erazo-Trivino I'm Dr. Audrey Erazo-Trivino, New York State Office of Mental Health.

Dr. Boufford Amy Gildemeister.

Ms. Gildemeister Amy Gildemeister. I'm from New York State DOH Division of Nutrition.

Dr. Boufford Barbara Bennett.

Ms. Bennett Hi. I'm Barbara Bennett. I'm from New York State OASAS.

Dr. Boufford Patsy Yang.

Dr. Yang Hi. Patsy Yang, PHHPC member. Thanks.

Dr. Boufford Mary McCormack.

Ms. McCormack Hi. Mary McCormack, New York State Department of Health.

Dr. Boufford Barb Wallace.

Ms. Wallace Hi. Barb Wallace, New York State Department of Health Division of Chronic Disease Prevention.

Dr. Boufford Janine. Sorry.

Ms. Logan That's okay.

Ms. Logan Janine Logan, Suburban Hospitalized New York State and Long Island Health Collaborative.

Dr. Boufford Jeffrey Moore.

Mr. Moore Jeff Moore, Medical Society for the State of New York.

Dr. Boufford Natarsha Waklatsi.

Ms. Waklatsi Natarsha Waklatsi., New York State Department of Health.

Dr. Boufford Thanks.

Dr. Boufford Cheryl Giler.

Ms. Geiler Hi. I already introduced myself.

Dr. Boufford I'm sorry. This is where we're going to get into trouble.

Ms. Geiler It's fine.

Dr. Boufford Let's see.

Dr. Boufford Deb Brown.

Ms. Brown Deb Brown, New York State Department of Health.

Dr. Boufford Wilma Alvarado-Little.

Ms. Alvarado-Little Good morning, everyone. Wilma Alvarado-Little, Associate Commissioner and Director of the Office of Minority Health and Health Disparities Prevention. Greetings, everyone.

Dr. Boufford Avital Havusha.

Ms. Havusha Avital Havusha at the New York Health Foundation.

Dr. Boufford James Welsh, I think we're called on you before.

Dr. Boufford Jill Cassar.

Dr. Boufford She went off mute, but I don't hear anything.

Dr. Boufford Anthony, are you back yet?

Dr. Boufford Patricia Clancy.

Ms. Clancy Patricia Clancy, Senior Vice President for Public Health and Education for the Medical Society of the State of New York.

Dr. Boufford Susan Cuomo.

Dr. Boufford Meredith Patterson.

Dr. Boufford These folks are all in DOH staff.

Ms. Patterson Hi. Meredith Patterson, State Health Department.

Dr. Boufford Chelsea Lemon.

Ms. Lemon Hi. Chelsea Lemmon, Director of Government Affairs at the Business Council.

Dr. Boufford Thank you.

Dr. Boufford Marthe Ngwashi.

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

Dr. Boufford I'm jumping around now on names that I think I've called before.

Ms. Shah Amy Shah, New York City Department of Health.

Ms. Mack Stephanie Mack, State Department of Health Office of Science and Technology.

Dr. Boufford Great.

Dr. Boufford Tina Kim.

Dr. Kim Good morning, Tina Kim, Acting Deputy Commissioner for Health Equity, Human Rights, New York State Department of Health.

Dr. Boufford Great.

Dr. Boufford Natalie Wedge.

Ms. Wedge Natalie Wedge, Western Region Public Health Program Nurse for the New York State Department of Health.

Dr. Boufford Keshana Owens-Cody.

Ms. Owens-Cody Hi. My name is Keshana Owens-Cody. I'm the Office of Public Health Workforce Director managing the Public Health Infrastructure Grant.

Dr. Boufford Nicky Tettamanti.

Mr. Tettamanti Hi. Nicky Tettamanti with the New York Foundation.

Dr. Boufford Kelly Firenze.

Ms. Firenze Kelly Firenze, New York State Department of Health Central New York Regional Office.

Dr. Boufford Mercy Mbogori.

Ms. Mbogori Good morning, everyone. This is Mercy Mbogori with the Community Health Care Association of New York State.

Dr. Boufford Sandra Ribeiro.

Ms. Ribeiro Sandra Ribeiro, GSK Director of Government Affairs and Public Health Policy.

Dr. Boufford Did I miss anybody?

Dr. Foster Jordan Foster, I'll be giving the initial sort of presentation. I'm one of the attendings at New York Presbyterian. I work as Director of Community Affairs for the Emergency Department.

Dr. Boufford Thank you.

Ms. MacPherson Maria MacPherson, Associate Commissioner New York Regional Office of the Department of Health. Thank you.

Dr. Boufford Nice to have all the regional directors here with us. This is fantastic.

Dr. Boufford Anybody else that did not get a proper introduction?

Dr. Boufford If you have comments later, please introduce yourself. Feel free to introduce yourself. Do that anyway so that we can track what's going on.

Dr. Boufford Perhaps, Dr. Bauer, I don't know if you'd like to introduce our colleagues from New York-Presbyterian Columbia who have a presentation on the hospital's work with community engagement. Would you like to do that? I'll pick up after that and manage this so you can manage the Q&A.

Dr. Bauer Thanks so much, Dr. Boufford.

Dr. Bauer Again, welcome everyone. At the committee's request, we have invited some guests to share with us an effective collaboration between a hospital and health department. The prevention agenda has always been about these collaborations. We're looking forward in the next cycle to really solidifying, those collaborations. We're delighted to have Monica Hidalgo, Corporate Director of Community Relations at New York Presbyterian Hospital and Dr. Jordan Foster, Assistant Professor of Emergency Medicine and ED Director of Government and Community Affairs with New York Presbyterian Columbia University Medical Center.

Dr. Bauer I will turn it over to you for the partnership presentation.

Dr. Bauer Thank you.

Dr. Foster Thank you, thank you very much.

Dr. Foster Is it alright if I show slides?

Dr. Foster Is that okay if I share?

Dr. Boufford Yep.

Dr. Foster Do you see the slide?

Dr. Boufford Yes.

Dr. Foster Perfect.

Dr. Foster This is talking about RELAY. I'm very proud of the work that we have had since 2017 developing this program in collaboration with the Department of Health. We all know that it was the beginning of just the rise in the public health crisis for opioid overdose. The city saw the need for new and innovative programs to deal with this. From the Mayor's Office, there was this desire to intervene at that point of overdose. Those who survive an opioid overdose can feel scared and vulnerable afterwards. It's a critical moment to be engaged by a peer who will listen without judgment about what the person is going through and connect them to information and services to prevent another overdose. In other words, in this sort of process of stages of change, the mere fact that someone now has experience, a near-death experience was hopefully going to be a precipitate to moving up in that sort of those stages of change. Michael's story. This was just to make it a little more personal. We'll talk about the structure behind it. Michael used heroin for the first time. Went to lie down. His wife found him in their bedroom, his throat swelling, his lips turning blue. She called 911. Paramedics revived Michael with two doses of naloxone as his two daughters, aged 3 and 4, peeked through the bedroom door. The next thing he remembers is waking up in an ambulance. This is a story we hear countless times in our profession. We may even have personal experience with this. That is how pervasive this crisis is. The city said, this innovative idea was this idea of connecting patients at this moment after overdose. When they're in the emergency department can we quickly get someone there to take advantage of this person's willingness to potentially go and do something different with their lives? NYP was chosen as the inaugural site for the city. It was a partnering on developing this collaborative process. Even early stages it was very simple types of problems that we had to make sure we addressed. How do we reliably communicate? Initially there was no 800 number. If we're going to do a 24/7 project how does one get contact? We realized early on that poison control was a potential great first step. We were just starting. It wasn't going to be overwhelming in terms of the numbers initially with one site. It was a 24/7 that every emergency physician knows the number of. Calling it and saying, we had an overdose. They would then initiate the process that needed to be done to get the RELAY program to your site in a timely fashion. Now, eventually, as the program expanded, the number of calls grew. They gave us time to establish an 800 number, an 833 number, where now that's a 24/7 number. 833EDRELAY. We're able to 24 hours a day, the same process to get connection between the hospital and ED and RELAY. Now, in addition, we've had to create ongoing training for the staff. Obviously, as new staff comes on board, but also just to remind staff that this is available and to

make that extra call. It is definitely an extra step. We try to make that step as easy and as convenient as possible over the years. One of the things we've done, for example, ED RELAY has been great at when they do come and talk to us, giving out pens with ED RELAY. We have mouse pads that have ED RELAY. Both the logo as well as the number in every area of our emergency department to remind people of this as they're working every day. The process was that we developed over the years, and initially it was if a patient arrives in triage and has been given naloxone or was suspected of an opiate overdose and almost given Narcan, a RELAY wellness advocate can be called immediately. The team calls and reports a nonfatal opioid overdose. Request a wellness advocate from RELAY to be dispatched to the ED. Poison control at the time, but now it's the ED 1- 800 number will contact RELAY. A wellness advocate arrives at the hospital sixty minutes. And once they arrive, the wellness advocate will alert the attending physician. We standardized the sort of the quote unquote uniform of the wellness advocate. We were able to also get them contractor IDs to the hospital, which made it easier for them to enter the hospital. We have contractor IDs and a whole process where that's kept up over the years. They wear these uniforms or recognizable outfits, so that people know who they are when they come, and they interact with the physician. And then they're told, and patients over there, and then they go, and they talk with the patient. The bag that you see there is the bag of stuff that helps them to connect with the patient, sort of a bag of stuff that encourages the patient to reward them for being in the program. When the patient is medically stabilized ED staff will ask the patient if they're willing to speak with the wellness advocate. It can be anything from do you want help? We can get you help. We have experienced peers here in the Emergency Department that could come and talk with you about reducing the risk of overdose. They could teach you about naloxone. They also have care bags that contain some food, water, Metro card. Would you be willing to speak with them? If they say yes or I'm not sure, we call them. If they say no, I definitely don't. We don't push it. If any question, we are encouraged to call. Just to get a sense of the first years now it's expanded five years ago, expanded at fifteen sites throughout the city. They're from their website. They talk about in those first five years distributing over 6,000 kits. After about a year, we expanded, not just for our Milstein, which our larger hospital will be expanded to the Allen Hospital, which is a smaller hospital that's in Northern Manhattan. Those first five years the number of NYPD RELAY interventions was about 170. This is where they actually make contact with someone in the Emergency Department. We see how it's expanded. In 2022, there was 300. In 2023, there were over 340 contacts that were made. These were calls. They come in and they touch base with the patient. It's not just the bag. It's not just the stuff that they get, including the Narcan and the training. It also upon discharge. This is the most important thing. The wellness advocates continue to engage with the patients to provide ongoing support and linkage to care for up to ninety days. We hear Michael's story continued is one of those kinds of stories. During the ninety days that Ben, who is the advocate who came in to see the patient, and Michael worked together, they worked out what he needed most. What they needed most, Michael said, was something to listen. They met weekly at a fast-food restaurant to talk. If I was having a bad day, I would just let him know, tell him what's going on. He would give me advice and just talk to me because I had a lot going on. Ben felt easy to confide in. He'd say, you're doing good. Stay focused. That was good motivation to get

him into a rehab program. In terms of the ongoing relationship between our Emergency Department and the DOH, we have monthly quality reviews that are designed to improve both surveillance accuracy as well as we... The DOH has surveillance data. They have just like surveillance data for potential influenza cases. They get surveillance data for potential overdoses. We have a list of patients that we can that I can go through, go through the charts. Some of them are other types of overdoses, but most of them are some sort of opioid overdose. Are there any missed opportunities? Where there are cases that the surveillance data said, well, this was an overdose, but we don't see that as someone who was called in. I get to reach out to the provider and say, you know, remember this case? Was there any difficulty in contacting? Reminding you of why this case was appropriate and what the benefit was. I get feedback to the staff. In addition, there are monthly drop ins by the DOH RELAY staff to interact with all the staff. Whether it's physicians, nurses, even security, and they give information and receive feedback on the process. That was me. We have Alan here who's one of the counselors who part of the program if he wants to say a few words. I encourage him. If you have any questions for him.

Dr. Foster Alan, if you want to say anything.

Mr. Dorvil Yes.

Mr. Dorvil Good morning. My name is Alan Dorvil. I work with the Department of Health and Mental Hygiene and RELAY Initiative. Thank you, Sir. You did a great presentation on our wonderful program, wonderful initiative. As the doctor stated, this is a unique initiative for the simple fact that we meet the patient right where they're at in the Emergency Department right after a non-fatal opioid overdose. We sit down and we have a discussion with them and just basically just try to build rapport and see how we can help them. One thing we like to do is use person centered care. We don't go in preaching. We don't tell anybody what to do. We use motivational interviewing techniques. You know, asking open ended questions, but selective listening and accurate empathy. As a person in long term recovery and lived experience I can actually connect with a person in the ED. It's important. You know, the data states that once we are able to consent a person to the initiative and then able to follow up with them. Their chances of having another opioid overdose is cut in half, as opposed to not being engaged by a wellness advocate. This work is very important. In New York Presbyterian one thing, like once we get to the ED we check in at the nurse's station and talk to the attending physician and find out some background about the patient we're about to engage. When we go see the patient we have just like an idea of what we're dealing with. Most of the time the process involved a non-fatal opioid overdose. Let's say he was talking about Ben in the example. A lot of times that person would use a substance that has opioids in it, mostly fentanyl now. They pass out in the street. Somebody calls 911. EMS is dispatched. Gives the participant Narcan. A lot of the stories they woke up in the back of the ambulance. They woke up in the ED. A lot of times they're disorientated once we arrive and get there. You know, with a soothing voice, calm, non-threatening, nonverbal body language. We're able to build rapport. Get the participant to consent to RELAY services. What that can look like in the ninety days

is going to a detox or going to an outpatient program where they could receive medication, supported recovery, maybe Suboxone, methadone... Listen, sometimes people we use harm reduction techniques. A person might not even want none of that. What we do we introduce overdose risk reduction strategies such as don't use alone. Use in a public place. Have a Narcan kit. One thing we do with each person, we educate them on the use of Narcan. We implore that they keep this kid with them. A lot of times this the blue bag that he just talked about. It makes a lot of difference. There's a Metro card in there. Socks, toothbrush, toothpaste, a comb, a water bag. I like to say, oh, you won the grand prize. I'll go to the bag and say, hey, look, you got a water bottle. You stay hydrated. You know it's been hot outside. Hey, you got a fresh pair of socks. Hey, you got some good hair there. You could use the comb. Trying to build rapport with them. With the ED staff, you know, and with the participants we try to hand out these pins. These are special pins. If you ever run into a wellness advocate, ask if they have a pin. These are very special. We also give out these hats that we have on. Very, very nice fit. You know, nice hat saying that NYC Health. Listen, I've worked in different modalities over my career. I can say that being a wellness advocate meeting patients and Emergency Department has been the most rewarding and fun filling position that I've had to date because I get to meet the person right after an opioid overdose where we can... You know, the stages of change. The doctor talked about that. Before they met with me, right? They were in pre conversation, which means they wasn't thinking about nothing. Now, when they meet with us now the contemplation stage comes in. We could give them choices. And then after we meet with them and give them a referral now they're in the preparation stage. They're starting to think like, do I want to continue with this? And then if we continue to meet with them they're going to the action. You know, now they take action on those thoughts. If they get connected to a program they're in in the maintenance. I can see because I've going through all these changes. I can see the stages of change come to life. That's why I'm so enthusiastic about being a wellness advocate. I thank the doctor for doing such a wonderful presentation. We need this initiative to continue to meet people where they're at after they survive a non-fatal opioid overdose. Myself and my colleagues, we can meet with them and offer them some choices, some help. Whatever they need we're there for them. I could go on and on about this initiative. With that, my name is Alan Dorvil. I work with the Department of Health and Mental Hygiene. I'm a full-time wellness advocate and really initiative. Thank you.

Dr. Foster Thank you.

Dr. Bauer Thank you so much.

Dr. Boufford I have some hands online.

Dr. Bauer We have a couple of questions around the room. I would ask people to put your cards up if you have a question.

Dr. Bauer I'm going to turn to Dr. Whalen.

Dr. Whalen Hi. I just want to say, first of all, thank you so much for a fantastic presentation. I really think this is such an important juncture to be able to address a patient when they're in the Emergency Room. It is a really critical point. And to have that involvement at that time is really powerful. I have one question for Dr. Jordan and one question for Mr. Dorvil. My question for Dr. Jordan is around metrics that you might be able to share with us about how many of these individuals that have been engaged have been subsequently gone into care. Mr. Dorvil, I just am so impressed with the passion of your presentation. I think the hospital's really lucky to have you there working with them. You really seem to be very knowledgeable about how this approach can be maximally effective. Can you talk a little bit about the training that's involved in being a wellness advocate? That is something that could be reproducible in other areas of the state. I guess Dr. Jordan, if you could answer the first question and then turn to Mr. Dorvil for the second.

Dr. Foster Certainly.

Dr. Foster Actually, the DOH does keep that data, but it's not something that can come back to us in the hospital. Unfortunately, there's a little bit of a wall once they are sort of enter into the DOH arena. We don't get any sort of specific feedback on our particular site. Hopefully, RELAY can talk about overall the number of patients that have actually been able to be connected to rehab services, maybe even Alan knows that. From our perspective, we definitely see a difference between those patients who do say, yes, I'm willing to talk with the advocate versus those are like no. I just want to leave. The patients who want to leave come back two, three times in a given month. The other ones do not. We see it practically in the Emergency Department, but specific data Alan may might have access to. The DOH really does keep a little bit of a wall between what happens once they enter that.

Dr. Whalen Thank you.

Mr. Dorvil Again, my name is Alan Dorvil. With that question that you asked Dr. Foster, maybe you could reach out to our data team. They keep excellent records. They do a great job with that. You might reach out to them. As far as the question that you asked me. Yes, we're well trained here at RELAY. We go to new hire orientation. Everything that we go through, we're taught step by step by step. They'll never send us out to an Emergency Department without being trained. After we receive onsite training, we do role plays, right? After we do role plays, we receive constructive criticism until we get a feel of it. You can learn the basics. There's no cookie cutter approach. It's like basic training. They give us the basic tools to work with. We go on to the field and do that. We also receive trainers and motivational interviewing for person centered care. We receive different trainings to sharpen our skill set.

Dr. Whalen Thank you.

Dr. Boufford Anyone else in Albany?

Dr. Bauer That is it for Albany.

Dr. Bauer Thank you.

Dr. Bauer I'm sorry.

Dr. Bauer We do have one question.

Dr. Bauer Go ahead.

Dr. Boufford Okay.

Dr. Boufford Thank you.

Ms. Battaglia Lynda Battaglia, the Director of Mental Health and Community Services for Genesee County. I'm responsible for representing the directors of Community Services throughout New York State. Also, we focus on Mental Hygiene Services, which is specific for mental health, substance use and developmental disabilities. Thank you for this presentation. When I hear information like this, when I hear programs that are implemented like this it provides me with a lot of hope that we can get something like this in my county. I also want to point out the sort of challenges. We know workforce is definitely a challenge, but I think the rural settings, which Genesee County is a rural setting. I think the rural counties have a bit more challenges with workforce and identifying, like you said, wellness advocates or even peers or CRPA. It's needed in the rural counties. Even with the salary increases for CRPA and for wellness advocates our barriers seem to be a bit more heavy in trying to implement programs like this. That's not to say that it couldn't happen. Just to say that we would like to implement this, but we would probably need help in doing so to make sure that our rural counties have services like this.

Dr. Boufford Thanks.

Dr. Foster One of the things that struck me is the willingness for the program to be as flexible as it has been for our patients. They don't just simply come in for the bulk of the patients which is right at the moment, and we call them within the hour. They also, if someone is an overdose and is too sedated to talk to you. They will wait until the sedation wears off. If the patient is admitted to the hospital, they will then know about the patient and then when the patient when they finally are stabilized in the hospital go into the inpatient hospital as they're first coming. As long as they know about the patient to say, you know, this is our services. Are you willing? During COVID, we were able to even implement a phone system where there was an initial phone interaction to be subsequently followed by some other sort of interactions as best they could during that time. Programs like this they're renowned for their flexibility. Hopefully, there's something that can work for you.

Dr. Boufford Thank you.

Dr. Boufford Dr. Moore.

Dr. Moore A great presentation. I think this is a very good template that should be expanded elsewhere. Dr. Foster my question is you mentioned in the beginning that the, so to speak, inclusion criteria were used or thought to use of Narcan and then mentioned at the end that there were some other people who were not opioids. Are those people that just thought, the thought was there, and they got in that way? Maybe there's a little bit more liberal attempt to get any kind of overdose?

Dr. Foster We've expanded. You know, on the one hand RELAY is not designed for withdrawal of patients. It's not designed for people who haven't experienced some event. That event can be very broadly interpreted by the DOH so that they come in. Patients who take cocaine and cocaine happened to be laced with fentanyl. They thought they were taking cocaine. They have no desire to take opioids. It was introduced into the powder or pills. Pills are being pressed all the time. Fentanyl pills. It turns out to be fentanyl. Anyone who comes in and the thought was that they needed Narcan, or they thought was that it was a poly substance with an opioid. They are happy to be called. They're happy to come in. This is still a person who could benefit from the resources that they had available to them.

Dr. Boufford Thanks.

Dr. Boufford Nilda Soto.

Ms. Soto Nilda Soto. I'm a PHHPC member. Dr. Foster, you said that one of the options when the person is introduced to a RELAY person is a referral, whether it's detox or residential program. How readily available are those options? Because I hear that there are long waiting lists.

Dr. Foster I think Alan could best answer that.

Mr. Dorvil Yes.

Mr. Dorvil To answer that question there's detoxes and rehabs throughout the five boroughs of New York. There's really no waiting list. I would just say let's say the time of day. Let's say if I go see somebody at 5:00pm and a lot of the detox is stopping meeting people, but they could be picked up first thing in the morning. In answer to your question, if a person wants to get into detox or rehab, we could get them there. We have a lot of different programs here in New York City. They work with us here at the Department of Health for Mental Hygiene. If a person wants to go to detox rehab, we could get them in.

Dr. Foster I do want to emphasize that sort of sort of implementing any kind of program that deals with social determinants of health has always been a struggle in Emergency Departments because of the time, the fact that we're already sort of have patients

waiting too long and walk out rates. This program was developed specifically so that I just have to pick up the phone, call this program and everything else is taken care of by the advocates when they come in. I'm not involved in trying to get a program. Everything is just handed off. I can go on and deal with all the other issues that are in the Emergency Department. In terms of implementation has been very well accepted by our physicians as being they take control. You always want something where one phone call results in a team of people sort of trying to help you solve the problem that you don't have to then be involved with.

Dr. Boufford Thank you.

Dr. Boufford Dr. Soffel.

Dr. Soffel From the perspective of the prevention agenda, I think we are particularly interested in how to successfully build collaborations between local departments of health and providers. I would love to have you speak a little bit about what facilitated the collaboration between DOH and Presby, and what challenges you might have encountered in that attempt at collaboration, and how you resolved some of those dynamics.

Dr. Foster I will say that I was very fortunate. This was the ideal type of collaboration where they came to us and said we have this idea. We want to do this. How can we do this together? If it had been my idea to do this and I had gone to a Department of Health had not thought of this yet. I can imagine it being years of sort of persuading and pushing and pulling. Any program that starts from the DOH and goes to a hospital has a multiplied chance of success in terms of speed, speed of implementation. I think we can go the other way, but this was the ideal type of format where they said, we're going to help you deal with this. As long as you can figure out a process that minimally interferes with the flow of patient care for other patients this can be a success. That's what we've striven to do. That's all we had to strive to do at that point.

Dr. Boufford Thanks.

Dr. Eisenstein.

Dr. Eisenstein Yes.

Dr. Eisenstein Thank you.

Dr. Eisenstein Great presentation. I think that this represents an excellent model. This meeting's about the prevention agenda. We know we have to address overdoses and opioid abuse. I do want to point out that there's a lot of people on the phone. We even had a question from Genesee County before. New York City's Health Department is uniquely situated, very different as a former health department leader. There certainly isn't staff in my former health department to do this. There is good news. My system now has a very similar program that we're doing with a very successful community-

based organization. I know the model of this presentation was it's through New York City's Health Department, but the one that we have is almost identical. I don't want to say it's identical because there's a few differences, but our Emergency Room physicians love it. They make a call that the peer advocate comes in and really takes a lot of the responsibilities off of the Emergency Room providers in a successful fashion and manner. For those who are saying there's no way my health is there a county health department that has six people or eight people in some counties. This can be done. We have a Medicaid waiver coming out that's supposed to strengthen community-based organizations. This is a perfect example I think as a model, but it doesn't have to be government based, although it can be. Nobody's a bigger supporter of government local health departments than me. When they can't other community-based organizations can. When there isn't staffing at health departments every county has people who have experienced substance abuse. In our model, all of the wellness advocates are former substance abuse users. They love doing this. Many of them are in recovery. It's made a dramatic difference. This is evidence based proven to work. I just want to advocate that this is a great model. That was a great presentation. Just because it might not fit every community the exact way that it was presented doesn't mean that as a concept we should throw it out. I think it should be something that we look at strongly as we go forward with the prevention agenda. Just my recommendation having been on both the government and the private side of it.

Dr. Boufford Thanks.

Dr. Boufford Great comments.

Dr. Boufford Dr. Lim.

Dr. Lim I thank you both for a wonderful presentation. I have a comment and a question for either Mr. Dorvil or Dr. Foster. It both kind of go back to I think a topic that we've discussed in another committee, which is basically ED congestion. In relation to what I think Nilda said. I was going to ask the same question about how easy it is to access post overdose these other services. Mr. Dorvil explained about that usually it's not a major issue, at least in the city. I just want to sort of make sure that for folks to understand that there's actually two different levels of detox. There's inpatient detox, of which there's two levels. There's outpatient detox. Very interestingly, you know, there's not a lot of hospitals that have inpatient detox services. A lot of the detox services are run by non-hospital entities. It's a very interesting sort of situation where actually the transportation to those places is dependent on that organization as opposed to this is a medical issue. They're going for inpatient detox. It's sort of an interesting dynamic that's set up that's different for some reason for this. There are all kinds of sort of things that have been put into place that have existed for years, which I think to some degree reflect how addictions care has been separated out from the general health system. How long people have to wait sometimes to get that transportation, I think, contributes to ED congestion. The other question and the specific question that I had was more general. This is essentially like a critical time intervention. It's post overdose. It's connecting people to care, which is so critical. The question that I had is, you know, Dr.

Foster like at Columbia or Mr. Dorvil if you know of other organizations. I think other hospitals whether they're participating in RELAY or not. Sometimes they have their own services or maybe work with other CBOs to not necessarily work with people who are post overdose, but people who are coming in repeatedly intoxicated. If we think about prevention, you know, we want to get to people even before they overdose, right? I'm not sure if there's an actual team or a model aside from like CRPA, which maybe some hospitals do or other kinds of teams that may be approaching people even before their overdose, you know, coming in repeatedly intoxicated or metaphysical like from substance. Of course, it's not just opioids too, right? I don't know if you have any familiarity with these other kinds of teams if they exist.

Dr. Foster You know, I think it does depend on... We've actually, over the years, worked with CBOs to have various degrees of what you're talking about. It still does boil down to the single phone call that goes to our social worker care coordination group that thankfully, at Millstein, we have 24/7 social work. Although during the days when they can really do most of their work with regard to CBO connection. That's really as close as we can get. What we do is we try to find those CBOs that will take as much of that process away from our social work, but social work still, or care coordination. That one phone call then engages a CBO that then will do all the work to figure out where that patient can go. You're right. That would be for repeated alcohol or even out or even withdrawal. Remember, RELAY does not really address withdrawal patients. We actually have a separate buprenorphine type of program, both for education. Our physicians over the years when buprenorphine came out in terms of being more comfortable giving it. More importantly, that sort of connection to follow up is squarely in the hands of our care coordination social work team. We do one phone call to them. They engage a CBO to do the next step. Our goal is to have that CBO take as much of the burden off of the social care coordination as much as possible, so that they don't have to do as much work, because they're also very, very worked for all these other issues in the ED as well.

Mr. Dorvil I can also add to that.

Mr. Dorvil If a person continuously goes into the ED, you know, alcohol intoxication or other my mood-altering substances. A lot of times we still get a call. We'll come out. We'll do an assessment. We'll find out that it's not an opiate overdose. But while we're there, we'll still have a conversation with that person and help the person with referrals and still have a conversation with them. Just because we get to the hospital and it's not an opiate overdose, maybe it's alcoholism... You know, whatever other substances involved we'll still engage with the person. We just don't just get there. Oh, it's not opiates and turn around. No, we don't do that. We'll still sit down, have a conversation with the person and look at the next appropriate stage, which they might want to go to.

Dr. Boufford Thanks very much.

Dr. Boufford In the interest of time...

Dr. Boufford I'm sorry. Dr. Foster, you had to comment on that.

Dr. Foster I just wanted to comment. The 833 number is a citywide number that everyone uses. It's for providers to call not patients. It takes advantage of that. Just as he said, patients would come in with alcohol overdoses. They come in. They're given Narcan many times nowadays by bystanders when they're intoxicated. Just the fact they got Narcan starts a process, and we see where it goes. The RELAY program has been very accommodating.

Dr. Boufford Two more questions and then we'll sort of wrap up.

Ms. Farrell Thank you.

Ms. Farrell I have a question for Mr. Dorvil or Dr. Foster. When does managed care get involved?

Mr. Dorvil For me, for us, managed care gets involved after the referral is made. You know, we're there to do the initial assessment, get consent for the person to join our initiative and then doing the basic assessment that's when managed care comes in. They'll say if they have to go to outpatient program, if they have to go to an inpatient program, if they have to go in an outpatient program, whatever pathway that they choose that's where managed care comes in. The initial engagement, you know, that's between the wellness advocate RELAY and the person in the ED.

Dr. Foster I don't have to think about that at all. I don't have to ask it or think about it. It's a referral regardless of anything else.

Dr. Boufford Dr. Watkins.

Ms. Farrell The coordination from the insurer or the managed care provider.

Dr. Boufford I was going to ask what is paid for? The funding for this program sort of building on that, Lindsay. Are they insured once the diagnosis is made? Who pays for the wellness advocates, the program? Is it the Health Department?

Dr. Foster Health Department.

Mr. Dorvil Department of Health and Mental Hygiene.

Dr. Boufford Is it part of the Mayor's budget? Do you know?

Dr. Foster That's how it started definitely.

Mr. Dorvil Yes.

Dr. Boufford Thank you.

Dr. Boufford Dr. Watkins, final question from our colleagues.

Dr. Watkins Well, that was going to be my question as well. This has been a great presentation. I really appreciate you guys sharing this with us. But in the Michael story, it indicated that Michael was found by his wife and his children. Can you tell us whether or not your program extends to the families who oftentimes have to deal with those who have overdosed in the households?

Mr. Dorvil Yes.

Mr. Dorvil Let's say, Michael, you know, went to the Emergency Room and he was engaged by myself or one of my colleagues. He signed a consent form. A lot of times we asked for emergency contact information, secondary contact information. Let’s say, he puts down his wife, or maybe she was there in the Emergency Room with her. We'll have that conversation with Michael and ask if it's okay if his wife can stay and be present. Once he gives us the consent, yes, then we'll also engage the wife. There's a lot of different programs I have for families. Different maybe 12 step programs for family members or there's other support groups for family members, or even if we have a conversation with the wife. Either way, she's going to be engaged and part of the process if Michael and herself choose that path.

Dr. Boufford Thank you.

Dr. Boufford Let me just note that we're getting a number of chats. We'll record those. Logistically don't have time to get into them. We'll make sure the chat folks; the register is sending their comments and also the questions are asked. I had two. One thing I wanted to point out that Dr. Lim said. I think that's really important is this distinction between primary prevention and secondary prevention. I think all of the... To the degree that the new model of the prevention that is really beginning to enter into the health care access quality area. I think the secondary prevention question comes up and then we don't want to lose sight of the primary prevention, as you mentioned Sabina. I appreciate you raising that. The last thing I wanted to mention is you mentioned two of your sites are Presby sites. There are fifteen sites you mentioned. How does that happen? How is it spread? Is that just a funding issue or the Health Department or whatever?

Dr. Foster That's my understanding that the Health Department gets the funding to expand. They look at the areas of highest overdose statistics and then they target hospitals in those areas. That's how they've been rolling it out.

Dr. Boufford Thank you.

Dr. Boufford Ms. Hidalgo, you're the other presenter here. You haven't said anything. You're in charge of all the external relations. Do you want to make any comments? Just in general, I think especially around the relationship question that Dr. Soffel asked about

and sort of the really engaging with community, trying to deal with conditions that may be able to prevent problems like what we've been talking about just now.

Ms. Hidalgo Thank you very much.

Ms. Hidalgo First, I want to start by thanking Mr. Dorvil and Dr. Foster for sharing such wonderful information with all of us here today. You know, we work very hard to continue to cultivate those relationships because there's a lot of great need in the communities that we serve in Northern Manhattan. We have a robust list of community-based organizations. One that we partner with very closely New York Columbia campus is Alliance for Positive Change. They to have a peer program that allows us to bring another group of experts to support our patients. While I have the floor thank you very much for inviting us to present today. It's very nice to be able to join this group and share some of our work.

Dr. Boufford That's great.

Dr. Boufford Let me extend our thanks also to Mr. Dorvil and Dr. Foster and yourself for coming. We appreciate it. We'll be in touch with you. I'm sure as the next month's go forward to learn more and to talk about how this might spread and be extended.

Dr. Boufford I'm going to go back to Dr. Bauer in Albany and see if she has any final comments on this segment and then I'd just like to introduce our next segment.

Dr. Bauer Thank you, Dr. Boufford.

Dr. Bauer Thanks for the rich discussion and the great questions. Thanks to our presenters, Ms. Hidalgo, Dr. Foster, Mr. Dorvil, for joining us today. Really appreciate you sharing the successful partnership with us.

Dr. Bauer Dr. Boufford will now turn to the next portion of our agenda where, our colleague---.

Dr. Boufford Thank you.

Dr. Bauer Sorry.

Dr. Bauer Go ahead.

Dr. Boufford No, no. He was waving.

Dr. Boufford You're welcome to stay with us. If you need to leave we understand.

Dr. Bauer We'll now turn it over to Zahra Alaali, who is our Prevention Agenda Coordinator here at the New York State Department of Health to present the 2025 to 2030 prevention agenda framework.

Dr. Bauer Dr. Boufford, I need to step away for a moment.

Dr. Bauer We'll leave the floor in the capable hands of my colleague Dr. Whalen.

Dr. Bauer Thank you.

Dr. Boufford If I may, before you start there, I'd like to give a little bit of background for the Ad Hoc Committee since we haven't. Remind everyone. I know everybody has day jobs. They're busy. We can take down the screen share just for a minute. Zahra, just so we can see folks. I appreciate that. We'll put up that slide.

Dr. Boufford I just want to provide a little bit of context for today's meeting why we're presenting this and what we're hoping to ask you to contribute to the conversation. This is the fifth meeting of the Ad Hoc Committee and its role as providing advice to the Department of Health on the prevention agenda. As Dr. Bauer mentioned, we are in the process of shaping the 2025 to 2030 agenda framework. The prevention agenda is the name used in New York for the State Health Improvement Plan, which is a legally required activity of hospitals through, the federal, if you will the Obamacare legislation originally and also the New York State, Health Improvement Plan requirements of local health departments and hospitals for assessing the needs and the health of their communities and developing service plans and health plans to address them. During the meetings we had of this committee in April and July and most recently February and now, we've heard from sister agencies asking them their reactions to the last cycle, the 2019 to 2024 cycle; what worked for them, what didn't work, how to improve, and move ahead and modernize, if you will, the framework for the next prevention agenda. We heard from OMH/OASAS/NYSOFA, Department of State, NYSACHO, Greater New York, HANYS. I'm hoping everybody knows all those acronyms. My apologies. We also reviewed the sort of updates from New York State about the health status around the states and what are the health problems states facing. We heard about other models of state health improvement plans that other states are using and talked about, began to talk about in an earlier presentation in February, this group got a general outline of the thinking of the desire to move much more in the direction of addressing social determinants of health more directly than we had been doing in the previous prevention agenda. We also heard from colleagues on the Master Plan on Aging. I noticed Andrew is here today and how that links might be made for older persons to assure that they get the attention intended in the prevention agenda. We also discussed hospital community benefit. We had a presentation on that, especially on the community health improvement category of community benefit, which is the hospital obligations to invest in community health status relative to their non-profit status. Heard the reports and from a colleague in Albany, University of Albany doctoral student who has been in health department before on how we're doing in the state, really looking at alignment of community benefit investments at hospitals are already making with the priority areas of the prevention agenda. We've gotten a lot of feedback. I think generally, local health departments, this is the idea of local health departments working with hospitals and health systems and bringing other colleagues to the table at the local level is something

that everybody valued. We want to see that strengthened in the future model. Attention is being paid to that as you've heard. The number of objectives was felt to be a little bit too big, too demanding. So much more of a focus was asked, requested. As I mentioned, a lot more sort of direct attention to social determinants. There's been a lot of back and forth with the staff thanks to Dr. Bauer and her team and the Office of Public Health Dr. Whalen involved. At this point, I want to mention Shane Roberts, who has moved on to another role in the Health Department and Zahra Alaali were very important in all this development. The Public Health Committee had raised questions, mainly questions about accountability and leverage going forward in this new model, which you're going to be hearing about. I think after a retreat in May of the PHHPC meeting and we had a Public Health Committee meeting in July where what you're about to see was fully presented and discussed the questions that the Public Health Committee had addressed. The Public Health Committee has approved the framework for the new approach to the prevention agenda that you will hear about. It has done that on behalf of the PHHPC, which doesn't meet again until September. The PHHPC has statutory responsibility for approving the approach to the prevention agenda. What you're going to see is the framework that was approved by the Public Health Committee, the sort of action steps that are imagined, the timeline that's imagined. What we are wanting to do in the discussion here today is to really ask for your feedback/your questions on the presentation. Secondarily, ask each of you to think about as you're listening how your agency could be involved in partnering with the state health department and with other agencies to advance the new model of the prevention agenda to tackle these social determinants. It's really two-timed question. First half after Zahra's presentation will be questions you have for her or clarifications. The second half really talking about how you see your organization engaging. We are recording this meeting. Everything that you say will be put in the transcript. We will follow up with you with those suggestions really as we go forward. The areas that the PHHPC will be looking at are you're going to be hearing about the social determinants domains and the specific activities projected there. Similarly, an effort to pull together an interagency group. I noticed some of our colleagues, Paul Byer and others are here. Finally, really looking at how the department may have tools to increase the collaboration, engagement, alignment of hospital community benefit investment in their communities in the prevention agenda priority.

Dr. Boufford With that, let me turn it over to Zahra Alaali to have her make her presentation. As I mentioned, we'll sort of divide the discussion into those two parts.

Dr. Boufford Zahra, over to you.

Ms. Alaali Thank you.

Dr. Boufford Let me just put that first slide up really quick and I'll dispose of it, if you don't mind. My apologies.

Dr. Boufford This was just to show the prevention agenda has really been evolving over time. I think that's the important issue is this is sort of the... This is the fourth

generation of the prevention agenda that's been used to guide the state health improvement plans. What do we learn from the earlier versions now plowed into this area? Let me just highlight two other pieces that the PHHPC has implemented as a result of their prevention agenda, which will have to be addressed by the PHHPC going forward is with the shift in the framework for the prevention agenda the acute care hospitals have been asked through the CON process to address how they are participating in the prevention agenda locally. That language will have to be modified in the CON effort. We hope to think about how that could be used to also increase the collaboration between hospitals and local health departments.

Dr. Boufford Let me stop there and let the Zahra now start.

Dr. Boufford Thank you, Zahra.

Ms. Alaali Thank you, Dr. Boufford.

Ms. Alaali Good morning, everyone. I will start with an overview of the process that New York State Department of Health used to develop the state health improvement plan or what we call here prevention agenda. I'll try my best not to use any acronyms, but if I do here is your reference slide for the common acronyms I'm going to use during this presentation.

Ms. Alaali On the screen, you can see the planning and implementation timeline for the new cycle of the prevention agenda. The process begins with forming the Ad Hoc Committee in March 2023. The Ad Hoc Committee members were invited to lead the State Health Improvement Plan. Data collection for the state health assessment took place in July 2023. Last December, our team provided a detailed description of New York State; population, demographics and health status. Last February, our team identified a list of health issues and started the prioritization and processes. As of today, we have a new prevention agenda framework and new priorities for the new cycle of the prevention agenda for 2025-2030 timeframe. And by the end of this year, we will finalize the SHIP, or the State Health Improvement Plan by creating five domain specific action plans. Implementation will start from January 2025 through December 2030. More details to come in the next few slides.

Ms. Alaali Eighteen months of extensive assessment, data analysis and input from our key partners, the New York State Department of Health identified forty-four health issues for inclusion in the new cycle up the prevention agenda. The identified issues include health outcome priorities and social determinants of health. As I mentioned, in February 2024, we started the prioritization process. Our team disseminated a survey to identify the highest priorities for the new cycle of their prevention agenda using a weighted voting tool.

Ms. Alaali We received a total of 230 responses. The response rate is 57%. About 31% of participants were from hospitals. 28 from local health departments and 27% from other organizations. Other organizations include community-based organizations,

professional medical associations, school-based health centers, NGOs, private and legal services, among others. Additionally, 8% of participants were from New York State Department of Health and 6% from other government agencies. For the new cycle of the prevention agenda, the top twenty-three highest ranking health issues were selected for inclusion. These top twenty-three priorities contain, again, a range of issues from socio economic factors to specific health conditions. We group them into six main themes. Number one is economic well-being. Number two, maternal and child health. Number three, maternal mental health and substance use. Number four, health care access and quality. Five, safe and healthy communities. Six, education, access and equalities in this table. I believe everyone has a copy of this light. I'm going through just the top ten there basically for the prevention agenda. For the next cycle, we selected the top twenty-three priorities. Number one top rated health issue was poverty. Number two was prenatal care and maternal mortality. Number three, nutrition security. Number four, drug overdose. Number five, health insurance access. I will skip the next table. Since again, we selected the top twenty-three and everyone has a copy of the slides.

Ms. Alaali You can move to Slide Number 13.

Ms. Alaali In this table you can see the list selected health issues. The least ten selected health issues include tick borne diseases, compulsive gambling, foodborne illnesses, cannabis use, end of life care and planning, health care associated infections, outdoor air quality, climate change and social cohesion.

Dr. Boufford Can I just make one comment?

Dr. Boufford Very often we found that when colleagues know that there is already a program dealing with outdoor air quality and other things and infectious disease prevention they don't tend to rank them as priority. I just want to as opposed to people not thinking they're important always.

Ms. Alaali Sure.

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

Ms. Alaali You can see the current prevention agenda five priorities in the left and the new prevention agenda on the right. So, the current prevention agenda has five priorities. The first one is preventing chronic diseases, promote health and safe environment, promotes the health of women, infants and children, promote well-being and prevent substance abuse disorder. And the last priority is preventing communicable

diseases. On the right hand, the 2025 2030 prevention agenda is centered around the healthy people 2030 social determinants of health domains, which is economic stability, social and community context, neighborhood and built environment, health care access, inequality, and last, education access and quality. The, one of the key questions, is why this shift and what are the reason behind structuring the new framework around the social determinants of health domains? So, our state health assessment noted a significant decline in the New York State health ranking. The 2023 two report shows that New York rank dropped from 11th in 2019 to 20 third in 2022. Much of this stemmed from the latest ranking algorithm, which includes social and economic factors that public health has largely not focused on before.

Ms. Alaali As you can see in the summary at the left side New York has poor ranking for low education levels, poverty measures, among others.

Ms. Alaali This table basically show some income and poverty related metrics by race and ethnicity. In New York, Black non-Hispanic have the lowest annual gross income. Looking at the percentage of families below the poverty line, the table show that Hispanic and non-Hispanic Blacks have the highest poverty rates in the state at 17.6 percentage and 16.5%, respectively. Also, if you look at the children who live in poverty rates there is around 18.4% of all children in New York living under poverty rate. When examining child poverty by race and ethnicity 28% of Black non-Hispanic children live in poverty, compared to 12% of white, non-Hispanic children.

Ms. Alaali We see similar trends also in unemployment. The unemployment rate was 9.2% among Black non-Hispanic and 8.3 among Hispanic compared to 4.9 among white non-Hispanic.

Ms. Alaali This slide provides a snapshots of high school graduation in New York. In America's health ranking New York State also ranked thirty-four out of fifty for students graduating high school in time. For the 2019/2020 school year the high school graduation rate was 83.5, which is below the national rate of 86.5. Looking at the trends here for high school graduation, although we see improvement in the last ten years. However, the high school graduation rate remained relatively flat.

Ms. Alaali By shifting the focus of the prevention agenda framework to social determinants of health we gain more comprehensive view of the health by considering various factors that influence well-being. This new framework not only enhances the existing prevention agenda by adding more dimensions, but also make it more robust and inclusive. Incorporating social determinants of health will strengthen the old framework by targeting the root causes of health inequalities, which basically will lead to more effective and equitable health outcomes. Last, the new framework, is better---.

Ms. Alaali Sorry, I heard someone. I think someone needs to be muted.

Ms. Alaali The new framework is better aligned with the New York State Department of Health vision, which is in the next slide. The new version of our department focuses on health equity and thriving community.

Ms. Alaali Moving to the most important slide here, which is the details of the new framework. At the top, we see the new vision of the prevention agenda, which is every individual in New York State has the opportunity regardless of background or circumstances to attain their highest level of health across the lifespan. The new vision statement shifts the focus from being the healthiest state in the nation to achieving health equity.

Ms. Alaali Next, you will see the foundation of the Prevention Agenda framework, which is centered around four foundations. Number one is health equity, which focus on addressing social determinants of health and reducing health disparities. Number two is prevention across the lifespan, advocating for increased investment in primary and secondary prevention at every stage of life. Number three is health across all policies which promote interdisciplinary, multi-sector collaboration. For example, currently we are working to improve the alignment of the prevention agenda and the Master Plan of Aging with the New York State Office of Aging. Number four, which is the last foundation here is local collaboration building, which promotes community engagement and cross-sector collaboration in local planning. One thing we will continue doing since we have been doing in the last cycles of prevention agenda, which is maximizing the impact of the intervention with using evidence based and best practices, intervention for state and local action.

Ms. Alaali Now, moving to the domain and priorities. There are twenty-one state health priorities grouped into the five social determinants of health domains. The priorities are in blue, and the category labels are in purple. I'm not going to list them, but since everyone has copy, I just need to mention that please take a look at the priorities. Today's meeting is an opportunity to gather your input on the selected priorities. We would love to hear your thoughts and perspective about the selected priorities for this framework.

Ms. Alaali Next.

Ms. Alaali I will skip that slide since I already covered the foundations as well.

Ms. Alaali For this prevention agenda framework for each domain we have an overarching goal. For example, economic stability, overarching goal is more a visionary goal here. That old people in New York have the financial security and support needed to thrive. You can see here each domain has an overarching goal or a visionary goal.

Ms. Alaali Next.

Ms. Alaali Each priority will have one to three objectives and at least one indicator to track progress. Some priorities will have more than one objective and possibly more

than one indicator, but we are aiming to have fewer objectives and indicators and less prevention agenda. Each priority will also have evidence-based intervention and we will provide resources for implementation. We will identify the population or age groups affected and less the parts in our organization that will play a leading or supporting role. We will organize work from the Ad Hoc Committee members and other partners to create five domain specific action plan. Just wait for it after the Ad Hoc meeting. The next few days we will send a survey requesting for members to volunteer to participate in those domain groups. Each working group will develop a final set of goals, equitable and inclusive objectives and indicators to assess the progress. The working group will also identify organizational level, evidence-based interventions to address these goals. The working group will be established by the end of July, beginning of August, and activities estimated to be completed by October 2024. To ensure health across all these priority specific action plans will be also reviewed by other state agencies. We will basically incorporate your comments and feedback. For the objectives, we will use framework to ensure the objectives are equitable and inclusive. Current round of prevention agenda use. We are using SMART goals. We are shifting to objectives.

Ms. Alaali In the following slides, we will address these questions raised by public health committee members and the Ad Hoc members in previous meetings. We will provide few examples of successful collaboration between hospitals, local health departments and local partners to address social determinants of health. We will discuss the cross-sector partnership and strategies for strengthening the collaboration. Health departments and hospitals can address social determinants of health in many ways. I think after the RELAY presentation they covered many of those methods. Hospitals can basically screen for patients for socioeconomic risk factors and connect them to community resources. Health departments, on the other hand, can improve data collection and analysis, enhance health care and social services connection, create or foster government wide collaboration and provide targeted training and support, among other strategies they could adopt to address social determinants of health. I will provide two examples from the New York State one from hospital and one from Department of Health. First example is the Well-Fed Essex County Collaborative between Essex County Health Department and other partners, including hospitals, forums and other institutions. This effort aimed to increase health food access for all residents, especially vulnerable population. Key projects include integrate farm stores into non-traditional businesses to provide local healthy food. Another project is Wellness Prescription, which offer nutrition education and voucher for fresh food and vegetables.

Ms. Alaali You can skip to Slide Number 36.

Ms. Alaali This is another example from a hospital to address housing instability. The linkage House at Mount Sinai in partnership with community organization. They provide services for elderly and aging patients with Alzheimer's disease. The linkage house has three objectives. Number one is to increase affordable housing availability in East Harlem. Number two is to provide meaningful engagement for older adults. The last objective is to improve access to health care. Bottom line from those examples is better data, cross-sectoral partnership. Training the staff is a way to address social

determinants of health. There are more examples on this slide, but I will give them. If you have any question you can contact me after the presentation. I will be happy to go over them with you.

Ms. Alaali In the next few slides, I will summarize the differences between the current and the new prevention agenda. The prevention agenda is designed. It's a tool. It is designed to be implemented by a wide range of public and private partners. Hospitals and local health departments are leaders in local community health improvement planning. However, the list of priorities, objectives and evidence-based intervention in the prevention agenda provides flexible options for other partners at the state and local level. This tool can be used by many partners. It's not just local health departments and hospitals. We have a few examples here in this slide of other partners who could use it. This is not limited again. These are just examples. Giving the complexity of the prevention agenda priorities cross-sector collaboration is always a key. It is always recommended and encouraged. There are several ways to support the prevention agenda efforts in addressing social determinants of health. I already mentioned the local health department and the hospital that they are the leader in local community health improvement planning. Another challenge channel is through leveraging hospital community benefit spending. We are having a discussion with hospitals in the upcoming weeks to discuss this topic. Another channel is Initiatives and investment by other community partners. The last one is the Certificate of Need. New York State health care facilities are required to submit a Health Equity Impact Assessment and to report activities that advance prevention agenda goal with the Certificate of Need application These requirements ensure the facility's proposed project aligns with the prevention agenda and enhances health equity. We are looking for opportunities to strengthen collaboration between local health departments and hospitals. We are also looking for opportunities to ensure a stronger alignment of hospital community investment with the local health department priorities. Last, we are looking to establish cross-sector partnership, and I will discuss this in the next slide.

Ms. Alaali This is a summary slide that compared the current cycle of the prevention agenda with the next cycle. Both current and new prevention agenda are six-year cycle. Current prevention agenda focus were around major areas of public health with emphasis on health disparity and determinants of health outcomes. However, the 2025-2030 shifts the focus to social determinants of health. For the objectives since advancing health equity is a key component of the prevention agenda, the new cycle of the prevention agenda is moving to SMART goals from SMART goals. Local plans submitted by hospitals and local health departments the new prevention agenda cycle will move to six-year Community Health Assessment and Improvement Plan submission for local health department. Current prevention agenda local health departments submit their plans every three years, and they are in sync with the hospitals. However, because this deemed to be a burden on local health departments. We are switching to a six-year community health assessment and community health improvement plans only for LHDs. Hospital will continue to submit their community service plan every three years to meet the Internal Revenue Service requirements for tax exempt hospitals. In both cycles, the Department of Health encourages hospital and local health departments to submit a

joint plan and involve local communities in all phases of the planning and implementation. We will continue doing this. For the priority selection and the current prevention agenda cycle hospital and local health departments were asked to select one of these options. First option is two priorities with one focus area each or one priority with two focus areas. At least one of the selected priorities has to address disparities and promote health equity. You would cycle hospitals and local health departments will be asked to select three priorities. I will give examples in the next slide. Currently, we are developing the guidance. There are more details when the guidance is posted.

Ms. Alaali Thank you.

Ms. Alaali Here's an example of the priority's selection. As I mentioned, there's two option, three priorities and their one social determinants of health domain. Here we have the domain social and community context. Our partners can select tobacco and e-cigarette use, adverse childhood experiences and healthy eating under the same domain. In the next slide they can select three priorities from different domains.

Ms. Alaali Next.

Ms. Alaali As I mentioned a few minutes ago, we are looking to establish a cross-sector partnership of the Social Determinants of Health Interagency Working Group. This is what we are calling it. Basically, is where we are looking to establish. We are exploring opportunities for existing interagency councils to create a working group to perform this function. The Social Determinants of Health Interagency Working Group basically will provide a forum for agencies to identify shared goals, opportunities, and resources. They will also promote a government culture that prioritizes health and equity for New York and across policy areas. They will incorporate health and equity into their state agency practices.

Ms. Alaali The next slide, we have a proposed timeline for the establishment of this interagency working group. By October 2024, we will define the mission and role 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 initial meeting to introduce members, outline objectives and review of the prevention agenda framework. After the initial meeting, the working group will start quarterly meetings to review the progress prevention agenda, goals and milestones.

Ms. Alaali This is the end of my presentation.

Dr. Boufford That's great.

Dr. Boufford This would be this sort of part of the conversation for questions, clarifications, feedback. I'll keep my eye on the clock. Maybe we'll take this down unless... I think somebody else in the chat about the slides. I think it was sent out to anyone that we knew was coming to the meeting and will obviously be posted. I don't

know if it can be put in the chat or if it is already for those who may want to look at it while they're considering their questions. Maybe we can open the floor then for questions, feedback, issues in terms of the presentation, and then we'll move into the partnership segment.

Ms. Oyler Thank you.

Ms. Oyler Thank you for the presentation. I benefited from hearing you, Jo, yesterday at the MPA coalition. Mentioned that you would be shifting to Healthy People 2030 as the framework. I had an opportunity to look at the CDC site. In their framework, they do mention developmental readiness for children. During this presentation, I did see reference to adverse childhood experiences, but I noticed under the education access, the focal point really starts at kindergarten, and up. I'm just wondering, based on earlier conversations I've heard here in previous meetings. We have talked a bit about social emotional learning in children ages; 3, 4 or 5 in that pre-kindergarten age range. Given what we know about the importance of social emotional learning for self-regulation and behavioral health through the lifetime and educational achievement, I'm just wondering if any thought has been given to where that may fit into the next prevention agenda. Thank you.

Dr. Boufford I don't know who's fielding questions. I'm not sure if Ursula's back.

Dr. Whalen I'm sorry. Dr. Bauer had to step out to another meeting. I'll be filling in for her for the remainder of the meeting, I believe. I think this is a great question and a great consideration. I mean, really, when you're talking about this age group you're talking about ultimate primary prevention. It is something that we would certainly consider within this framework, which is an all-ages approach. I think that these points are well taken. Your feedback is very important, and we will see how we can incorporate that.

Dr. Whalen I don't know if you have any additional.

Ms. Alaali Yeah.

Ms. Alaali We have ACA, the Adverse Childhood Experiences and we are still drafting the intervention. I think this is the place where all the primary intervention falls.

Dr. Boufford I think the working groups that you mentioned that would be formed after this could help develop what's happening under the different domains.

Dr. Boufford Dr. Watkins has his hand up.

Dr. Boufford I'll start with the folks on the screen. I'll turn it back to you, Liza, for the folks in Albany.

Dr. Watkins Yes.

Dr. Watkins Thank you for a great presentation. My question would be for local health departments and the hospital. When would you expect this to be presented to New York State Department of Health? I'm looking at your proposed timeline. Is it between September of 2025 that you were expecting these to be presented?

Ms. Alaali I'm not clear about the question. You are talking about two different topics here. Are you talking about the guidance for local health departments? Are you talking about establishing the group for the domains?

Dr. Watkins We need to prepare this document so that we can submit to you. Local health departments and hospitals are working together. What is the time frame in which they need to submit their document to the Department of Health?

Ms. Alaali Okay.

Dr. Boufford That's connected to where they would get the guidance too. Kevin, you know, apropos of your timetable, Zahara, talking about the work you'll be doing over the next several months.

Ms. Alaali Right.

Ms. Alaali Currently, we are working on the guidance for local health departments and hospitals, and their submission should happen and December 2025. Their plans will be submitted next year in December.

Dr. Watkins Thank you.

Dr. Boufford Other questions?

Ms. Dyer-Drobnack Thank you.

Ms. Dyer-Drobnack Cristina Dyer-Drobnack from the New York State Association of County Health Officials. I guess it's not so much a question as maybe just this feedback for the department to consider as they look at rolling this out this shift to the social determinants of health. You know, some of those areas, I would say a handful of them don't... The work doesn't necessarily fall under the core public health areas that local health departments are typically reimbursed for. I think it would be fruitful to maybe engage with the local health departments and have that discussion on what type of activities they be able to fund in those areas. I understand not all work is done by the local health departments with your community improvement plans, but I think having that conversation as we look more broadly at social determinants of health to see and allow that flexibility and funding to have them support that work as they engage in this new model will be really important.

Dr. Boufford I think this is one of the issues that the Public Health Committee had raised. It has been addressed to the degree that the initial focus in the domain areas and objective areas is really around guidance for health departments and hospitals relative to their, if you will, their spheres of influence with colleagues. The interagency piece becomes really important. Because a lot of the funding for issues like housing or transportation or education are certainly not in any health department, even at the state level. I think it's an important question. NYSACHO's been pretty involved in these conversations. I'm sure you will continue to be critical as areas develop more fully. Thanks for that comment. It's really, really helpful.

Dr. Boufford Dr. Eisenstein, you want to comment/question.

Dr. Eisenstein To Krissy's point from NYSACHO it's the same for hospitals. We are certainly not able to build housing. What it means to me is that we all just have to collaborate with agencies that do it. It's one thing to say that. It's another to have the flexibility written into these programs and the funding streams written in that allows us to collaborate. If we, as a hospital or a health department doesn't provide a service that we're able to partner and potentially fund the partners, the people that do that service to do it. I think that the evidence shows moving towards addressing social determinants of health is the right way to prevent illness in the long run. We just have to have the tools and the funding, both health departments and hospitals, even for them. I've spoken at NYSACHO to say we should be working together, health departments and hospitals. To me it becomes all about collaboration and enabling the partner that does that work to carry it out on everybody's behalf. Just my recommendation.

Dr. Whalen Thank you.

Dr. Whalen I just want to make a little point here. These comments are so helpful. I think with this paradigm shift it's understandable that people are trying to grasp this framework and how it does align with the work of local health departments. Many of you know that my role prior to coming to New York State Department of Health was as local health commissioner for Albany County, which is a job I did for eight and a half years. I have been through this prevention agenda cycle a couple of times. We have always talked about using the lens of health equity and the importance of the social determinants of health. What this framework really is doing is making that organic to every bit of work that we do and fleshing this out and developing these evidence-based programs and innovations that really might do things a little bit differently. The collaboration that we heard earlier in the meeting was a great example of that. You know, when you talk about housing, I know when I was at Albany County we had a collaboration with our housing, the City Housing Authority, where they had community health workers. They were people that lived in the housing that went to inform people in the Housing Authority about the programs and services that were available to them through the local health department. In that role they were allowed a little bit of a reduction of their rent. We worked out this collaboration. It was very organic. It did promote housing in that kind of way, shape and form and promoted the health of those that were living in public housing. It was a little bit non-traditional. To your points, which

I, understand completely. I think if you look at the priorities, if you look at the priorities, in that Slide 23. Most of them, not maybe all of them, but they do align with core public health and the work that local health departments do. It enables them to look at this in a wider swath and consider how they can make kind of a double impact within the communities that they serve to get this work done and really enable it to be focused on the social determinants of health.

Dr. Boufford Thanks.

Dr. Boufford I have two questions on the screen, and then we'll shift back to you Liza.

Dr. Boufford Dr. Moore, and then Jamie Logan.

Dr. Moore Yes.

Dr. Moore Thank you, Jo.

Dr. Moore As a physician who has spent twenty-five years plus really focusing on lifestyle medicine and so forth. Things that people told me I couldn't get paid. One of the hard lessons there is that all the science, all the evidence base doesn't matter if there's not a business model. Because here in the United States, you know, it's a capitalist society and everybody's got to get paid for what they do. You need a ball carrier who's going to get paid to do a job. Ultimately, that's the hard lesson. The news for me was that it was sort of what I was just hearing is that doesn't mean you can't do things. It means you have to improvise a little in terms of interpreting the rules. So, for instance, in the case of physicians, secondary prevention is where you can get paid to do this stuff because it's disease care. It's not primary prevention. It's disease care. Upstream factors can be addressed. The challenge is in linking to community-based organizations, because there's not a good business model between the health care providers and CBOs. I guess my advice would be you have to really be open minded about how we approach these kinds of problems in SDOH because it is addressing upstream factors is where 85% of the health outcomes come from. We're not yet got either a disease care system or really a public health system that is geared towards addressing those. We have to sort of be a little innovative, I think, and less reliant on evidence based, but more evidence informed and good notions of like, hey, we could do this very much like the presentation this morning from Dr. Foster and so forth. Thank you.

Dr. Boufford Thanks, Dr. Moore.

Dr. Boufford I want to use your comment just to indicate that the Healthy People 2030 work which has been, and this is like a, I think the 30th or 40th round every ten years, you know, the U.S goals are set. This is the first time they've ever included social determinants. I think part of it was because going forward there might be an opportunity, relative to at least public insurance scheme starting to fund some of these activities. I think the juries out yet. It's a really good first step. I think mirroring those social

determinants in the New York plan really opens up the conversation more widely. We're urgently, I think dealing with payment schemes, as you point out. Obviously, the waiver was mentioned earlier. I know the Master Plan in Aging has been discussing a lot about how Medicaid and Medicare could be influenced to improve payment for prevention in older persons. Anyway, really, really important point.

Ms. Logan I just want to concur---.

Dr. Boufford Say where you're when you first speak just so people know.

Ms. Logan I direct the Long Island Health Collaborative, which is a coalition of about 300 organizations, organizations, hospitals, community-based organizations, etc. on Long Island. I just wanted to concur with my colleagues who just spoke Dr. Moore, Dr. Eisenstein, and also I don't remember her name, but the representative from NYSACHO. I wholeheartedly agree with what they said. Over the years I have seen more and more collaboration between hospitals, community-based organizations and also the local health departments. It is always an issue of resources, and it is an issue of being innovative. As Dr. Moore said, oftentimes there are many programs that I've seen community-based organizations work with hospitals and develop what might not exactly be an evidence-based program, but certainly is an informed evidence-based program. Oftentimes, when it gets kicked up to the state it gets not looked at as valid as perhaps an actual evidence-based program. Just some observations that I've had over the years. I do think that this framework, including the social determinants of health, which the collaborative that I'm involved with has been looking at for a dozen years already is the right way to go. I just wanted to offer those comments.

Dr. Boufford I was just going to say part of the development process over the next few months with these working groups, especially is looking at this evidence and experience informed. Interventions would be identified that are possible interventions with ways of measuring effectiveness.

Dr. Whalen Dr. Bauer is back.

Dr. Whalen I wanted to make a comment as well.

Dr. Boufford Please.

Dr. Whalen I want to in particular thank Dr. Moore for his feedback and for mentioning lifestyle medicine, which is a board certification of mine as well. I think that primary prevention, as you point out is not necessarily aligned to our current medical system. This is one way that we can really work to try to change that. I do think that as time has evolved and as the medical system in this country gradually spends more and more and learns that we are not getting the outcomes that we want from that spending. A lot of players are looking at ways that they can work with community-based organizations as well. That model of creating a business proposal and a business model, as you point

out, will drive future successes and will drive future efforts. I really want to say that I agree with the importance of that. Thank you for bringing that up.

Dr. Boufford Are there any other questions in Albany?

Dr. Boufford If not, I'd like to move to the partnership conversation part of this conversation.

Dr. Whalen I do think we have some questions in Albany.

Dr. Whalen Mrs. Zuber Wilson.

Mrs. Zuber-Wilson Thank you so much.

Mrs. Zuber-Wilson Zahra and Dr. Whalen and I appreciate you taking the time to meet with me and have a conversation last week about the agenda. I'm concerned that we're not talking about underage substance use and adult misuse. You have on this chart educational access and quality and K through 12 student success and educational attainment. If kids are using substances, we're going to miss the boat on that piece. It is very important that we start further upstream as we're talking about substance use. Kids have greater access now to substances. That's something we're finding out in terms of access to cannabis and pills on the internet. We are hearing from the schools that we work with, state ed, that we're seeing an increased use of substances. We really want to get to kids at a much younger age. We're talking about brain development. We want kids to have healthy brains. To have a state prevention agenda that does not speak to the prevention of under-age substance use is very concerning to us. I just think that that is really important. I know someone mentioned social emotional learning. Just want to let you know that OASAS is funding social emotional learning programs throughout the state. Actually, has a pilot right now where we're working with pre-K to really talk about social emotional learning and have on deck three school districts, full school districts where we're going to be doing social emotional learning from pre-K through high school. I just had to say that it's really important that we talk about underage use and not just overdose. Please know, that we really appreciate the fact that overdose prevention is part of this agenda, but we have to talk about primary prevention and underage use.

Dr. Whalen I know Zahra has shared that, you know, this feedback session is going to provide us with information that we can use to work with the metrics that we have and expand things. Your feedback is very important.

Ms. David Thank you.

Ms. David Courtney David, Executive Director for the New York State Conference of Local Mental Hygiene Directors. Our association consists of the county mental health departments, the directors of community services, the local governmental units for the fifty-seven counties, and the City of New York. By legal statute, are directors for the county mental health departments have oversight and responsibility for the three mental

hygiene systems locally for mental health, substance use disorder and individuals and families impacted by developmental disabilities. To that point, I was really, again, to Pat's point about some of the concerns of things that are left off the table for this. I'm glad we're having an opportunity to provide some additional feedback. As far as the local health departments, you know, our folks are very much collaborators with the local health departments. For those three individual mental hygiene systems our directors are really the key contact point for the mental health system. When we're talking about the whole person and looking at the whole person I think behavioral health was a little missed in this document. You know, social determinants of health obviously will help folks with mental health disorders. Really missing that key piece. I know there's a couple of priorities outlined in there, but there's a couple that are missing. I know that we provided Dr. Boufford and Dr. Bauer with a memo from the conference outlining what the importance of prevention programs side and what the services should look like from a mental health perspective. I'm happy to reshare that. I know I shared it with Shane, but I know, I know Shane's not here anymore. I'm happy to reshare that, but I really hope that some of those recommendations that are included in that document are strongly considered as part of this final document. I wanted to ask my colleague Lynda Battaglia if she had anything to add.

Ms. Battaglia Yes.

Ms. Battaglia Thank you.

Ms. Battaglia Director of community services for Genesee County. I'm also very concerned similar to what Pat said that we're in a youth mental health crisis right now on the mental health side. It's concerning that it does not appear to be a focus right now. When I think of ACS, you know, I feel like ACS is at the core of so many current issues. I work very well with my local Department of Health. I sit on their fatality review board. I conduct the next of kin interviews with family members who have lost someone to overdoses. The common theme and trend that I am being told during those interviews is that children have a severe trauma at very young ages. Now, we have ACS, and that sets the trajectory for a whole host of different concerns, including substance use and including mental health, and including medical and physical disabilities as they move through their lifespan. My concerns are youth mental health crisis. When I think of collaboration everybody needs to be at the table if we want to have an impact on a community. That includes hospitals, that includes CBOs, but it also includes the local mental health departments who have their hand in pretty much everything in the county as it relates to an agenda, including suicide prevention, including health trauma informed communities, crisis planning. We're in schools. We're in hospitals. We have our hand in everything. Our brains, our services, our experience, our area of expertise needs to be tapped. Thank you.

Dr. Boufford If I may like to just to comment briefly on this. I think in the previous prevention and obviously one of the five areas priority area of work was in a sense, you know, DOH, MH. It was Office of Mental Health and OASAS colleagues helped develop it. I think one of the early areas we've talked about this, and I think just given some of

the staff moving around and other things going on in the health department. The Office of Mental Health, OASAS, Department of State and NYSOFA have been core partners, agency partners in the previous iterations of the prevention agenda. I know there have been some staff level outreach to those departments as priority areas, really to address some of the issues you're talking about. We did hear from agency heads of those agencies and senior officials early on in their review of the prevention agenda. I think them talking about their own prevention strategies within those agencies. Now's, the time to really bring those prevention strategies together so that there's really good synergy with the broader prevent this prevention agenda work, integrating work across the key departments that have been so fundamental to achieving progress in the prevention agenda. Thank you for that comment. Sorry for interrupting.

Dr. Boufford I'll go back to you for anybody else in Albany.

Dr. Whalen Thank you.

Dr. Whalen I do think there's another question, but I also wanted to thank you very much for your comments and point to the fact that we are looking at establishing an interagency task force. We want to be sure that everybody has their voice heard and that we're working together. You know, so much of what the work that all of us do. We hear all the time about breaking down silos and how we come together to create strategies that will enable collective impact. If we work together, we work stronger. I do hear everything you're saying, particularly about the crisis of youth mental health and the importance of primary prevention. You'll be hearing more about that.

Dr. Whalen I think there was one other question here.

Mr. Bishop Yes.

Mr. Bishop Lloyd Bishop, Greater New York Hospital Association. Not a question, but I guess a concurrence. Another concurrence. Janine, I want to concur with what Janine said and Dr. Eisenstein and Dr. Jordan and others. I think I've said here before that we are supportive of this new model bringing social determinants of health to the forefront is terrific. Bringing more players to the table is very important. Hospitals and local health departments obviously can't do it all. They're the ones who report. Having more people around the table statewide, as well locally is very, very important. In terms of partnership, the NYP presentation was terrific. There are models like that around the state and around our membership of those things, including this program, including things like gun violence and breastfeeding. I saw tobacco cessation on the slide, all in partnership with local health departments. Dr. Eisenstein did say that a lot of that can be driven by local health departments of the examples. We've seen that certainly among our membership in New York City. We are now partners with New York City DOH MH on their new initiative Healthy NYC. Ken and I were recently at an opening. We are partners on that. That's a model that really works. Those partnerships with local health departments are very important. Those examples I gave, those came from the local health department. My colleague who is sitting behind me at Greater New York hired

him a couple of years ago. I first met him when he presented at one of our meetings to talk about a partnership with DOH MH on a program using Citi Bike with DOH to increase physical exercise in the community. That's very important. Healthy NYC provides a good model as well. That's something that we will continue to use in New York City. I should say that maybe we shouldn't have already, but we've already been briefing our members on the new prevention agenda at its model. we'll be ready for that conversation we'll have in a couple of weeks.

Dr. Boufford Thanks.

Dr. Boufford If there's nothing else in Albany, I'd like to use that segue really to talk about to... We're getting into the partnership conversation. I want to take it a little further.

Dr. Whalen That's great.

Dr. Whalen I don't see any other questions in the room.

Dr. Boufford Great.

Dr. Boufford Thank you.

Dr. Boufford We've heard from colleagues from OASAS, OMH, which is great. I didn't hear anyone from NYSOFA online. They may well be. I want to perhaps ask Andrew who from the Master Plan on Aging, although he's technically in the Health Department to maybe talk a little bit about the linkage potential linkage, especially the work going forward between the Master Plan on Aging and the prevention agenda. I know we have Nora O'Brien-Suric and Terry Fulmer and a bunch of other folks that are part of a large nonprofit coalition that's ready to work on this issue.

Dr. Boufford Maybe, Andrew, would you like to make a few comments? If not, I can turn it over to Nora or Terry.

Mr. Lebwohl I'm happy to.

Mr. Lebwohl By the way, Charlie Williams just stepped back in.

Dr. Boufford Absolutely.

Mr. Lebwohl Charlie, you were out for the exact second that Dr. Boufford was looking. The question being about the linkage between prevention and the MPA. Obviously, part of the point of prevention agenda is addressing the sorts of things that create demands on the systems that we're dealing with in the course of the MPA. And that's why prevention has been such an important part of it. It's the happy confluence of what people want, which is to be healthier and live longer and better lives. Also, the fact that we need to look ahead and manage the demands that are going to be on our systems of support and prevention is the best way to do that. The master plan has not taken

such an expansive view of prevention is to say that maternal fetal medicine is part of its purview. You know, ongoing collaboration is going to be critical. Many of these priorities are priorities that we identified for the MPA as well. Housing is a major one. We had workgroup addressing mental health and substance use issues. Fundamentally, the social determinants of health are a major part of what we're looking at the MPA. It's a whole of government approach and that it's also an interagency effort. I think like the prevention agenda the MPA is going to be an ongoing process. It's not a document that's issued at one moment in time and then controls the entire future of New York State government policy. What this really is, is its ongoing collaboration and ongoing coordination across the two programs to make sure that we're doing the best job we can of building the supports for the policies that need to be in place to make sure that we are recommending complementary policies and that they are working in tandem with each other. It's recognizing the way that all of these things influence each other. That housing influences health care, that transportation is part of that mix, that we all need to look at the people who are providing care and making sure that there's an adequate force there. Fundamentally, we are working towards the same goals. We're going to need to on an ongoing basis keep that conversation going to make sure we're doing that effectively.

Dr. Boufford Thanks.

Dr. Boufford Do you want to add anything there?

Dr. Boufford Maybe let Nora and Terry may want to comment.

Mr. Williams No, I think Andy had it right that that the goal of the Master Plan for Aging and the prevention agenda while somewhat different focuses have commonalities and goals in terms of making sure that people throughout the aging experience something that everybody does regardless of age is set up best for success and able to enjoy the things that they enjoy to do as they age and remain in their communities of choice and conduct the activities that they get enjoyment out of. That results from constant collaboration, innovation and seeing where shared resources can achieve those ultimate goals.

Dr. Boufford Thanks.

Dr. Boufford Nora, do you want to say anything?

Ms. O'Brien-Suric Just a couple.

Dr. Boufford Why don't you mention the coalition? Because I think some people may not be aware of it. I think it's an important network for CBO and advocacy engagement and the aging issue.

Ms. O'Brien-Suric Thank you, Jo, for saying that.

Ms. O’Brien-Suric FYI to everyone here the New York State Master Plan for Aging Coalition actually was started November 2021, I believe. We continue to meet monthly. This coalition was very effective and successful in having Governor Hochul make a statement in her State of the State address in January of 2022 I believe. Years are interesting after COVID. To say that she would commission a Master Plan for Aging, which she did sign into law, the Executive Order in November of 2022, and the first meeting started in January of 2023. We are working very much towards that. There's a whole official, as I say, group of people, of which Andy is leading the charge along with now we've got Smart Growth involved with Paul Beyer and Greg Olsen at the New York State Office for the Aging involved in that. The coalition is a coalition of nonprofit organizations, many advocates focusing on aging and people with disabilities. We meet monthly to keep everybody informed on what's happening with the Master Plan for Aging, really making sure that everyone is responsible for moving the master plan forward, that process is being held accountable. We also act as a liaison between coalition members and the official people in DOH and NYSOFA. Anyone who's interested in joining the coalition very happy to add you to that email. I will put my email address in the chat so that you can reach out to me directly. I can put you on that email list. I just want to say a couple things that, of course, I know Terry will fill in a lot more information. A couple of things regarding the prevention agenda and the Master Plan for Aging. First of all, it's very important with the Master Plan for Aging and what we consider all the social determinants of health. We're very interested in keeping older adults and people with disabilities living in the community of their choice for as long and as healthy as possible. The other thing that I want to mention is part of that in addressing that is really these partnerships that you've been talking about. Partnering with community-based organizations, health systems and health plans is very important. We had a workgroup that I chaired looking at critical partnerships and systems building. Our recommendations for the Master Plan for Aging were that the state would support the development of these networks. Was actually the 1115 waiver being one example of, but working with health systems, forming these networks, and Lauren from Inclusive Alliance is certainly a wonderful example. I think she might still be on us in our meeting is forming one of those networks. Just really want to emphasize that because as we're discussing the social determinants of health in the prevention agenda and these critical partnerships are really important to see how that all aligns with also the recommendations in the Master Plan for Aging that are now going through its process to be finalized and will go to report to the Governor. The Master Plan for Aging is focusing on age friendly, which takes into age friendly ecosystems, which takes into account everything I've discussed. Terry is our expert on that.

Ms. O’Brien-Suric I'll turn it over to Terry.

Dr. Boufford I’ve got to hit some of these other social determinants on the agency side and get some other comments.

Ms. Fulmer Thank you.

Ms. Fulmer Great job really summarizing that.

Ms. Fulmer I want to point out that the public health infrastructure is crucial to older adults in this state. There is no doubt that without public health offices thinking through their aging agenda, we will not meet the needs of older adults in the state. Everything that we can do. I've been chatting in my content and my links in order to enter into the record. The last thing I'll say, just to top off what Nora indicated was the ACL, the Administration for Community Living is working on the National Plan for Aging, and so it will pull all of us over the fence in a really important way. Due to Nora's good leadership and we are right in lockstep with that.

Ms. Fulmer Back to you, Joe.

Dr. Boufford Thanks.

Dr. Boufford I wanted to see if Paul Beyer is on. I lost him. I had him on the screen. Just talking about sort of Smart Growth principles. Department of state has been very involved, which of course is incredibly relevant to issues of built environment, economic development, etc..

Dr. Boufford Is Paul still with us or not?

Mr. Beyer Yes.

Mr. Beyer Thank you, Dr. Boufford.

Mr. Beyer The built environment is one of those binding characteristics that cover both the prevention agenda and the Master Plan for Aging, particularly our public realm infrastructure, allowing people of all ages to get out of their homes to exercise for physical health, but also to interact with other people for social health. It's a major component of social determinants of health. The Governor has certainly made that a priority, not just in the master plan, but I might highlight here her new initiative, called Get Offline, Get Outside that's focused on getting kids and families to put down their devices and go out and enjoy outdoor recreation activities again for both physical and mental health. It's really amazing in reading her material. First of all, how important the built environment is the public realm, but also to how far we've come with mental health. Because while she emphasizes both physical and mental health she's casting it within her wider net of children's mental health. We're starting in both of these forums, the Master Plan for Aging. The aging population probably suffers more isolation, social isolation than anyone else. We're finding this this common theme of not just the emphasis on mental health, but the overlap of mental health and physical health. Built environment, very important. Just wanted to drill in on one little component because Department of State of course is the community planning and development entity. We are funding so many projects throughout the state that we think feed into both of these initiatives.

Dr. Boufford Could you tell that just very briefly on the developments, just sort of the economic side, because that's one of the critical priority areas that we all feel it's so hard to deal with this issue of poverty and economic development. Just give us a moment or two on that, if you would.

Mr. Beyer Well, the Regional Economic Development Councils had come a long way, in part because some of the work that DOH, NYSOFA and DOS have been doing to educate them on the built environment, but also on just the economic benefits of attending to the older population and providing the right services and infrastructure for them. Over the years they have really come around. They've come to understand the economic side of both health of health for all ages, but also in particular maintaining and prolonging the health of older New Yorkers. That's another exciting trend that it's become an economic issue. Not just the health, health and quality of life issue.

Dr. Boufford You have a government governmental budget for the work for the initiatives that you put forward in the Department of State, which is really important. Apropos, we may not have a business model yet on the healthcare reimbursement side, but they're funds that are going into conditions and communities for sure that we can take advantage of.

Mr. Beyer Absolutely.

Dr. Boufford Any other interest or other nonprofit networks that be part of this group as our state representatives of nonprofit organizations and networks, advocacy groups. I think that's one group, the Community Health Center Group that have been stalwarts in our Ad Hoc Committee. I don't know if they want to comment at all or health, their health plans folks who are on as well, and the Business Council. Let me finger those three groups to say something about how their members might effectively partner to sort of advance the prevention agenda.

Mr. Beyer I'm going to defer to my partner here.

Unknown Speaker Yes.

Unknown Speaker Thank you.

Unknown Speaker Our Clinical Excellence and Innovation Department, through which we have been focusing on social determinants of health and supporting over 70 FQHCs in collecting this data and patients and building relationships and community partners to make those connections for services that are beyond what the FQHCs themselves do provide. This has been in our radar for a few years now. Implementing, data collection practices, utilizing the EHR to document this information and then make those connections with the community. This is something that FQHCs have been focusing on. We really are looking forward to the next step, level 15 waiver to see how we can use that work forward.

Dr. Boufford Great.

Dr. Boufford Thank you.

Dr. Boufford Is our colleague in the Business Council still here?

Dr. Boufford Because I think one of the things we learned in the last round of the prevention agenda is how important mobilizing business is at the local level for promoting health and healthy conditions in communities. Certainly, in their interest to do so. I think it was Kim who was here at the beginning. I don't know if she's still on. If she's not, we'll chase her down. Because I think this issue of having the business council involved is something we can do going forward that has not... We have not been as effective in doing that in the past. It's great that she was present.

Dr. Boufford The last group I wanted to ask about was health plans and then I'll have Dr. Moore talk about the medical association because he's had some air today.

Dr. Boufford Anybody from the health plans, state level associations of health plans?

Dr. Boufford Interestingly, I think one of the entities in the health care delivery system that we're it's a win/win for them to keep people well. They should have a lot of interest in the primary prevention agenda and some of these other areas as well. We'll try to get them more involved going forward.

Dr. Boufford Dr. Moore, you want to speak about the Medical Association, New York State Medical Association?

Dr. Moore Well, I'm here from the Medical Society.

Dr. Boufford I'm sorry.

Dr. Moore I'm trying to think more about talking more about health plans here. Having brought up the subject of business models this is probably a third rail, but I'm going to touch it anyway. The thought is sort of along the lines of employers, the Business Council, but also that would include self-insured employers and also non community based, you know, non-self-insured employers. That raises the concept and has this has been in the back of my mind for ages about Department of Financial Services and the state actually potentially putting some muscle into making sure that at least there's some budget in health plans for addressing, social determinants of health. Certainly, Medicare's now at least covering assessments and referrals for primary care physicians. The beginnings of a business model in primary care. The idea here would be to broaden the scope a little bit. I think that is in as you were alluding to with, you know, trying to get I think it was Chelsea Lemon actually was from the Business Council was with us this morning. Getting their participation so that employers... Because I know their workforce wellness teams really do begin to understand some of these issues. That's never been coordinated. Employers are doing their own workforce wellness staying. The doctors

are doing whatever they do for prevention. Rarely do those two ever come together. I really think that there's a place perhaps for not that I'm a fan of an unfunded mandates, but the government speaking loudly, but I think this is an area where the state could maybe help bring some people together and help create the business model.

Dr. Boufford Other organizations?

Dr. Boufford It's not accidental the language on the Ad Hoc Committee to support the prevention agenda. The idea is not only that you advise on shaping it, but also in past years your organizations have been incredibly helpful once the final model is out to really engage people, especially your members at local level in the kind of consortia and partnerships that are being talked about to make a change, make a difference, make a difference in local communities.

Mr. Feliciano When I hear what Jeffrey and everyone is saying, I think there's that part of the partnership is also figuring out where CBOs can help with peers. You know, we talked about coming up working, but we're also bringing just peers, people who live in the community being part of some kind of smaller type of committees and conversations. CBOs can play a role in that partnership as well. I think we think more of also these peer models to work through and particularly for us in housing works. We use that a lot in our harm reduction work. I just wanted to like we emphasize that it's not just the CBO, but it's the informal partnership that we can create and put together. That is the role of the chiefs of contracting out alone and also creates a business model. I just wanted to bring that up.

Dr. Boufford Thank you.

Dr. Boufford Last comment, Lauren, and then I'll switch it back to you, Liza, in Albany.

Lauren I won't spend a lot of time describing community care hubs, but I will put a link to the partnership to align social care resources about what they are they exist to help align the human service sector with the health care sector. There's an increasing focus on how they can be an extension of the public health infrastructure. I think it's worth looking at, and to the extent that that function exists in communities across the state. Whether it's a social care network, a network organized by the OFA or the local directors of community services, tapping into those networks of human service organizations could significantly support the direction that this is taking.

Dr. Boufford This is great.

Dr. Boufford Thank you.

Dr. Boufford Dr. Torres, who is having trouble getting his hand up, but now that he has it, he gets the last comment from the screen, and then we'll move to Liza.

Dr. Torres Thank you so much.

Dr. Torres You know, there is such a great value in really connecting with the hospital provider, the insurance provider and all the systems that really circle around this vulnerable life in the community, which we are at times struggling to advocate. I think that that's key. Lauren, you mentioned something which is of great value as well. Many of us are looking forward to seeing how this rolls out, which is part of the social care network. How do we bridge together look at the supports, the strengths, that each one of us has so that we don't re-enter siloed moments in care coordination.

Dr. Boufford Thank you.

Dr. Boufford Liza, do you want to wrap it up in Albany, and then I'll just make final comment I'd like to make before we close.

Dr. Whalen Yes, I'm happy to.

Dr. Whalen I just want to thank everybody here. This has been a really robust discussion. So many important points have been made. My mind is kind of swimming with ideas. That's a good thing. I think we've heard a lot about the importance of children, the importance of primary prevention, the importance of aligning with our community partners. The especial importance of aligning goals between hospitals, payers and public health, which I think is such a real unique opportunity. I have had time in clinical medicine. I have had time working for payers. I have had a lot of time in public health. It occurs to me that there is so much potential for synergy. You know, all of us know at the end of the day in our health care system money to speak. The importance of developing these models that are sustainable, that do drive down health care costs, and that do result in better health equity and reduction of health disparity is really a goal of this work that we're doing. The people that are assembled in this room have a tremendous amount of influence and input in how that's done. I'm very enthusiastic about this work going forward. We need to make sure that we are aligning with the wishes of our partners, looking at this from, the perspective of health and mental health as hand in hand, looking at this across the spectrum of ages and really looking at how these organizations can best collaborate. I think this has been a really great step. We are going to take a lot of this feedback back with us to incorporation into the priorities. We look forward To further discussion. Thank you to everybody who's been here today.

Dr. Whalen Dr. Boufford.

Dr. Boufford Thanks very much.

Dr. Boufford The Ad Hoc Committee has been such an important factor over the last decade or more. I know a few of you have been with us from the beginning on the prevention agenda. Today was just an example of how valuable this input is. I wanted to repeat the fact that we are recording this session. We will be getting a transcript of the suggestions that were made, the ideas brought forward, as well as the comments in the chat so they can be shared. We're delighted to have Dr. Whalen going to be leading or

our point person, at least on the prevention agenda going forward with the Office of Public Health. That's terrific. I do want to mention that, as I mentioned, the Public Health Committee did act on approving this framework at its last meeting. The next meeting of the PHHPC is in September, when they will be endorsing our support. Part of our resolution, I think, in terms of supporting it is exactly along the lines of what's happening. Let's make sure that this outreach is there and that the conversation really in developing the guidance is rich in the way that was discussed. During a lot of your comments today, that the interagency work is happening and then that there are vehicles and the intention to really increasing the connections of the hospitals and the local health departments to advance with other stakeholders at community level these activities. Again, the PHHPC has a role on the CON relative to certainly an equity index is being asked for. There may be a tweak to that, but also the prevention agenda like, which will need to be, advanced. I just mentioned that for my colleagues. We are planning another Public Health Committee meeting for sort of progress reports in September and November. We will have another Ad Hoc Committee meeting in December. That'll be during the December 2024 cycle when there'll be this we'll hear sort of where the sort of final plans is relative to the guidance and get your input. In the meantime, I'm sure many of you will be involved. Liza will, I'm sure, take advantage of all the things that have been learned in the feedback she's going to get and really help develop these working groups over the next several months. The information to make this a very, very rich and important next step in prevention in the state. Thank you all very much.

Dr. Boufford I did want to thank Dr. Bauer for her leadership. She mentioned earlier this is her last, formal meeting with us. She and her team under very challenging, challenging circumstances, starting with the doing this at the same time as COVID was going on and being resolved, but also a lot of the other pressures that are inevitable in public health. We really appreciate her leadership with her team, and it's been a pleasure to work with her. Thank you Ursula, and all the best in your next chapter.

(Clapping)

Dr. Boufford Thank you all very much.

Dr. Whalen Thank you.