NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
AD HOC COMMITTEE MEETING
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TRANSCRIPT

Dr. Boufford Let me call our meeting to order. Thank you, those of you who made the trip along with me from New York City and others from around the state to join us in person today here in Albany. We also welcome those that are on Zoom. I understand from the PHHPC, we have Dr. Strange, Dr. Watkins and Ms. Soffel on the line and others joining us. They'll let us know. I'm Jo Boufford. I'm the Chair of the Public Health Committee and the Ad Hoc Committee to oversee the state health improvement plan. I'm happy to call this Ad Hoc Committee meeting to order and welcoming, members, participants, and observers. Again, we are webcasting. The usual reminder for all involved that we are subject to the Open Meetings Law and are being broadcast over the internet. The broadcast can be accessed at the Department of Health's website on demand for a minimum of thirty days after the meeting. There is synchronized captioning. We ask people not to speak over each other. Please do identify yourself. We have so many people on Zoom. Not just the first time, but each time you speak if you identify yourself. That would be great. Whether you're a council member, obviously. Obviously, we have hot mics. There is a form to be filled out, I think before this meeting. Since this is not a decision-making body of the PHHPC, there will not be a period of public consultation at the end. We'll shoot to finish a little before 1:00. I'll try to manage time in order to do that. Let me just make some opening, welcoming remarks and maybe just quickly go around the table. Everybody just tells us who's here so everybody can know.

Dr. Boufford Can we start over in this corner? Just your name and where you're from.

Ms. Preston I'm Kathy Preston. I'm with the New York Health Plan Association. I'm a member of the Ad Hoc Committee to support the prevention agenda.

Dr. Boufford Great. Thank you.

Ms. Phillips Good morning. I'm Kristen Phillips, Director of Community Health Policy with HANYS, the Health Care Association of New York State and also a member of the Ad Hoc Committee.

Dr. Boufford Great. Thank you.

Ms. Ravenhall Good morning. I'm Sarah Ravenhall, Executive Director at the New York State Association of County Health Officials, and a member of the Ad Hoc Committee.

Ms. Wetterhahn Good morning. I'm Lauren Wetterhahn. I'm the Executive Director of the Inclusive Alliance. I'm also a member of the Ad Hoc Committee.

Mr. Bishop Lloyd Bishop, Greater New York Hospital Association, and also a member of the Ad Hoc Committee.

Mr. Feliciano Morning. Anthony Feliciano, member of the Ad Hoc Committee from Housing works.

Mr. Williams Hi. Charles Williams, New York State Office for Aging. Also, a member of the Ad Hoc Committee.

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

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

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

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

Mr. Rugge John Rugge, member of the council here to listen and learn.

Dr. Bauer Good morning. Ursula Bauer, New York State Department of Health.

Mr. Khan Good morning. I'm Salman Khan. I'm also with the Department of Health.

Ms. Alaali Good morning. Zahra Alaali, Department of Health as well.

Mr. Roberts Good morning, Shane Roberts, New York State Department of Health.

Ms. Walsh Bridget Walsh, Senior Policy Analyst at the Schuyler Center for Analysis and Advocacy in Albany and a member of the Ad Hoc Committee.

Dr. Boufford Thank you very much.

Dr. Boufford Online start with Kevin. I see you up in the right-hand corner of the screen.

Dr. Watkins Kevin Watkins, member of the council.

Dr. Boufford Denise, why don't you go next?

Ms. Soffel Hi. Denise Soffel, council member.

Dr. Boufford Ted Strange.

Dr. Strange Dr. Strange, Staten Island council member.

Dr. Boufford Thanks.

Dr. Boufford Other colleagues, I don't know who you are because you don't have labels, or if you do I can't see them even with my glasses on.

Ms. Fulmer Terry Fulmer, the John A. Hartford Foundation

Ms. Guzik This is Joan Guzik from the United Hospital Fund.

Ms. Foti Ali Foti, New York Health Foundation.

Dr. Moore Geoffrey Moore, Medical Society of the State of New York.

Mr. Seserman Michael Seserman with the American Cancer Society.

Ms. Ashley Lauren Ashley from the Health Care Association of New York State and AD Hoc member.

Ms. Goldberg Jordan Goldberg, Primary Care Development Corporation.

Dr. Kline Dan Kline, New York State FACHE Medical Association. I'm also on the committee of the leadership board for American Diabetes Association for Greater New York.

Dr. Boufford Great.

Dr. Boufford Anybody that's not been introduced or introduced themselves?

Ms. Firenze Hi. This is Kelly Firenze, Central New York Regional Office, New York State Department of health.

Mr. Crowley Hello I'm John Crowley with GSK Vaccines.

Dr. Harrison Myla Harrison with New York State DOH.

Ms. Logan Hi. It's Janine Logan with the Suburban Hospital Lines New York State and Long Island Health Collaborative and a committee member.

Ms. Clark Amy Clark, the Department of Health, Western Region.

Ms. Mack Stephanie Mack, Department of Health.

Dr. Boufford Great. Thanks very much. These are folks we can't see either. A little bit of a disadvantage, but I really appreciate the engagement of our Ad Hoc Committee members especially. It's really wonderful to have you with us. We've kept you busy the last few months. We appreciate your staying with us. I just want to kind of summarize briefly. This is the fourth meeting of the Ad Hoc Committee for the cycle of the prevention agenda, which is to be reviewed and revised for the 2025 to 2030 period and to sort of shape the thinking around it. Prevention agenda is the state's health improvement plan, which is really part of its accreditation process. The Ad Hoc Committee is the public consultation body that's part of the accreditation process. The State Public Health and Health Planning Council met last week and has reviewed what we've been doing. Everybody is sort of tuning in at the PHHPC now because our role is to really approve the next plan for the next cycle of the prevention agenda. This Ad Hoc Committee met in April and July, during April and July and more recently. We heard from our sister agencies who have been core members of this process; OMH, NYSOFA, OASAS and the Department of State, who has been a stalwart along the way on a panel asking for their really reactions to how the prevention agenda had been working for them as agencies and what recommendations they had for change. Similarly, in another meeting in September we had a panel with NYSACHO, and I think NYSACHO's come twice actually, but a panel with NYSACHO and Greater New York and HANYS talking about sort of the local health department hospital relationship and the hospital's responses and suggestions for the next round of the

prevention agenda. We also discussed community benefit, especially the community health improvement category of community benefit relative to aligning the investment hospitals are making with the sort of local priority setting that has been part of the prevention agenda. What the feasibility of that to do that is going forward. We also reviewed New York State's updated health plan. We're going to hear, report from our colleague, Chris, Davis about that today. Also, the staff have done a really nice job in looking at what other states are doing relative to their state health improvement plans and how it might give us ideas for structuring or restructuring our own. The Public Health Committee has met November, December and last week in February, and have had presentations on updating the dashboard by the staff in the department. We heard about the Master Plan on Aging, which also has a subcommittee on prevention that's looking to certainly align with whatever comes out of the prevention agenda relative to the needs of older people. We also heard about a survey that I think Shane will tell you a little bit more about and had an initial presentation of an alternative framework for the prevention agenda, which had questions and suggestions from the Public Health Committee. We're bringing that to you today to get your input and suggestions. The next steps would be for our department staff. We would all be working on potentially a next last, I promise, last set of meetings in April, coming up with sort of a final plan that would really be the structure for the 2025-2030 prevention agenda. Today is really a chance to get your input on the presentations and sort of looking at some alternative models. We could do what we wish relative to coming up with a model. We're really looking forward to hearing your comments. Again, I think there are two levels of this. One of them is the sort of statement of state health priorities and how we'd like to see broad interagency working as well as enabling work that all of you are doing at the local level, which has historically been led by local health departments and hospitals with other local stakeholders that have come to the table, as well as the implementations for an implementation framework, whether implementation framework is helpful, how it could be changed, whether it could be lighter touch more in the way of the Healthy People of 2030, which is a global statement. Everybody kind of comes back every year and says how they did. We're on a continuum of trying to look at what makes the most sense both from the point of view of improving the health of New Yorkers and also the ability of local health departments and hospitals to partner in that effort. I'll stop there, invite Dr. Bauer to make any comments, and then we'll get underway.

Dr. Bauer Good morning. Welcome. We're really delighted to have you here today. We look forward to the dialogue and the conversation. As Dr. Boufford indicated, we have done quite a bit of stakeholder engagement and input gathering over the past year. Based on what you have shared with us we have developed two frameworks, two potential frameworks for the prevention agenda. We'll share those with you today. We are eager to hear what your reactions to those are, what you would prefer. As Dr. Boufford indicated, there's one. There's the other. There's a mix up of the two. There's anything outside of that. Really critical to get your input and your discussion. What we are presenting today is based on what we have heard from you all and from our stakeholders. If we can make a decision how we want to move forward that's wonderful. We can further develop the path that you chart or as Dr. Boufford indicated, we can have another set of meetings in April to enrich the discussion.

Dr. Bauer with that, we can turn it over to the presentations.

Dr. Boufford Very good.

Dr. Boufford I'd like to introduce Christopher Davis, who's online, who's Population Health Data Manager for the Office of Science in the department. He's going to give us an update on, general health status of the state of New York. You recall the last cycle of the prevention agenda was heavily influenced by the report of health status in the state and also especially causes of preventable premature mortality and morbidity.

Dr. Boufford Over to you, Christopher.

Mr. Davis Let me just pull up my screen here.

Mr. Davis Hopefully, that is being displayed.

Mr. Davis Just confirming that everyone can hear me.

Dr. Boufford Yes.

Mr. Davis Great.

Dr. Boufford Can we make your slide any bigger?

Mr. Davis That should be full screen now.

Mr. Davis Good morning, everyone. Chris Davis, Population Health Data Manager in the Office of Science. Pleasure to be here with you this morning. Conducting a health assessment of the population as part of our planning cycle every five to six years and helps inform our next state health improvement plan, as well as fulfills necessary criteria for the department to maintain its accreditation status with the Public Health Accreditation Board. This presentation is just one piece of the overall state health assessment and is really a data heavy description of the general health status and some population demographics of New Yorkers. There are other sections and components that are being conducted as well for the state health assessment. Within this presentation, we largely have a series of screenshots from a variety of health topic areas taken from our many different dashboards that we maintain in the Office of Science. This was a team effort in collaboration between the Office of Science and the Office of Public Health Practice. We started by casting the net really wide for topic areas and kind of work together to organize the topic areas, as well as the selected indicators that are included in this presentation. It's important to note that what's shown in this presentation is just a representative selection of the many health outcomes, health behaviors and demographics that we do maintain on our many different dashboards. I would like to ask to please hold any questions until the end because there is a lot of material to go through. There are also a number of supplemental slides at the end that contain more information and color on some of the things that we're presenting. The slides will be available after the meeting today.

Mr. Davis With that said, let's start the presentation off with our overall summary findings. These findings are an interpretation of the broader indicators set that we analyzed and present for you. Where possible, in this presentation, we try to present indicator data by race and ethnicity and other socio demographics. First, America's Health Rankings saw New York consistently improving until the 2022 report. As new focuses on social determinants of health and the built environment lowered New York's rank from 11th in 2019 to 23rd as of 2022, as did higher Mortality. That was related primarily to COVID-19. As well as the opioid crisis, which were major issues contributing to declining life expectancy. Chronic disease continues to be a major burden, including cancers and

asthma. We're making good progress in some maternal and infant health indicators, including teen pregnancy and breastfeeding. More work needs to be done to address disparities. We are on the path to end AIDS but do have challenges in reducing STIs. Testing homes for lead and radon continue to be a key prevention agenda outcome that we track. We have seen declines in homes being tested for lead hazards. Obesity, smoking, and physical activity continue to be public health risk factors impacting New Yorkers. The New York State population is aging and becoming more diverse. There are significant disparities in many outcomes in social determinants of health across racial and ethnic categories, education, and income levels. Access to health care has improved, but many New Yorkers still have access issues. Social associations, disconnected youth and single parent households are complex issues potentially contributing to poor mental and physical health. For three decades, America's Health Rankings has provided an analysis of national health on a state-by-state basis evaluating a historical and comprehensive set health, environmental, and socioeconomic data to determine national health benchmarks and state rankings. Now, as you can see here, New York State has improved its rank drastically over the last few decades and was ranked 11th in the nation in 2019, which is up from 40th in 1990 and up from 26th in 2008, when we began the prevention agenda. Now, due to modifications in the calculations and algorithms, which America's Health Rankings uses it now focuses much more on social determinants of health and the built environment. We saw our ranking go down in 2022 to 23rd. Now, given the COVID-19 pandemic, America's Health Rankings did not conduct state rankings in 2020 or 2021. That's why you're seeing a two-year gap here on this chart above. With that said, the first thing we as public health practitioners ask ourselves is what happened to cause this drop? I alluded to it, but after investigating the issue we found that each year there's some minor methodological changes in the America's Health Rankings, but there were major changes implemented in 2020 through 2022. They were the most sizable since 2016. The rankings are now heavily focused on social determinants. We were also hurt in our ranking by premature deaths. It's important to note that the data for 2022 does use a lot of data from 2020 or 2021. We actually are projecting that we're going to see less premature deaths in later rankings and hopefully help boost some of that. As we're going to see we're going to have challenges in some of the other areas that are in the formula.

Mr. Davis Let me go ahead and show you what that looks like.

Mr. Davis I know it's not projecting well, but I will zoom in. It's for illustrative purposes. What you're seeing here is the cover page for New York State, kind of the total summary of the 2022 annual report from America's Health Rankings. The national report contains graphics just like this for each and every state in the United States. It shows the strengths and challenges of public health areas within each state across different social and economic factors, measures in the physical environment, clinical care behaviors, as well as health outcomes. One main finding to highlight was a 31% increase in premature deaths from 2019 to 2020, a result of both the COVID-19 pandemic as well as the opioid crisis.

Mr. Davis Now, I won't go through this entire report, but let's zoom in a little bit here just to get a better look to give you an idea of what these reports look like. We're just zoomed in here on the top portion of the report. On the left you can see some notable strengths relative to the nation, which were a low prevalence of frequent mental distress, low prevalence of multiple chronic conditions, and a low uninsured rate. Two notable challenges in addition to the increase in premature deaths and obesity, which are specifically called out on the left side of the overall graphic is that we have high income inequality, high Black and white racial segregation, and a high percentage of households

experiencing severe housing problems. We do anticipate that future versions of the reports will show a decline in premature death as we come out of the pandemic, but other measures such as income inequality, the built environment are going to be much more challenging for us to move the needle on. With premature death being cited as a weakness for New York, we thought we would start out, assessment here by looking into health outcomes and some of the life expectancy and premature death related information. This graphic shows the life expectancy at the beginning of each age interval. Each of the colored bars that you see on the chart correspond to a year that shows how long on average someone in an age category is expected to live. The table below has the numbers for ease, instead of trying to interpret the length of the bars. For the most part, we see life expectancy increased for most age groups up until 2020, which was the first drop in life expectancy for New York State in many years. It dropped across all age groups in 2020 with an average loss of 2.84 years. Why the decline? Again, primarily due to the COVID-19 pandemic as well as the opioid crisis. There were high absolute drops in life expectancy in those in their 20's and 30's, but the relative declines in life expectancy in those age of 65 and older exceeded 10% that was attributable to COVID-19.

Mr. Davis This figure here shows the leading causes of death taken from our Leading Causes of Death Dashboard in New York State from 2012 to 2020. The leading cause of death does remain heart disease as of 2020. Though, the rate did spike in 2020 after gradually declining over the years. This may have been due to some delayed care seeking during the pandemic, as people were afraid to go out and seek care and avoid hospitals and things like that. Cancer death rates have steadily decreased over the last eight years. Unintentional injury contains opioid related deaths. You can see how the rates increased from 2012 to 2017 moving to the third leading cause of death up from the 5th leading cause in 2012. As you can also see, COVID became the second leading cause of death in 2020 pushing unintentional injury lower. While unintentional injury became the 4th leading cause of death in 2020, the rate of 40.7 per 100,000 is actually the highest it's been since 2012. We saw premature deaths were impacting our ranking in America's Health Rankings. We cited that COVID-19 was the second leading cause of death in 2020.

Mr. Davis This graphic shows the wave of deaths associated with the pandemic. First spike on the left-hand side of the graph was the initial wave. The alpha and beta strains. The next wave we see was the Delta variant in late 2020 into 2021. This is also when we began pushing out the vaccination campaign, which is important to note. We saw another wave in late 2021 into 2020 with the Omicron variant. Since then, COVID deaths thankfully have come down through a combination of vaccination and natural immunity, and perhaps less virulent strains. COVID is still taking the lives of New Yorkers with nearly 4,000 New Yorkers losing their lives to COVID in 2023. With that said, again, we do expect our premature death rate to improve fewer overall deaths of COVID as we move forward.

Mr. Davis As we showed in the Leading Causes of Death graphic and we as public health professionals know; the opioid crisis continues to rage on. The crisis is taking the lives of New Yorkers prematurely. In New York State in 2021, the number of overdose deaths from opioids is over 4,200 with 21.5 deaths per ten deaths per 100,000 population. Number of naloxone administrations by EMS over 19,000 in 2021. There were over 12,000 emergency department visits from opioid overdoses in 2020. Why does the burden continue? There are many reasons. The opioid burden could be in part explained by the high number of opioid prescriptions that are being given out with over 200,000 opioid prescriptions of 90 or more prescribed for at least one day and over 340,000 opioid prescriptions that lasted for a week or more when patients were opioid naive. Finally, it's

worth mentioning that to treat patients with opioid use disorder there were 414.5 buprenorphine prescriptions per 100,000 in 2021.

Mr. Davis This table shows different general health indicators and includes the three-year averages of mortality, premature deaths. Here's a potential life lost and potentially preventable hospitalizations among adults across major race and ethnicity categories. As I mentioned, we try to present as much data as we can stratified in this presentation. What jumps out here are the Black non-Hispanic data points, as this group had the worst outcomes for these indicators. Non-Hispanic Asian and Pacific Islanders fared well in all indicators except for premature deaths, where white non-Hispanics also had the least at 35.5%.

Mr. Davis The last slide started to show some of the racial and ethnic disparities. We're going to continue to present many of the outcomes and health behaviors by socio demographics. We want to give you an idea of some of the more pronounced differences between racial and ethnic subgroups. This is a complicated looking figure that shows what was called the index of disparity. That's a methodological approach that calculates the differences between racial and ethnic groups relative to state averages. The most basic level, the way to think about this is that the longer the bar for a category the higher the percentage. That means there is more differences between the racial and ethnic subgroups. What it does not tell us is what racial and ethnic subgroups are faring the worst. It does flag our attention to where there are significant disparities between the racial and ethnic subgroups. As you can see, the greatest length of the bars or greatest disparities among different racial and ethnic subgroups are in the new HIV case rate as emergency department visits among youth, the gonorrhea case rate, teen pregnancy rate. The lowest disparities on this list were in stroke mortality, motor vehicle mortality, and preterm birth.

Mr. Davis Now, in the next few slides, we're going to show you a few tables of indicators by race and ethnicity in some of the major outcome areas. Let's dig a little bit deeper here. This table shows selected birth related indicators among the different racial and ethnic subgroups. Percentage of low-birth-weight births for Black non-Hispanics nearly twice that of white non-Hispanics. Black non-Hispanics also had the highest percentage of premature births. This could be in part to just 65.8% of Black non-Hispanic births receiving early prenatal care. Teen pregnancy was flagged as one of the highest disparities in the last slide that we showed you. As you can see in the table, Black non-Hispanic rates have a teen pregnancy rate over five times that of white non-Hispanics and over eight times that of Asian non-Hispanics. Teen pregnancy rate is also elevated among the Hispanic subgroups. A few other points here. Non-Hispanic Blacks have the highest infant mortality rate. That is over twice that compared to all other racial and ethnic groups. This table shows the three-year averages of seven different injury indicators for the racial and ethnic subgroups. Asian Pacific Islanders have a rate about half that of all of the groups for motor vehicle related mortalities. This group also has three times less unintentional mortality compared to the other racial and ethnic groups. Now, while Black non-Hispanics and the Hispanic subgroups often have some of the worst health outcomes and highest disparities there are higher disparities in white non-Hispanics as well that are noteworthy. For example, fall hospitalizations among white non-Hispanics ages 65 and up are about twice that of all other groups. In addition, the white non-Hispanic subgroup also has twice the rate of suicide compared to the other racial and ethnic subgroups.

Mr. Davis This table looks at several respiratory disease indicators, again, stratified by race and ethnicity. Asthma is a major burden for Black non-Hispanics and Hispanics

compared to white non-Hispanics and Asian non-Hispanics. In fact, the rate is five times that among Black non-Hispanics compared to white non-Hispanics, while the rate is also four times that for Hispanics compared to white non-Hispanics. We also see similar trends in asthma hospitalization for those ages 0 to 17. However, white non-Hispanics have the highest chronic lower respiratory disease mortality per 100,000 that may be linked to some smoking rates that we'll see later. While Black non-Hispanics have the highest rate of chronic lower respiratory disease hospitalizations.

Mr. Davis Again, with the same type of presentation we're looking here at selected cancer indicators. Few differences stand out. White non-Hispanics have the highest incidence of lung cancer per 100,000. It's actually twice that compared to Hispanics. Colorectal cancer incidence is pretty similar across racial and ethnic groups, but highest among Black non-Hispanics. Black non-Hispanic Females also have the highest breast cancer mortality. They have the highest late-stage breast cancer incidence, cervix, uterine cancer mortality, and cervical cancer incidence compared to all other racial and ethnic subgroups.

Mr. Davis Shifting gears slightly. This is a bit of a busy table. It's taken from our most recent HIV AIDS Surveillance Annual Report. What it is showing here is the newly diagnosed cases of HIV in 2021 by sex, age, race and ethnicity and risk categories. There's also some information here shown for concurrent HIV and AIDS diagnoses. Now, what's important here is that while the rate of HIV has declined for the last few decades, new cases are still frequently being diagnosed in males, as males had over four and a half times more total diagnoses compared to females. The case rates are also highest among those in their 20's. There are severe disparities by racial and ethnic subcategories. In fact, Black non-Hispanics have a rate of new diagnoses seven times that of white non-Hispanics. The highest risk factor categories all remain known, such as injection, drug use and MSM practices, and over half of all new HIV diagnoses were in the MSM risk category.

Mr. Davis Following on with the HIV slide, we wanted to present some common STI data. What you're seeing here is what's tracked by our prevention agenda. The key point we want to make with this table is that we've done an excellent job in reducing HIV. We're working to reduce the rate of increase in STI rates. However, the rates of STI have been steadily increasing over the last decade. When you look to say early syphilis you see that the rate is actually three times that what it was in 2010.

Mr. Davis Another busy slide here. Again, we try to present as much data. We have a wealth of it on our dashboards that are stratified by many different subcategories of demographics. What we're looking at here is severe maternal morbidity per 10,000 hospital delivery stratified by urban and rural residents, race and ethnicity, income quartile by ZIP code, maternal age, and health insurance status. We see higher rates of maternal morbidity, nearly a 120 per 10,000 deliveries in large metro areas, relative to about 80 per 10,000 in other areas. The highest maternal morbidity was seen in Black non-Hispanic deliveries. Nearly 200 per 10,000 while white non-Hispanic and experienced the lowest at less than 80 per 10,000. Disparities are also noted by income quartile with a clear trend in higher rates of maternal morbidity as income declines. Younger mothers also saw higher rates of morbidity. Interestingly, we noted here that the uninsured category saw the lowest maternal morbidity relative to those on Medicaid or other public insurance. We wanted to include some information on firearm violence. Firearm violence is a major public health issue. We see firearm assault related hospitalization rates per 10,000 population from 2016 to 2019. The prevention agenda objective is 0.38 per 10,000 population. That has been met as the rate in 2019 was only 0.27 per 10,000. As new data comes in, we'll

continue to monitor it. The good news is, at least in this time frame, the rate has been coming down each year. While the trend is good news, there remains a lot more work to be done to reduce firearm related violence in the state.

Mr. Davis We also wanted to include some information on Alzheimer's. This infographic provides some key Alzheimer's statistics in New York State. Alzheimer's is a condition that leads to poor health outcomes and comes at great economic cost. The number of people with Alzheimer's in 2020 was 410,000. That's actually projected to increase 12% to 460,000 by 2025. 2019, there were over 3,700 deaths related to Alzheimer's. Over $35,000 per capita Medicare spending is on people with dementia. Total Medicare costs for caring with people with Alzheimer's in 2020 exceeded $5.4 billion. There's a projected 15.6% increase in cost by 2025. It's estimated that we need a 39% increase in geriatricians to help meet demand by 2050.

Dr. Boufford Chris, this is Jo Boufford. I'm just looking at your slide deck here. This is great data. I'm so happy everybody's going to have access to it afterwards. I'm wondering if you could give us some highlights or sort of figure out how to move through your material in about twenty minutes. I'd like to leave about ten minutes for questions at the end if that's okay with you. Thanks.

Mr. Davis Sure, I'll try and move it along a little bit here.

Mr. Davis Let's move to, some help behavior data. This is just another index of disparity looking at behavioral outcomes. We see a lot of disparity in opioid burden, current smoking in high school students and less disparities among consuming fruits and vegetables, preventative medical visits in the last year, etc.. Looking at some smoking data, New York State 12%. Smoking prevalence is higher in males relative to females. We see it highest in the age 35 to 44 category. Highest in white non-Hispanics. We do see the lower education level the more there is smoking. Same thing with income. Less income, more likely to smoke. If you have frequent mental distress in the last thirty days you're much more likely to smoke. Here we're looking at high school students being physically active. Not much to say there. Binge drinking is an important topic. I'd like to spend a moment or two here. Much more prevalent in males. We also see an educational trend that's actually opposite of what we see in smoking. Higher education more likely to binge drink. Same thing that we see with income. Here we are looking at the prevalence of vaping. This is an up-and-coming topic. Continues to be an issue here. Just one thing to point out. There are some racial disparities. It's more common in females than males as well as some regional disparities. Marijuana use. We wanted to include some marijuana use data. You're looking here at the United States versus New York State. We wanted to include this because marijuana is now legal in New York State. Of course, you can't buy it as a high schooler, but we wanted to see what the usage looked like. Thankfully, we've seen a drop off from 2019 to 2021. That was a little bit surprising. We covered major health outcomes, health behaviors. We have some data here on the prevention agenda progress, which I can kind of zip through.

Mr. Davis The color scheme may look different than you've seen in the past. Our new dashboard uses kind of this purple to blue color scheme. Of the 99 indicators we have 26 were met. That means the remainder of them were unmet. Of those unmet 16% have improved. About 30% are statistically stagnant. 28% have actually moved in the wrong direction. Important to note, however, that these directional comparisons are based on the two most recent time periods of years of data available. We're not comparing where we're at now to the start of the prevention agenda. The dashboard compares the two most

recent time periods. This just looks at the progress across prevention agenda priority area showing the distribution of what was met and unmet. We're doing pretty well in the communicable disease area. Seem to be struggling in most other areas in terms of meeting the target.

Mr. Davis This slide is very similar to the slide before it. It just removes those that are met to give you a sense of the distribution across the directions of those that are unmet. Again, even in prevent communicable diseases, even though we haven't met five of them, three out of the five are moving in the right direction in the promote healthy women, infants, and children. Six are moving in the right direction. Six are moving in the wrong direction. We're struggling to move the needle either way in the prevent Chronic Diseases Bucket, where 17 of the 22 that were unmet are statistically stagnant.

Mr. Davis In the supplemental slide, again, I have a complete list of which indicators are doing what. Members can refer to that when they peruse the slides at a later time.

Dr. Boufford I just want to ask you one question. I don't know if you know this. These are great. This is really important information. One of the issues, obviously, is that the way the structure has been. Local areas can pick two issues are going to work on out of the five that are statewide. I don't know if you have any data about... I mean, many of them that did not do well might not have been tackled by anyone. I mean, I think that's part of the issue here. I'm not saying that's the reason, but I wonder, is there any way to crosswalk that or from the data that you've examined just going forward? I don't want to stop your presentation. If we don't know, we don't know.

Mr. Davis I don't know the answer to it right now. I do know Office of Public Health Practice is actively tracking what's been worked on. One of the separate components of the state health assessment that will be featured when we put that on the website does look at the local health planning and operational processes that show what's worked on. At this time, we haven't actually crosswalk what's been done locally versus what we're seeing at the state level. This data is just from what we're doing on our state tracking dashboard.

Dr. Boufford Thank you very much.

Mr. Davis I will take a look at that.

Mr. Davis The next couple slides just kind of look at the distribution of the directionality and what's happening here across each focus area. I won't go into too much detail. This just kind of breaks out across focus areas. Chronic diseases we're seeing pretty much an even distribution, across those that are statistically stagnant across each focus area. The healthy and safe environment. One thing that stands out here is that six of the eight unmet indicators is injuries, violence and occupational health were moving in the wrong direction. Here is the promote healthy women, infants, and children. Pretty much an even distribution of improving or worsening across the focus areas. For the well-being and prevent mental substance use disorders, we see six of the nine that were unmet are moving in the wrong direction in the mental and substance use disorders prevention focus area. Here we have again, the communicable disease focus area. We actually met all of the outcome targets for sexually transmitted infections. A few are improving. One in Hep C, one in HIV, one in vaccine preventable.

Mr. Davis That part of the presentation was all about health outcomes, health behaviors, and then the prevention agenda progress. Why didn't we do it in that order? Because the

prevention agenda and what's on our tracking dashboard is pretty much outcome and behavioral based. The next couple parts of the presentation move us into the demographics and social determinants of health. Because this is a lot of what public health is starting to look at and focus on and recognizing the link between health-related social needs and health outcomes. I'll just quickly go through a few of these here. Some measures on economic stability. Again, we've seen tables like this before just looking at the distribution here. Again, across race and ethnicity, percentage of families below the poverty line. Hispanics and non-Hispanic Blacks have the highest percentages here. One thing that actually... This to me was shocking looking at the data is that 18% of all children in New York State live below the poverty line. There are, of course, stark differences by race and ethnicity. 28% of Black, non-Hispanic children living below poverty versus 12.1% of white non-Hispanics. Another one of the slides that are stratified across many different socio demographics here. This is food security among those with an annual household income less than $25,000. Prevention agenda target 61.4. We are lagging that significantly at 48.1. We do see it is the highest among white non-Hispanics. Perhaps unsurprisingly, a little bit of an educational difference here. Lowest perceived food security in those with the lowest levels of education. We also see some regional differences and differences by disability status. Those with a disability less likely to have perceived food security. Some quick things on health care access and quality. There's some information in the supplemental slides about providers. We know we need more providers. We know we need to work on boosting health insurance, even though compared to the nation as a whole we're doing better in terms of insurance but there are still about 5% of New Yorkers without health insurance.

Mr. Davis This slide here, I think, is important. What it shows is data from the behavioral risk factor surveillance system. This is showing those that actively avoided seeking health care because they couldn't afford it. It's stratified by race, education, gender, and household income. Perhaps not surprisingly, when you look at the household income chart as you move up in household income, affordability became less of an issue. It's similar trend that we see for education. There are also racial and ethnic disparities as well.

Mr. Davis Just quickly on the immunization targets. We are lagging our 4313314-immunization series target. There are regional differences. New York City a little bit behind what we're seeing in rest of state. We are, of course, badly lagging the 70.5% objective here.

Mr. Davis Prenatal care, prenatal care is very important. Again, a very busy slide for our Maternal and Child Health Dashboard. Some quick things that stand out. We did actually meet our prevention agenda objective, which is great news, but we do see stark differences across socio demographics. Age of the mother, as it goes up more likely to have prenatal care. There are racial and ethnic differences. White non-Hispanics more likely to have early prenatal care, than Black non-Hispanics and Hispanics. Education level goes up, we see more early prenatal care. Insurance, of course, a big issue. If you're uninsured, less likely to have early prenatal care.

Mr. Davis Moving on here. Another access measures. Children, adolescents having a preventative dental care visit. We wanted to include something related to oral health. The goal was 81.5%. We are lagging that target. Two items standing out on the demographic trends. Those under 5 are lacking a preventive dental visit. I think there's some work that could be done here. We see that if there is a higher education of the adult in the household they are more likely to have the children visiting the dentist for preventive care.

Mr. Davis Neighborhood and built environment. This is another potential core holistic area that we were alluding to for potential framework to organize the next state and health improvement plan by. Just some quick things here. I think it's important to monitor air quality because when it's unhealthy air quality days it's very sensitive for unhealthy groups such as those with asthma. As we saw, there's a lot of asthma urban areas. It's impacting Black and non-Hispanics and Hispanics in particular. The most part, we only see one or two days where air quality index is pretty high overall. We did note an unusual spike in 2023. That was related to the Canadian wildfires. I'm sure we can all remember those days where we couldn't see very far and felt like we were going outside and being in a billiard hall full of smoke. That's what we're seeing there.

Mr. Davis Residents with community fluoridation in their water systems. What you're seeing here, we have a lot of information that are presented as maps across the state on our dashboard. This is a statistical basis for quartiles. Anything in dark blue would be quote unquote higher concern. Lighter green is of lower concern. That just means that there's less fluoridation or more fluoridation. The challenge with this indicator here is that in order to get fluoride into the water to help prevent dental caries you have to work with your municipalities, your governments and your water supply operators. Also, important to note is that in rural areas a lot of residents are on well water, which adds an additional challenge there.

Mr. Davis Homes being inspected for lead and other health hazards. We did see a noticeable dip in 2020, probably because of the pandemic when we're in a shelter in place for a few months. That explains that dip. We are trailing the prevention agenda objective of 23,000 homes annually.

Mr. Davis Radon tests, on the other hand, we have met the prevention agenda objective. We kind of held firm around 95,000 homes inspected for radon. One thing I think is important to note here, this is actually the number of radon tests performed. Not number of homes. We see radon tests performed a lot in real estate transactions. As we came out of the pandemic, the real estate market started booming. We're expecting to see this number actually inflect in the next two years of data as well.

Mr. Davis Finally, just some basic population metrics if I could. We're getting to the end of the data slides. Just a distribution here looking at our population. As I mentioned in the opening, we are becoming an older, more diverse population. We see between 2006 and 2021. That's a fifteen-year time period. The median age of New Yorkers is higher. We're seeing a lower percentage of the population in those under age 10. On the slide, you might see on the left a huge set of bars in the 40 to 49 population. That kind of moved along and moved up to the 55 to 59, 60 to 64 population. We are becoming an older population. Just a breakdown of our racial ethnic distribution. We are becoming more diverse since the last time we looked at this slide. Nearly 45% of the state is comprised of white non-Hispanic population subgroups. A couple of important things. We thought that it was pretty vital to talk about kind of social connectedness and social cohesion in a way. We went to the county health rankings for the next three slides. Social isolation in the literature suggests perhaps more leading to substance use, poor mental health, poor health outcomes.

Mr. Davis The figure that you're seeing here is looking at the percentage of youth that is disconnected. What that means is that they are not working, and they are not in school. Overall, New York State that is 6%. We saw the highest percentage down in Green County at 23% with the lowest in Allegheny County at 3%.

Mr. Davis In keeping with the theme of social connectedness, this is social associations per 10,000. What this is a measure of are the number of different member organizations and communities that can be civic, political, or religious, sports or professional. Overall, 8.1 per 10,000 population. County with the highest number per capita is Chautauqua at 17. It's lowest in the Bronx at 2.8 per 10,000.

Mr. Davis children living in single parent households. In New York State 26% of children live in a single parent household in 2022. The range for the state counties. Schuyler is the lowest at 11% and highest in the Bronx at 15%.

Mr. Davis Violent crime. It may not look it from this chart, but we actually have seen a steady decrease over the last decade in violent crime. There are regional differences. There is more violent crime in the New York City area than there is in the rest of state area. We have seen a decline overall for the state from 397.3 per hundred thousand to 361.8 per 100,000.

Mr. Davis Major depressive episodes among adults. These are two-year averages. We are just above the prevention agenda target of 6.2. The data has been relatively stable. Six out of every 100 adults are having a major depressive episode.

Mr. Davis Last couple of slides with some educational data. Here we're looking at two educational indicators in the language access indicator. We see a much higher percentage of Black non-Hispanics and Hispanics dropping out of high school relative to the state total of 7.3% and relative to white non-Hispanics and Asian Pacific Islanders. We also see a higher percentage of white non-Hispanics and Asian Pacific Islanders with a bachelor's degree or higher. In terms of language access, Hispanics and Asian Pacific Islanders see a high percentage of not speaking English very well. An early start to education is associated positive life outcomes. Here we see two lines on the figure for those ages 3 to 4 years old enrolled in schools. The percentage has been relatively stable around 60%. New York City is doing better than the rest of state overall. I think it would be in all of our best interest to try and move the needle on an indicator like this at the risk of editorializing a little too much.

Mr. Davis That was all the data I was hoping to present today. There are a number of supplemental slides. With that, I want to say thank you. I know it was a ton to throw at you. I want to thank staff members in the Office of Science and the Office of Public Health Practice who met with me many, many different times and helped organize this presentation, come up with selected indicators for the talk, and hopefully it serves as a wealth of data to help inform where we're going with the next state health improvement plan.

Dr. Boufford Thanks, Chris, very much. This is terrific. While other people are thinking of their questions I want to ask you a little bit. The data that you presented on the broader social determinants of health, education, economic status, housing, air quality, etc. is that easily accessible to you? Is that something that's routinely collected? Do you connect with other agencies to get that information? That becomes, I think, a really important issue for us in terms of how one includes more attention to social determinants in the work.

Mr. Davis Yeah, it really depends on which indicators in question. I would guesstimate that about three quarters of the data related to the social determinants come from the American Community Survey, which is updated annually. We are able to get fresh data for our dashboard each year from that data source. A lot of the educational measures, the

income and poverty measures come from that source. We do go to the Department of Education to get dropout related data. That is updated annually as well for age cohorts. Things related to housing quality that also comes from national surveys that are updated annually. Health insurance data comes from a small area. Health insurance estimates from the census. That one, I think is updated every other year. I have to double check. But the data is routinely updated and should be easily and publicly accessible to anyone. You can obtain it from our dashboards, but if you'd like to get it sooner or play with your own data. A lot of that is available at the county level, and in some cases you can get it at the subcounty level as well.

Dr. Boufford I guess last question of built environment issues like housing, transportation, other issues. Is that accessible or not?

Mr. Davis Some things like modes of transportation to work, mean travel time to work that is available from the annual ACS updates. Houses built before 1940 and 1950. That is something that they collect as well from the census. When you start getting into houses that have severe problems you can get that from the American Housing Survey. There's also a lot of local organizations that do look into that. We do obtain that from the census as well. I think the bigger issue there to note is while we track it what can we do as public health professionals to try and improve that, especially since it's one of the components that America's Health Rankings is using? It's awfully difficult to say we're going to revamp our entire infrastructure. That's why I do caution that. When we're looking at our America's Health Rankings going to be very tough to move the needle on some of those issues.

Dr. Boufford I think that you put your finger on one of the points that's been discussed a good bit on the Public Health Committee and others.

Dr. Boufford Let me open the floor. Thank you so much. Obviously, stand by for questions. We're going to have ten minutes or so for those.

Dr. Boufford Folks here in the room for questions.

Dr. Boufford Yes, please.

Dr. Boufford Just identify yourself, as I said each time, so everybody knows who you are.

Ms. Battaglia Thank you.

Ms. Battaglia Lynda Battaglia. I'm the Director of Mental Health and Community Services for Genesee County. Thank you very much for all the data that was presented. It was very interesting to hear your interpretations and to see the data. I have a couple questions. I'm going to try to limit them. In regard to premature deaths, where does suicide fall into that data? That's my first question. It's maybe more of an observation for myself, but there was one particular mention of major depressive episodes for New York State. I was just curious as to why that was one particular side focusing on that particular episode of treatment.

Mr. Davis So, definitely suicide mortality does contribute to premature death. The exact component to how that is impacting us. I don't have that answer yet. I can look into that. I just have the composite deaths before age 65. We'd have to look a little bit more into the causes of deaths there. We do have percentages of suicide mortality overall and in teenagers on our dashboards that can provide some color to that question. In terms of how heavily it's impacting premature death, I would have to get back to you on that. For major

depressive episodes, we were trying to include a different selection and different indicators by topic area. That one is on our prevention agenda tracking dashboard. It is an outcome tracking target that is in the current prevention agenda. That's why we elected to select that one in particular.

Ms. Battaglia Thank you.

Dr. Boufford Thank you.

Dr. Boufford Chris, could you put your stop share so we can see the other folks that are on the screen?

Dr. Boufford Dr. Watkins has his hand.

Mr. Davis Sure.

Dr. Watkins Great presentation. Just want to clarify, for premature deaths has the state moved from death prior to age 65 to age 75? Are we still looking at deaths prior to age 65?

Mr. Davis That's actually a great question. That's something that I actually asked myself when I was starting to first look at the data when I came to Public Health Information Group many years ago. Some sources have 75. Some have 65. For the prevention agenda, we did target 65. I believe on our Community Health Indicators report series. I hope I'm not misrepresenting this because we are going to the update right now. I believe we present 75 as well. 75 was always a traditional target. I don't have the exact recommendations for why the committee chose to use 65 in the prevention agenda. I think it gets a higher risk category. That is my assumption. Just looking at the average life expectancies. I think we are now around that cusp of 78. I think we're somewhere in the 73 to 74 for males. 77 to 78 for females. It's right around that target. I have to look into that more. Maybe some folks on this committee may have some insight into that as why we chose that target for the prevention agenda cycle. We do present it as 65 on the Prevention Agenda Dashboard 75 elsewhere to my knowledge.

Dr. Boufford Can I extend that question? How much of your data on chronic disease sort of death rates and others age is stratified by age after 60 or 65? Because one of the issues that we had hoped to do, and I think we have not... We got to work on it and look at it as the degree to which we were really dealing with focus on older persons in the relevant categories of the previous cycle or prevention agenda. We ended up with adults over 50. I wondered, was that a data question? What was the basis for that? Obviously, could you then begin to unpack some of the relevant target areas by age going into 60, 65, 75, sort of in the way that Kevin was asking?

Mr. Davis It's kind of a two-part answer there. For the Prevention Agenda Dashboard, a lot of the targets are really homed in on what was outlined in the state health improvement plan and what was chosen to be tracked by program as measurable targets. We do try to stratify data by FCS categories where available, especially if you go there, you can see there are stratification. We try to give subcounty data, county data. Other dashboards that are not prevention agenda do provide data across age categories. One of the big ones is that Community Health Indicators Reports Dashboard. That one has many, many hundreds of different indicators, many of which are stratified by different age categories.

Dr. Boufford Thank you.

Ms. Zuber-Wilson Good morning. Pat Zuber-Wilson, Mew York State OASAS. Question for you. A lot of the data that I saw. I came in little late was really in the prevention world of OASAS is consequence and consumption data. Do you collect any data regarding the why? We look at Hawkins and Catalano Risk and Protective Factors. That's how we really drive the work around prevention. I'm just wondering if data is being collected regarding perception of harm. We know that kids think it's harmful to smoke tobacco, but their perception of harm of smoking cannabis is very low. They think it's okay. I'm just wondering how are we tracking that? How do we look at the synergy around the plans for prevention? Because I know the county health departments are doing one thing. The LGUs in our system are doing another thing. On our provider level, we're not all looking at the same things. That's really a concern for me. We're all going in the same direction.

Mr. Davis That's a bit of a larger question that I think I can address fully. First, I want to say that I think that's part of why public health practice really wanted to engage a lot of our other partners. We've had a number of different meetings with different panel members to get different insights about what we should be looking at. Sticking to the data, in terms of the why questions, I know there are a lot of different surveys that are conducted, such as the Youth Risk Behavior Survey. That does include a little bit more of the why at the national level, which includes the state data. I'm not sure if our specific programs like our Tobacco Prevention Program is doing a little bit more of that collection of data that is more qualitative in regard. A lot of our data, of course, on our dashboards is outcome behavioral based, but not always getting at some of those questions as to why this/why that? It is an interesting thing that I do think is important to the overall piece of the pie. To my knowledge that it's not anything that we have currently on any of our dashboards. I will go back and take a look over the near 1,000 indicators that we do have across all these dashboards and consult with my team just to double check. I would say primarily it is outcome and behavioral focused for the measures currently.

Dr. Boufford Pat, you raised a really important issue that came up when your commissioner was... I think you were here actually with the Commissioner for Mental Health and NYSOFA as well is really beginning, especially because you have the... Just the current cycle, at least there is a very explicit target around mental health and substance use and or wellbeing. I think there was discussion there about how all the three agencies have really been sharing data and looking to align data. At the time, I think because the DOH Office of Science policy was being formed and everybody was churning a bit, it wasn't as clear that the health department folks had been as involved as they might be in terms of the alignment you're talking about.

Ms. Battaglia I think it's really important that we align the work because I'm looking at Courtney. We have a requirement in terms of county plans and then the health department has requirements with the county health departments in terms of county plans. And then, for example, the 150 agencies we fund doing prevention work in communities, in schools. We have work plans that we require them to do. We're all looking at different data, which is okay if we want to drill down to local solutions to issues, but we're not aligning what we're doing. That's a concern when I hear people say to me, oh, we're just going to look at ACFS. Well, it's more than that. I think we really have to have a conversation about how we align our planning so there's some synergy.

Dr. Boufford Very important point.

Dr. Boufford Other questions or comments?

Dr. Boufford Any of our colleagues on the council?

Dr. Boufford Anybody else here questions? Comments?

Dr. Boufford Thank you so much, Chris. You will hear more from us. Thank you. It's terrific. We're delighted that it'll be available to everyone.

Mr. Davis Thank you for the opportunity to present.

Dr. Boufford Thank you.

Dr. Boufford We'll move on then to our next agenda item. We're going to hear the framework proposals, options. Shane Roberts and Zahra Alaali are going to present that, and I think as Dr. Bauer said at the beginning and I said also, I think what we're looking for. We've had some really good and I think critique of the current structure or the cycle of the current structure what has to do with the numbers of years involved wanting the cycle to be extended. This would apply whatever we did. I think everybody's agreed that there needs to be a much-streamlined number of objectives. Obviously, we have to really figure out what really matters. I think the second thing was we were at one point hoping to have sort of two paths, latest point, more of an alignment, especially with the sort of data and metrics beyond the public health professional's notion, including the work from OASAS and OMH. Fourth, if we have a mental health, specific mental health item. I think people when we get into some of the other agencies if we were to choose food security. It's clear that some of that data can be made available from other sources by Department of Health. Obviously, some of that data might need to be accessed through other agencies if we chose to really look at how to mobilize around some of the social determinants. These are critiques that apply to whatever you hear. The idea here, I only mentioned, one thing, I think the Public Health 3.0 concept is that public health people are sort of the glue reaching across this community strategist, I think is the term of art now trying to look about connecting with other sectors. One of the challenges in thinking about the next cycle is at what point can those connections take place to make change? What's at the state level? What's at the regional level? What's at the county level? What's at the local level? It's a really important and complex conversation.

Dr. Boufford The glue reaching across this community strategist, I think is the term of art now trying to look about connecting with other sectors. One of the challenges in thinking about the next cycle is at what point can those connections take place to make change? What's at the state level? What's at the regional level? What's at the county level? What's at the local level? It's a really important and complex conversation.

Dr. Boufford Shane, over to you. You and Zahra lead us through this.

Mr. Roberts Thank you, Dr. Boufford.

Mr. Roberts As Dr. Boufford said, I'm Shane Roberts. I'm the Assistant Director for the Office of Public Health Practice. This is my colleague, Zahra Alaali, who is a Prevention Agenda Coordinator for the office we work in, the state Department of Health under Dr. Bauer, who is our Deputy Commissioner for Public Health. We are going to present today on two proposals that we have for the structural framework of the State Health Improvement Plan, which is in New York State, the prevention agenda. Just really quick before we get into presentation, I think what we're looking for from the committee today is

we would like to present these two framework proposals, and then we would like feedback and advice and which direction you favor in terms of which way we go or if there's a third model or a bunding of the two frameworks that could potentially occur. We would like that feedback as well. Going forward we're going to review the current, structure of the prevention agenda. We'll get into the revised framework, which is taking a structural format out of Healthy People 2030. We're going to also look at an integrated framework, which keeps our current structure but integrates in some social determinants of health focus areas. We're going to talk about the prioritization of the focus areas, which is a process that you are all involved in currently throughout that prioritization survey that went out last week. We'll give some next step updates.

Mr. Roberts I'm going to start just with a brief overview of what the state health improvement plan is and what the state health improvement planning process is. The prevention agenda, as I said, is New York State's Health Improvement Plan. Sometimes referred to as a SHIP. Every state in the country and the territories and DC all plan a SHIP. They all conduct a SHIP process. It is a strategic plan for each state's health throughout a certain time period. Some states do a ten-year time period, like Healthy People and then some states like New York here. We do a six year. It's different in every state. There are really two components to the SHIP process. One is the State Health Improvement Plan, but there is also the state health assessment. You just received a presentation on a section of that State Health Assessment by Dr. Davis. That really informs the planning process in terms of the major focuses of what we're going to do our efforts for the next six years. The other thing is, is that ASTO maintains a comprehensive guidance on the SHIP framework. Most states follow that guidance, including us, and when we conduct the planning process. The SHA, which is state health assessment, the SHIP, the state health improvement plan and then the health department strategic plan are three components that are prerequisites for Public Health Accreditation Board Accreditation. That's why these three things are important. One of the reasons they're important. As I mentioned, for the SHIP process there's three phases. They're not quite as distinct as I have them laid out here. They blend together a little bit. They're stakeholder engagement, which for us would be this committee, the Ad Hoc Committee and then all of the efforts that spiral out from this committee. It is the State Health Assessment, which we just discussed. It's the health issue prioritization. That process is when we gather the stakeholder feedback in the state health assessment, we then undergo a process to prioritize what the issues are for the next six years. The organizational structure for how the SHIP process works in New York state is we have the Public Health and Health Planning Council, of which Dr. Boufford is the Vice Chair. This Public Health Committee, which she Chairs is a subcommittee of that council and then the Ad Hoc Committee, which is the advisory body of the prevention agenda is also a subcommittee of that committee. We here at the department as I mentioned, where we are within fall within the Office of Public Health and the Office of Public Health Practice, which coordinates the prevention agenda. Really, the health issue prioritization and stakeholder engagement. We do that in conjunction with the Office of Science. It really coordinates the state health assessment. You can see the three phases of the SHIP planning process here on this diagram and where they really occur. The stakeholder engagement is ongoing. We continue to do that throughout the entire process even while we are finalizing health issue prioritization. Just a brief history of where we have been with the prevention agenda. The original prevention agenda, the first prevention agenda has been three cycles so far. Started in 2008. At that time, we had ten priorities. Now, in this most recent two cycles we now have the five priority areas that you're all familiar with. We're in the final year of the third cycle here, the 2019 to 2024 cycle. Our goal here is to have a finalized plan before the end of this year. We're required to have a

finalized plan before the end of this year. We are looking to potentially change the way in which these reporting cycles work. I'll talk a little bit more about that in a little bit.

Mr. Roberts Just give an idea of what the structure of the prevention agenda is like. We have those five priority areas, which I'm going to start with those right here, actually. We have; chronic disease, we have healthy and safe environment, healthy women, infants, and children, promote well-being and mental and substance use disorders and the preventing communicable disease. These are the broad structural categories of the domains under which all the focus areas occur. Underneath those, as I was just saying the focus areas are really the health issues that have been identified through stakeholder engagement and the SHA process. Each focused area has goals, measurable objectives. There's an evidence base that supports it. There are resources that are identified through the SHA for implementation. There's identification of priority populations, age groups affected. There's an identification of organizations that play leading roles. All of these things are provided in the prevention agenda so that when local health departments and hospitals are developing their community health assessments and their community health improvement plans they have access to these resources to help bring together their plan.

Mr. Roberts Let's talk a little bit about some definitions here that might be helpful when we think about the prevention agenda. Just as we have the state health assessment and the state health improvement plan, our counties have community health assessments and community health improvement plans. Hospitals have a community health needs assessment and a community service plan. This is sort of the implementation phase of the prevention agenda in New York State. The counties and the hospitals work together in most cases to conduct an assessment of their region. They form a health improvement plan or an action plan in order to identify which areas they want to work on. They will select two priority areas or two focus areas under a single priority. That's from that list that we previously, shared. I just want to say, if you think about the prevention agenda and state health improvement plan in the concept or in the framework of Healthy People 2030, which is sort of the nation's version of that. Basically, for the next six years setting up a strategic plan for the state's health goals. Zahra is going to present on these two structural frameworks and then she's going to talk a little bit about what that health focused prioritization process looks like. After that, we'll go on to next steps.

Mr. Roberts I'll turn it over to Zahra.

Ms. Alaali Thank you, Shane.

Ms. Alaali The process of identifying priorities for the next cycle involves the following. A careful review of the state health assessment data, which was presented by our colleague Dr. Davis. We also conducted numerous meetings with vital health partners over the last eleven months. These partners consist of members of the Public Health and Health Planning Council, the Ad Hoc Committee members, state government agencies such as the Office of Mental Health, the New York State Office of Addiction Services and Support, the Department of State, and the New York State Office of Aging. We also have representation for hospitals and hospital associations and the local health departments in New York State. Additionally, we held several meetings with internal stakeholders from various New York State Department of Health programs and offices. We ensured that the priorities are in alignment with the topic outlined in Healthy People 2030. Finally, reviewed of the progress, of the current cycle of the prevention agenda to identify successes and area that require more attention.

Ms. Alaali Next.

Ms. Alaali The identified public health priorities have been structured in two distinct frameworks. The first one is the integrated framework to the left, and the second one is the revised framework to the right. For the integrated framework the 2019-2024 Prevention Agenda serves as the guiding framework. The five main public health domains of priorities have been maintained without changes. Within this framework existing focus areas are included and a new one has been added along with the new goals. In other words, the new identified health issues and the social determinants of health has been incorporated into the existing 2019-2024 framework for the revised framework. The Healthy People 2030 serve as the guiding framework. In the revised framework, the priority areas are oriented toward the five social determinants of health domains. I will give more details about those domains in the next slide. The revised framework includes new focus area labels and new goals. In general, the revised framework is comprehensive approach that looks at the health not just in terms of medical condition, but also in terms of social, economic, and environmental factors that can impact the health outcomes. In this slide you can see the Healthy People 2030 five social determinants of health domains. The first one is economic stability. Second domain is social and community context. Third domain is neighborhood and built environment. Fourth domain is health care access and quality. The last one is education access and quality. The revised framework will have these five domains. When we compare the integrated versus revised frameworks, the priorities or domains in both frameworks overlap. Both frameworks share the same identified health issues. The integrated framework expands the 2019-2024 prevention agenda to include social determinants of health factors. However, the revised framework priorities are more concrete and places a stronger emphasis on social determinants of health and highlights the importance of addressing social determinants of health to reduce health disparities. Each domain in the revised framework will have the following focus areas. Targets indicators to track the progress and evidence-based interventions. However, what we have been doing differently this time is we have the evidence-based interventions at three organizational level. One is at the hospital level, the health department level, and other organizations. We will also have resources for implementation, identification of populations and age groups affected by this issue. A list of partners, organization that play a leading or supporting role. Moving to each domain of the revised framework. Domain number one is economic stability. The overarching goal is to ensure all people in New York are financially stable and supported in pursuing economic prosperity. We have four identified issues. I just want to highlight that those identified issues are the one also in the integrated framework. They are similar. Number one is poverty, unemployment, housing stability and affordability. The last one under this domain is nutrition security. Domain number two is social and community context. The overarching goal is to ensure all people in New York live in communities that foster and supports a quantum of services that address all residents unique physical, social, and behavioral health needs. There are eleven identified issues under this domain: healthy eating, depression, suicide, anxiety and stress, drug overdose, death, alcohol consumption, cannabis use, tobacco and e-cigarette use, compulsive gambling, adverse childhood experience, and social cohesion and connectivity. Domain number three neighborhood and built environment. The overarching goal is to ensure all people in New York have equitable access to safe and healthy communities and fair, stable, and healthy housing. We have ten identified issues here. Number one, safe community to access to exercise opportunities, injury and violence, lead poisoning, indoor radon, outdoor air quality, healthy schools, environment, water quality, climate change, built in indoor environments and proximity to contamination. The main number four is health care access and equality. Overarching goal is to ensure all people in New York have access to comprehensive, high quality and affordable health care across

their lifespan. We have sixteen identified issues: health insurance access, physical access and proximity to health care services, prenatal care and maternal mortality, infant mortality, receiving appropriate screening and services for children, oral health, healthy aging ecosystem. For example, under this health issues the preventive services for chronic diseases and associated risk factors. Continuing the sexually transmitted infections; HPV vaccine for adolescents, teen pregnancy, HIV, Hepatitis C, foodborne illnesses, health care associated infections, tick borne diseases, and end of life care and planning. The last domain we have is the education access and quality. The overarching goal is all people in New York state have equitable opportunity and access to quality education. We have three identified issues here; access to high quality educational opportunities for all ages, early intervention education, and the last one is increased language access to person with limited English proficiency. Now, I will move to give some examples about social determinants of health. I will provide more details about the goal, indicator, interventions, and resources. Poverty is one of the identified public health issues related to economic stability domain. The target example here we have for poverty is to reduce the number of people living below 200% of the federal poverty line. The indicator could be the percentage of individuals with income at or below 200 of the federal poverty level. Again, the indicator is just an example. It's not final indicator. The interventions and strategies to address poverty and other identified public health issues in this revised framework will be categorized into three levels at hospital level, health departments level, and other organizations such as community-based organizations. Here in this slide, we provided three examples of evidence-based interventions for hospitals. This include forming partnership with local nonprofit to incorporate economic services such as financial coaching and tax preparation into primary care settings and clinics. Another intervention could be implementing strategies to screen patients for economic hardship and social needs with the aim of connecting them to community resources. Taking a closer look at the intervention number two I just mentioned, which involves screening patients for resources, insecurities, and social need. We have identified several implementation resources and evidence-based resources for implementation. You can see also a list of potential partners that could play a leading or supporting role in this intervention. For instance, our list includes the Department of Social Services, government benefits project and Street Cred. Also, here we provided three examples for evidence-based interventions for health departments and other governmental agencies. This includes increasing low-income families access to financial aid, creating partnerships with community organizations and banks to promote the use of saving and investment programs such as children saving accounts and baby bonds. The last intervention is expanding income support policies. The last intervention example here is for the other organizational level such as CBOs. One strategy could be enhancing the skills of community-based organization staff to implement evidence-based programs and community facing health disparities. This could include workshops, support tools such as tailored resources, mini grants, and technical assistance. We have identified the health issues. The next step is to go through the prioritization process to objectively rank the forty-four identified public health issues and making a decision about what to include and what to exclude. We will follow the following steps. Number one is we will use a weighted voting method to rank the forty-four identified public health issues. I will give more details about this method in the upcoming slides. Once we identified the issues to be included in the next cycle of the prevention agenda, we will hold feedback session with stakeholders to discuss the results of the survey. Also, we want to ensure that the most critical issues in the state are identified and included in the next cycle. If there is a consensus on the selected public health issues and priorities then we will start drafting the final framework, including the indicators and the evidence-based intervention and resources. The prioritization process basically is designed to streamline the focus and focus the prevention agenda. In the left

side you can see the pyramid here, which is the current prevention agenda 2019-2024. Sorry, I mixed my right and left here. On the right side we have the how do we envision the prevention agenda for 2025-2030? The existing prevention agenda contains five priorities. We have fifty goals and 210 objectives and 99 indicators. With this prioritization process, we aim to have a more streamlined and more focused prevention agenda. We aim to have fifteen goals. The goals here refer to the public health topics we want to include in the prevention agenda. Each of those topics will have one goal, one target and one indicator. One of the issues we were facing in the current prevention agenda is we found it that it was difficult in counties that has high population to basically align the selected priorities between hospitals and counties, especially when there is, major hospital systems. By adopting a more streamlined and focused framework, we anticipate a higher level of collaboration between the hospitals and local health departments. Moving to the first step of the prioritization process. The weighted voting method. We will use an online survey that is based on seven criteria. I believe by know everyone in this table has received the survey yesterday. The survey score will be used in determining the priorities for inclusion in the 2025-2030 prevention agenda. There are seven criteria for this survey. Number one is the severity of the problem's health consequences. Number two is the number of individuals affected by the issue. Number three is whether there is disproportionate effect in population subgroups. Number four refers to economic and social cost of the issue if not addressed. Criterion number five, whether the problem is crosscutting with an effect across the lifespan. Number six is the feasibility of addressing the problem. Number seven, whether evidence-based interventions are available and can be implemented with relative ease. The survey has been electronically distributed to the following entities. New York State Department of Health programs, centers, and offices, including regional offices, local health departments, all nonprofits' hospitals, New York State Association of County Health Officials. I got the name right this time. Greater New York Hospital Associations, the Health Care Association of New York State, other governmental agencies, and the Ad Hoc Committee members. As for the next step, we will present the results to stakeholders. We will conduct a feedback session to ensure that we haven't missed any important topic to be included in the next cycle. Once we have consensus on the included health issues we will finalize the framework, the focus areas, and indicators. We will have interventions and evidence-based strategies. This is the end of the presentation.

Dr. Boufford Thanks.

Dr. Boufford Maybe we could leave the last slide up. I think it's probably important just in terms of next steps.

Dr. Boufford I had a question, about which other agencies beyond the ones you mentioned. Those are sort of the core group that have been involved. Is it all state agencies? Who beyond the OMH, OASAS, NYSOFA, DOS.

Mr. Roberts When you say, which agencies to be involved...

Dr. Boufford Getting this survey.

Mr. Roberts It would be all of our state agencies that we have contacts for within the Ad Hoc Committee. I can get the list of all of them. I don't have it right here in front of me. There are more than just the ones that participated in the more formalized stakeholder engagement process with the meetings that we do have contacts for. That survey did go out. I will follow up to ensure that we try to get as many responses from them as we can.

Dr. Boufford Because I know we've had Ag and Markets here. We've had energy here. Some of the other agencies haven't been involved, obviously, since COVID. Re-engagement. There are few but not... Some of the others obviously would be important relative to the social determinants area. I think it's probably important to get their feedback there to know what they're doing. It's sort of like what OASAS is doing in a particular area. Similarly, what is housing doing. What's transportation doing.

Ms. Soffel This is Denise Soffel. I'm sorry. Could you flip the video back so that we can see the people at the table? Because right now we're just looking at the slide, and that's not as helpful.

Dr. Boufford Just a minute. Denise, I just wanted to ask a question about the slide then we'll take it down.

Dr. Boufford Sorry. Could you just put it back up a minute? My question was focused on the slide.

Dr. Boufford I was going to ask what the stakeholder discussion who's going to be involved in that? What's that process that you listed? That's all.

Mr. Roberts Sure.

Mr. Roberts The stakeholder discussion would happen here with the Ad Hoc Committee. I think that the intent is to get as many of our stakeholders into that discussion as possible. It doesn't have to happen all in a meeting. We can have that ongoing either through additional meetings or whatever other format makes sense. The goal would be that this committee provides the feedback on the final product.

Dr. Boufford Dr. Soffel has a question.

Dr. Soffel At this point, I was going to wait. I just wanted to be able to see all your faces. That's all for the moment. Thank you.

Dr. Boufford There appear to be only two of you that are still with their cameras on.

Dr. Boufford Just introduce yourself again.

Ms. Zuber-Wilson Pat Zuber-Wilson from OASAS. What is the expectation of our agencies and our partners on a county level to get the input from the people that do the work? That's my question. Because be honest with your hospitals don't do substance use prevention work on a community level. It's our folks on the ground doing programs in schools, doing community prevention coalitions and other work, our partners with the LGUs and the DHSs that are doing the work. Is the expectation that the state agencies are going to go to our partners that do the work in the community and get their input? Because I feel it's kind of a little bit of government coming down and saying these are the priorities without getting everybody's input and the people that do the work, it makes sense.

Dr. Bauer Thank you for that question. Ursula Bauer, New York State Department of Health. I think that's part of what we're trying to get input from this committee. What should the priorities be? Is it within the scope of our organizations around this Ad Hoc Committee, which this is just a subset of the Ad Hoc Committee. I think we have over 100 members, but this is clearly a very committed group. What is within our purview? We have OASAS at

the table. We have the local health departments at the table. We have the hospital associations at the table. OASAS has a huge role around substance use, but I'm guessing local health departments are part of the solution. I'm guessing hospitals are part of the solution. I'm guessing mental health services are part of the solution. Do we decide? Do we agree? Do we want that to be a priority within our prevention agenda or not? If we do, then who are the partners that we need to have around the table?

Ms. Ravenhall Hi. Sarah Ravenhall, NYSACHO. Thank you for the presentation. I am absolutely fascinated by the revised framework. Actually, I think it makes a lot of sense if we're looking toward addressing inequities in health disparities. I do have a few thoughts. I look forward to hearing what our members say in the survey results as well. The first comment is that you specifically had cannabis use listed out as one of the focus areas under one of the priorities. It would be great to see OCM at the table as well since they have helped people working with them. Maybe we can align some data points around that or priority areas around that. If we were to as a state move with the revised framework. Do they have any requirements specific to what local health departments need to submit for their community health assessment? Will this new revised framework meet those requirements through the Accreditation Board? That's something to think about. Unfortunately, I find that in the public health landscape, our members because of the decrease in workforce that we're seeing and just they're really stretched to capacity. They're working in alignment with what is required of them from state statute or what Article 6 funding will allow them to do. Thinking about Article 6 funding and aligning some of the reimbursable expenditures under that with some of the focus areas that are laid out in the revised framework with Healthy People 2030. Not saying it can't be done, but just want to make sure that things like poverty, I think it should be addressed, but making sure that whatever action they can take with their community partners can be reimbursable under Article 6. I also thinking about poverty and how to address that in rural communities. Are there enough resources or community-based organizations working on these types of issues if it is identified as a priority? Maybe challenging for our rural local health departments to make headway and move the needle on something like poverty. Those are my thoughts. It's exciting to be a part of. Thank you.

Ms. David Thank you.

Ms. David Courtney David from the Conference of Local Mental Hygiene Directors. I just want to help support what Pat was saying about the local side, especially on the behavioral health side. Not forgetting the local mental health departments. Obviously, we work very closely with the public health departments at the local level, but also the social services locally, social services departments. I know in one of the slides you have New York City DSS, but every other county has a DSS department. Bringing in that vision that focus around. Another thing I didn't see specifically called out here while you have housing and housing instability and poverty. Homelessness is a huge issue. Homing in on that and working through those local systems will help develop some of those strategies. Just one more point. I think I brought this up at the last meeting, but, really putting a focus more around children and youth and what that looks like on the behavioral health side.

Dr. Boufford Your comment raised the question in terms of Pat's comment. I think one of the questions... Because this has been a discussion in the Master Plan on Aging process as well. I think it came out in the panel when you presented with OMH and NYSACHO is the degree to which agencies such as the ones we've talked about have local infrastructure. A lot of it's funded through federal pass-through funds or statutory requirements or other things. I'm just thinking straight government agency now or agency

funded. Area offices on aging is offices come up a lot who really are very involved in all things addressing older people in many communities. There has been a discussion over there. I'd like to have a little bit of it here about the degree to which and I think the hope had been that local offices of mental health, local offices, OASAS, groups, NYSACHO a little bit later into the game with local health departments and hospitals would be kind of core parts of having their local frameworks connected to each other. I think that has happened in some counties. It hasn't really happened in others. Rather than seeing it as Big Brother coming in, I guess the question... I want to reframe the question a bit, which is wouldn't they be logical levers to sort of encourage their community based, not the NGOs of their funding, but their community based official sort of elements of their departments to align with a set of agendas. If we could agree on them if we agreed on them.

Ms. Zuber-Wilson Well, first of all, the LGUs it's not just substance use that they address. They also address mental health in many counties. There are some counties in the state where the LGU also does social services. It's all under one big agency.

Dr. Boufford Till it reminds us of what the LGU is.

Ms. Zuber-Wilson Local government unit.

Dr. Boufford Thank you.

Ms. Zuber-Wilson I apologize.

Ms. Zuber-Wilson That work happens with our local counties. Because it is a lot oftentimes one agency. Their work plan, the county work plan, the county plans are really developed. We have an entire system that addresses not only substance use disorder, but also mental health and developmental disabilities. It all goes into one plan from our county partners. For us, we have direct contracts with local government. They provide services and sometimes we have contracts where the local governments put the money through to local partners. It's not only federal dollars, but it's state dollars also. It's a range of funding.

Dr. Boufford Thank you. That's really helpful.

Mr. Beyer Dr. Boufford playing off of your comment about the Master Plan for Aging. There's very robust discussion in that framework in a committee that I Co-Chair called Community Design and Development, where we're really making some fascinating interconnections between service outreach and provision, both mental and physical, and the planners and local developers that do community design. I think we can do that here. I believe that the revised framework seems to be most conducive to making those interconnections. I'd be happy to report more on our recommendations, maybe at a future date, but I'll just make a point that I think I make at every meeting. That is that the planners, local planners, really have their finger on the pulse. It's not just about buildings. It's now interconnecting with services, public spaces, social interactions, social isolation, things like that. I'm glad we're moving in that direction there. I think we're moving in that direction here too.

Dr. Bauer Thanks. I really appreciate these comments. I'm thinking out loud a little bit here. Should we be advised to move forward with the revised framework? Sarah, to your point, it seems like as we look through those evidence-based interventions, we can kind of subset what's an evidence-based intervention for a more urban county versus a more rural county? We can add categories. What is the evidence-based interventions for the social

service agencies or looking at what the LGU work plans are or the local community. how do we integrate that activity that's already underway that we can, to use your word, Dr. Boufford, synergize with? If we do move in this direction, I think there's a lot of opportunity to make those connections actually in the framework itself.

Dr. Boufford We'll give Lloyd a shot and then. Sarah.

Mr. Bishop Thank you.

Mr. Bishop I just wanted to say the integrated framework does sound intriguing. Because it does bring more players to the table with their resources. I think that's very interesting. The integrated model is very intriguing. It brings more players to the table. I'm interested in that. I want to see what our members say in response to the survey certainly. Bringing more players to the table is going to be very important. I think everyone knows we're involved in an advocacy campaign to increase reimbursement to hospitals, which are very severely under-resourced. The more players and the more resources that are brought to the table for us and bouncing off of what Sarah said as well is going to be very important. Those are my thoughts.

Dr. Boufford Sarah.

Ms. Ravenhall I think this might be a question for Courtney and the LGUs. There are at least two local health departments that oversee both public health and mental health, the LGU. I was wondering if, Courtney, do you happen to know if the LGU plans in those counties are aligned at all with the community health assessments that the local health departments have to do?

Ms. David I can answer that, but we have our Chair of our Planning Division for the DCS and for the LGs. I'll let her speak on that.

Ms. Battaglia Awesome.

Ms. Battaglia Hello, Lynda Battaglia. I'm the Director of Mental Health and Community Services for Genesee County. I have a few comments, Sarah, I'll definitely get to your inquiry.

Ms. Battaglia In regard to the LGU, as Pat mentioned, the local governmental unit is responsible for developing the local services plan. What I absolutely love about the local services plan is that I'm not writing it. I am bringing all my providers and community partners to the table to assist me in developing it, because they are the ones providing the work on the front line. A lot of counties will have individuals that are providers, agencies, organizations, peers, individuals with lived experience, family members so that we can get a very well-rounded perspective about what the needs are in the community? What are the services that are being provided? Where are the gaps in services? How do we fill the gaps? Because it has to be a very panoramic approach. We can't just look at it through a silo or with tunnel vision. The local services plan is really an opportunity to develop the plan, work in correlation with your departments of health, your social services commissioners, law enforcement. There are coalitions. There are grassroots coalitions that are involved in these planning processes also. If you have an urban county versus a rural county, the rural county that local services plan is going to be much different than an urban. Our challenges are different. Genesee County I'm sandwiched between Erie County and Monroe County. My services look a lot different. I oversee the clinic. I'm also

the director. I have a dual role. I think the utilization and the involvement for this particular agenda has to incorporate the local services plan and the LGU. I think that data needs to be shared. I appreciate the point earlier in the meeting about who's looking at what data? Is the data the same? I the data different? Because that's going to make a difference in the development of your local services plan.

Ms. Battaglia I'm not sure if I answered your question. Like I said, some of the LGUs have dual roles, social services commissioner, public health director, and director of community services. If you've seen one county you've seen one county. They're all going to operate differently. I also want to point out that I really appreciate in the prevention agenda that topics such as suicide are going to be included and depression and anxiety. If you want to talk about a holistic and a broad approach to what a person's overall health is; mental health, substance use, developmental disability, all of that is incorporated into the mental hygiene system, which is overseen by the LGU. I appreciate these additional topics. I hope that some of those prevention on topics like suicide can be incorporated into early death. I think that there's probably a lot of organizations and individuals who are not at the table that might need to be at the table. Thank you.

Dr. Boufford Thank you.

Dr. Boufford I'm going to go to the screen for a minute.

Dr. Boufford Oh, I'm sorry.

Dr. Boufford Sarah, go ahead.

Ms. Ravenhall I wanted to say thank you. That was very helpful. What you're describing with the LGUs is very much how the local health departments operate and develop their community health assessment. What's interesting is the majority of the county's selected substance use disorder and mental health as a core priority, a secondary priority for their county. There's absolutely synergy and overlap here. Thank you.

Dr. Boufford We'll have our last person in the room and then I'll go to the screen.

Ms. Ravenhall Thank you.

Ms. Phillips Kristen Phillips from HANYS. Thank you for the very informative presentation. It was evident that a lot of work went into planning these proposed frameworks. I echo Lloyd's comments that I look forward to hearing from our members on the survey. I would like to also echo what he said about hospitals being severely under-resourced and just ask that we keep that in mind as we consider new focus areas to add. A question that I have is, do any other states follow a similar framework to the revised framework?

Dr. Roberts I think actually that's a great question. New York is one of nine states that has not really moved in that direction. A majority of states do use a similar framework. They don't all follow Healthy People 2030. A very, very similar framework. We did collect that data and I can share that with this committee again just so that everybody has that, and they can see the results.

Dr. Boufford You have done a summary of other states relative to those frameworks. Maybe those slides, I think they're probably somewhere, but we could recirculate them as a result of this discussion.

Dr. Boufford I'm going to go to the screen now.

Dr. Boufford I've got let's see Myla Harrison and then Jeffrey Moore.

Dr. Harrison Thank you.

Dr. Harrison I'm Dr. Harrison, Medical Director in the Office of Health Insurance Programs of the State Department of Health representing Medicaid. I've said this to our internal staff before, I want to make sure that what we're proposing also aligns with the new Medicaid 1115 New York Health Equity Reform Waiver. It sounds like it does since that is around social determinants of health. Social care networks will be forming across nine or so regions in New York State. There will be mechanisms for identifying at least in the Medicaid population, which is a significant portion of the New York state population, particularly of the kids' populations. Somebody mentioned kids. There will be mechanisms, infrastructure for the identification of social needs as well as connections to community resources. We kind of, I think, really need to tie some of these ideas together. I mean, that's a little bit down the road, but this plan is also a little bit down the road. Making sure that we stay sort of in lockstep on some of that work to be as additive as possible. I wanted to kind of put that out there. The one other thought I had about how Shane and Zahra laid this out. It looked like all of the issues around mental health and substance use disorder fell into the social and community context and not into the health care access and quality context. Yet, health care access is critically important for people with substance use and mental health issues, suicide, depression, anxiety. I know we're still early in the planning. I like the idea of the revised framework. I just want us to be thoughtful about. Maybe it doesn't matter how you categorize it. What matters is what you decide to look at for your goal. I just want us to be mindful of that as well. Nobody has yet said it, but I don't think I've been in a meeting in the last two to three years where workforce hasn't come up as a challenge that needs solutions. I think if we're going to move on some of these prevention agenda items we're going to have to figure out where the health care workforce fits in as well. I just wanted to put out that out there as an idea.

Dr. Boufford Just clarify, the Public Health Committee has picked the public health workforce at least as the single issue they're going to be working on going forward. We know the health care delivery system will focus on the health care workforce. Your point is well-taken. I think it's not necessarily something that this group has taken up but are well aware that it needs attention.

Dr. Boufford Dr. Moore.

Dr. Moore Yes, thank you.

Dr. Moore Oops. I got to get my notes back up on the front.

Dr. Moore I think this is really encouraging as an advocate of addressing social determinants and what I prefer to call health ecology. I think this is an excellent direction to go. I have concerns that echo sort of things that Mrs. Ravenhall and David and Phillips have said. I'm surprised nobody has used the word yet today, but this is taking an upstream approach. In that context, the health system is downstream. The challenge and partly its workforce, but the challenge is, and I agree that the 1115 waivers, the kind of thing that's going to help, but I think it's going to have a long learning curve. It's been mentioned that hospitals don't have bandwidth or under resourced in primary care. I'm

curious what Dr. Rugge thinks about this, having pioneered a lot of these kinds of things. I also have some concern about transitions because from where we've been in the last decade plus those are the people involved in those things' kind of feel like they just got dropped. I would hate for that kind of thing to happen, although in the grant sort of world that's often the way things go. I'm curious if the grading system for New York State that puts us 23rd changes in six years are we going to change again? I think I would advise careful consideration of where you are now, where we think you want to go, how you're going to get there, how are you going to make a transition. I would think that just instead of maybe having another five-year plan that actually have a transition period that will help segway where we are. Because I do think there's going to be a big learning curve, especially in the health system that led in the disease care delivery system.

Dr. Boufford Yeah, I'd only say, Dr. Moore, I think your notion of thinking about a transition process is really an important one. This group does stay upstream. We are the upstream group. We're not really looking at the delivery system. I know you've been a big advocate for not forgetting it. We won't forget. Obviously, the health care access issue is on the table in the new framework. It's certainly a legitimate set of concerns. We haven't had the big influence like the waiver has or some of the other major policy areas. We've been focusing much more on prevention. Your transition caution, I think is a really important one.

Dr. Boufford Doctor civil.

Dr. Soffel Hi. Denise Soffel, councilmember. When this was presented to the Public Health Committee last month there was a really robust conversation about what is the role of hospitals, what is the role of local departments of health in focusing on and trying to address social determinants of health. A concern that hospitals are not going to be the entity that reduce the poverty level across the state of New York. That's just not their job. It's not what they're good at. It's not what they have been created to do. There are, in fact, community-based organizations who do some of the evidence-based practices that the Department of Health has identified, such as linking people to services across the board that are already out there and do it well. It seems to me that we should not be asking hospitals to step up and do something that's not part of their mandate, when in fact there are already entities out there for whom this is what they do full time. The prevention agenda really sort of speaks to the role of hospitals and the role of local departments of health. They are not the principal actors who determine access to education or poverty or jobs or nutrition. In some sense, I am concerned that we are creating indicators that we can't achieve because we have identified the problems correctly as these much more broad-based social determinants of health. They are obviously not easy to move the dial on those kinds of indicators. It certainly is not the principal job of health care delivery entities such as hospitals to tackle those particular agenda items. I have a concern that we are asking hospitals to do something that other people have already proven that they can do well, or at least that's what they are created to do and be. That the state itself will be creating a set of expectations around being able to achieve indicators and outcomes over a five-year period when we don't have the current players at the table and when the resources to do it. I mean, if it was easy to reduce poverty, we would have figured that out, right? It's not easy to reduce poverty. I feel like we want to be perhaps a little less ambitious in the way we look at the prevention agenda of over the next five years and try to recognize social determinants are absolutely essential, but define them in a way that feels like A, we have the right people at the table as Dr. Moore said and B, that these are things where we can actually see incremental progress over a five year period.

Dr. Boufford Thanks very much.

Dr. Boufford I'm going to go to two folks who've been waiting.

Dr. Bauer If I could respond, Dr. Boufford.

Dr. Boufford Sure.

Dr. Boufford I'm sorry I didn't see.

Dr. Bauer Because Dr. Soffel, I regretted that I didn't try to address this issue at the Public Health Committee meeting. I don't want to miss an opportunity here. I'll share very quickly that I have a friend who had a heart attack, landed in the hospital, and she left the hospital with SSI. That SSI check was transformative for her, lifted her out of poverty, gave her an income. That was the hospital, the discharge planner, the social worker who changed her life. Hospitals also play a role in their community, often as an anchor institution, certainly as an employer, certainly as a procurer of goods and services. That is a vital role to the health of that community, to the well-being of that community, to the economic vitality of that community. I encourage all of us to think broadly. It's not hospital's mandate to solve the poverty problem. Nobody's saying that here. Do hospitals have a role to play like everyone else? They absolutely do. Thank you.

Dr. Boufford Thanks.

Dr. Boufford Quickly, we have two comments from the floor and then Dr. Moore wants to come back again.

Ms. Wetterhahn Thank you.

Ms. Wetterhahn This is Lauren Wetterhahn. I'm the Executive Director of a network of non-licensed community-based organizations. The ones that you have indicated would be involved in a lot of the initiatives to try to address upstream social determinants of health. I want to voice support for the concept of a transition period for another reason. If I were to try to circulate this survey among my members, I would probably need to do several webinars to explain what we're talking about. I think an opportunity to begin that communication process, to begin making sure in partnership with our local health department and LGU friends that we're reaching out to those CBOs and getting them involved will result in having the right people at the table. I also had a quick question about the criteria in the survey. Are those in rank order of weight or is the number assigned to them just random?

Ms. Alaali Yes, each criterion is weighted criteria. Let's say severity. One is less severe and five is more severe. If there's two people voted five, it will be multiplied by the votes.

Ms. Wetterhahn That's great news because I think as you guys suggested the strength of evidence for interventions to address some of these non-clinical issues is going to be patchy. If that was going to be a heavily weighted criteria, I think that would be detrimental.

Dr. Boufford Could you tell me the name of your organization slowly? Because I wanted to be sure I've got it straight. It sounds really important.

Ms. Wetterhahn We're called the Inclusive Alliance. There are regional CPO networks across the state. Some of us are waiver oriented. Some of us are not. All of us do the kind of coordinating work that could help bring CBOs to the table to support this.

Dr. Boufford Terrific. Thank you so much.

Ms. Preston Hi. I'm Kathy Preston from the New York Health Plan Association. Thank you for these presentations. They were really helpful. I also like the new framework. I think it would give us all an opportunity to better integrate social determinants of health into everything. I think it also gives us an opportunity to have a broader perspective so that this is not just about local health departments and hospitals being responsible for everything, right? I think it offers the opportunity to have better partners, more broad partners. I also want to echo what Dr. Harrison said. I realize that the waiver is a little bit down the road, but we're looking at a lot of the same things. We're also looking at how to have partnerships between providers and community-based organizations to address social determinants of health. The same folks are going to be involved in all of that. You get to a bandwidth issue pretty quickly, right? It would be nice if these things could be aligned a little bit as we go forward. Dr. Harrison's comment about when we talk about access to health care, we really have got to start talking about medical and behavioral health in everything we do. It has got to be aligned. It has got to be integrated. Conversation that went on back and forth here between the local government entities. I think when you look at some of the items on this list about proximity to health services that needs to be medical and behavioral. When we're talking about children, that needs to be medical and behavioral. Frankly, maternity. All of it. Maternity needs to be medical and behavioral too. They all need to be integrated. Thank you.

Dr. Boufford Thank you for that.

Dr. Boufford Dr. Moore and then two more in the room and then we'll have to wrap up.

Dr. Boufford Dr. Moore, briefly, please.

Dr. Moore Yes. I had one other comment that I forgot. In my day job, so to speak, we create tools to help practices. We have SDOH tools. They're covering all the domains. I can't tell you what to top of my head how many questions there are, but there's something like thirty. They all come from the BRFSS. I guess I have doubts. Each of the domains has three or four items that are food security and stuff like that. The questions that go into an overarching calculation for each of the major domains. I guess I'm skeptical that one indicator per intervention is enough. I think they're probably going to have to be... That that would be two, probably two specific and not sensitive enough to a broad domain. That would be my concern about that.

Dr. Boufford Thank you very much.

Dr. Boufford Go ahead, please.

Dr. Boufford And then Sara, get the last word.

Ms. Wetterhahn Lauren Wetterhahn from Inclusive Alliance. Again, just to note that the 1115 waiver might seem far off in the rearview mirror, but it's coming at us at like 90 miles an hour. I think OHIP just published a presentation that shows that social care networks

are meant to be stood up in delivering housing, transportation, and food services in October of this year.

Dr. Boufford I think the real challenge you point out is they're moving very quickly. We are moving not quickly, but in the same general pattern. I think the real question is this focus of the waiver and health care delivery has been on the individual services to the individual. We have been trying to focus more on conditions in communities that affect populations. We're now talking about maybe trying to put one foot on each of that bridge and bring the pieces together. It's a really exciting conversation.

Ms. Ravenhall I was going to say the same thing in terms of I know the state is getting money out to community-based organizations. Can we tie that in? I don't know. The waivers already approved. I don't know if we can. Can we tie that funding?

Dr. Boufford the RFA is out for the first tranche of money. The idea is that these some of these networks could be set up by August I believe.

Ms. Ravenhall Got it.

Ms. Ravenhall And then the other thing is, it would be great to hear from some hospitals and local health departments on ways that they are working to address social determinants of health with community partners. Maybe that's something for a future agenda.

Dr. Boufford We were hearing there's a number of counties that have done a really good job with this. Part of what we wanted to do was present. We couldn't get anybody here today. We do definitely want to hear how people that are putting it together are working together. Because that's got to be a goal of whatever model we use, I think. Absolutely.

Dr. Boufford This is great discussion. As Dr. Bauer said, I mean, what we'll try to do. This is an input session. We hope to get the survey results in the next couple weeks and get them tallied and then will, I think, have one more cycle of formal convening. Again, perhaps at that time, as Shane indicated, maybe bring other people in that have been identified as owning a particular determinant that needs to be discussed.

Dr. Boufford Any other comments?

Dr. Boufford Thank you all very much. Really appreciate it. You'll hear from us. Please fill out the survey if you can or ask questions. I'm sure Shane and Zahra will be happy to answer the questions so that you can try to process it. Thanks.