

**NEW YORK STATE DEPARTMENT OF HEALTH**  
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**  
**PUBLIC HEALTH COMMITTEE**  
**October 16, 2024, 1:00 PM – 3:00PM**  
**90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOM CR C, NYC**  
**TRANSCRIPT**

**Dr. Boufford** Good afternoon, everyone. I'm Jo Boufford, Chair of the Public Health Committee. I'm happy to call our committee meeting to order and welcome our members who are here with me in New York City. I don't know if there are any online. I see our staff colleagues from the department, but I don't know if we have any members online. I want to remind council member, staff and audience that this meeting is subject to the Open Meetings Law. It's being broadcast over the internet and the webcast will be available no later than seven days after the meeting for at least thirty days, and then there'll be a copy that's kept. Because we have synchronized captioning, we remind everyone it's important not to talk over each other. Similarly, when you speak, if you can give your name and affiliation with this meeting. That would be great. Also, the mics are hot, so all commentary is available to the public. The record of appearance forms... Where are they? We have them here in the room. We are in the small conference room next to the larger Gellhorn, formally Gellhorn Conference Room if you need to fill out one of these forms. That is something that's required. You can go online on the Department of Health website [www.NewYorkHealth.Gov](http://www.NewYorkHealth.Gov). Under Certificate of Need, there will be a form that you are asked to please fill out and send into us. With those opening remarks out of the way, I wanted to thank Dr. Whalen and her team for putting together what I think is going to be a very rich meeting. We have three very meaty agenda items. I want to just orient everybody to these items so we can recall why some of these items are on and what the... Maybe by bit about what this committee's work has been with them. The New York State Public Health Workforce Update. We've had a couple of updates in the organizing phase from Keshana Owens-Cody. Her agenda today is to give us a further update, but also because this is the one issue the committee decided you wanted to work on this year. We've been a bit preoccupied, understandably, with their prevention agenda. Starting in 2025, we will take up our collaboration on the Public Health Workforce, and we're looking to Ms. Owens-Cody, to give us some sense of what she feels the priorities are and how we could be helpful as a committee and ultimately also bringing issues for more public conversation at the PHHPC. The second agenda item is the update on the prevention agenda. This is the first of two public health committee meetings we'll have before the end of the calendar year to get a progress report on the implementation, plans and activities relative to the prevention agenda. Our next meeting will be December 4th here in New York, and then we'll have an Ad Hoc Committee meeting on December 9th in Albany. Those should be on the calendar already, but we'll be sure and get those materials. We're looking forward to hearing today about the sort of specific implementation at local level, progress has been made, the status of the interagency planning activities and then the community benefit discussion that we want to keep. Those are the three buckets we want to keep moving in as a committee going forward. Finally, we have an update on maternal mortality from I think, Kirsten, I don't see her online. Kristen Siegenthaler, maybe she's being represented by someone. Anyway, this is because the Public Health Committee several years ago now had had a white paper on maternal mortality where we had raised a number of issues and pulled different parts of the department and other collaborators, folks that are interested from the city, from around the state and at the time maternal mortality. I think some of the work that we did there has had a lot of influence on the high visibility, the Governor's commission, various other thing, the commissioner's group, etc., that went on in between

now and then. We've had one progress report, I think about a year ago. We wanted to just keep up with what's going on in that space, see if people have any other thoughts or ideas, but mainly just to keep it up as an issue of concern.

**Dr. Boufford** Are there any other questions before we get started?

**Dr. Boufford** We have Mr. Perry, Dr. Eisenstein, Dr. Yang, Dr. Heslin, as a surprise visitor. We're always happy to have Dr. Heslin. Dr. Lim and myself here in New York City.

**Dr. Boufford** I'll pass it over to you, Liza. I don't see Dr. Whalen. I don't see any other committee members online. I think it's just staff.

**Dr. Whalen** Thank you so much, Dr. Boufford, for your remarks.

**Dr. Whalen** It's great to be before the committee again. In the interest of time, I know we have a lot of information to share with you. I think I will just turn over to the first agenda item which will be shared with us all the update on the Public Health Infrastructure Grant from Keshana Owens-Cody.

**Ms. Owens-Cody** Good afternoon, everyone. Thank you again for having me. I'm excited to give you all updates on how we've been progressing with the CDC Public Health Infrastructure Grant. Just the level set, I thought it would be great to start off with how we arrived at the Public Health Infrastructure Grant. You may remember about almost two years ago now that we were awarded a CDC Public Health Infrastructure Grant that is groundbreaking in our country, and it's really focused on rebuilding the public health infrastructure. There's a large focus on these three focus areas for the grant. The first area or A1, as you'll hear me actually reference is workforce. That's where a lot of our funding is really focused on recruitment, retaining efforts and increasing the size and diversity of the public health workforce. A2 is really largely focused on foundational capabilities so that strengthening our systems, our processes as far as training and development funding also falls. A lot of focus has been also on improving organizational systems and processes as well. The last category 3A is data modernization. There's a lot of effort to make sure that our data infrastructure is modernized and interoperable as well. The overall outcome of this grant is really to make sure that we're prepared and responsive to public health threats in our future and that we are able to address those through our workforce. Just another level set of public health foundational capabilities. We love to use the slide internally as well, because we're working with all of our centers across the Office of Public Health to make sure that these foundational capabilities are strong within each of the centers. My team that has grown tremendously. We're all working on different areas of these foundational capabilities with each one of our centers, as well as the local health departments and regional offices. Also just to make sure everyone knows the LHD, or local health departments also receive 40% of our grant. They're able to work on the same focus areas that we are. Some of our short-term outcome goals that you can see up here. We were hoping that local health departments would have a chance to hire and fill various vacancies. Also working on retaining their current public health workforce, as well as the same improving foundational capabilities, making sure that their staff have professional development and training and development opportunities. Long term goals are to begin to take some of the investments and also work in the community and do a lot of community-based engagement as well. So, so far, this is what we've seen. A lot of our local health departments start to use their funding. I think I shared the slide earlier in our discussions as well, but the numbers were much lower. We can see that local health departments are using their funding to strengthen their facilities, making sure that they have the

improvements and furniture and those things, also attending conferences. They're strengthening their foundational capabilities. You can also see that there's a lot of investments in retention as well. In terms of giving you an A1 workforce update, I wanted to share that we had 100 public health professionals that were hired through the grant last week, which is very exciting. This number of public health workforce professionals were hired both in this our count with the local health departments as well as state agency. I can share that the top classification of these positions was in the business improvement area as well as program managers. The top titles that were hired within the local health departments center around community health workers and environmental workers. Inside of the department, the top positions that were hired were epidemiologists, statisticians and data scientists. Even though we have about a little under twenty positions left to hire within the department, but our work isn't done. Because even though we have filled the positions that are geared towards the grant, we recognize we still have to focus on also building and strengthening our pipeline as well as filling other positions that are outside of the grant. Some other things that we've done in the A1 focus area are we created an internship in this Summer. We started the soft launch in the regional offices, recognizing that sometimes they may not get as much internship opportunities or paid internship opportunities. All of our interns were paid. What was nice is that we built not only a mentoring and supportive environment for the interns, but we also built that same supportive environment for the leaders or the supervisors. They were also able to gain leadership and training and development experience. We also were able to add on to job descriptions that they have now accelerated in different supervisory responsibilities. That will help with career mobility for those staff that have participated. Another thing that we've worked on is modernizing our recruitment efforts, just recognizing how our staff. How are people finding physicians in public health? We've worked on job titles. We've worked on job descriptions, making sure that we're attracting the right candidates. Real focus on driving those that are really passionate about working through and advancing health equity. We've also looked at where are we posting positions and invested in different areas to post different positions. We've also worked on increasing awareness of public health careers, which I'll talk about a little bit later. We've been attending career fairs, education institutions, going to their onsite career fairs, as well as volunteering to be a part of panel discussions. We've also worked with workforce development institutions just to raise awareness of public health professional opportunities and also working with community-based organizations. Another thing that I'm excited to share is that we are starting to work on exploring or are expanding our tuition assistance opportunities. We currently have a program that many of you are probably familiar with called Public Health Leaders of Tomorrow. We're looking at if there's an opportunity for us to invest, use some of the grant funding to invest in that space to looking at what does the program currently support? Are there gaps? There's expansion of different programs. Maybe there's some degree programs that we're not included. We're also exploring that. Hopefully, in the future I'll be able to share that we have a new or we've expanded our tuition assistance opportunities as well. That's my update on A1 related to workforce. I brought Kendal Pompey with me today. She's my director of Public Health Continuing Education. I thought it would be a great opportunity for her to share what she's been working on as it relates to workforce development.

**Ms. Pompey** Thank you for having me again. I am Kendal Pompey. I'm the Director for Public Health Continuing Education. In my role, I work alongside my Assistant Director, Michelle Stefanik. Really, the goal of our team is to direct the design of the public health continuing education strategy and keeping equity in the centers teaching. Keshana mentioned those; the foundational capabilities, our ten essential public health services with equity centered in the middle to make sure that we have a training plan where we can

continue to conduct ongoing training needs assessments with all of OPH and the local health departments.

**Ms. Pompey** Can you go to the next slide?

**Ms. Pompey** Our mission is to make sure that we're assessing what the core competencies learning are for each of the centers, all of all OPH, so that they can do and perform the task of their everyday work and more effectively serve the communities of New York State. Because we want to always make sure that we're leading to reducing or eliminating health disparities and leading towards more positive health outcomes. How we've been able to look at some of this and build out our strategy is a couple of different ways. One, we've looked very closely at the data. We've turned the public health workforce interest needs or the PH survey data basically inside out to see what the training needs are. We've been able to identify a few areas that will be rolling out as part of our strategy for 2024/2025. Diversity, equity and inclusion, along with some trauma informed responsive practices for leadership. In addition to the leadership and management, we're also going to be doing Public Health Live, where we're working with SUNY Albany to roll that out as well. We'll be working with some of our other partners from ASCO and across the state who have implemented some of these components for training and education related to trauma informed training throughout the nation.

**Ms. Pompey** Next slide.

**Ms. Pompey** In addition to looking at the data and seeing how we could best use that to develop quality training and education plans as it relates to the unique needs of the workforce, we have two work groups that we're leading. The first is the Public Health Infrastructure, Public Health, Continuing Education Work Group, which consist of not only the workforce members that are internally, but our external partners as well. We also work alongside subject matter experts in professional development. Also, we have education institutes that we're working alongside to help as we go through and look at where the training gaps are, to see what they provide, to see where they can help us close these gaps and optimize and enhance the skills and knowledge of the workforce. In addition to that, our strategic plan that rolled out we serve as lead on the strength and diversity of the workforce initiative to where our focus is professional development. Again, we were able to take a close look at the data, some of the enumeration survey data to see what the workforce was saying, but additionally having consultation meetings with the workforce to utilize them as key informants to direct us. Because we're starting to find out that outside of the core competency training needs, there's also a need for technical training, soft skills. We've been able to work with our partners to identify that as well. Those are some of the items that we'll be working on for our strategy from 2024 through 2025 and assessing our learning management system as well to make sure that it effectively meets the needs of the workforce.

**Ms. Owens-Cody** Thank you.

**Ms. Owens-Cody** Thank you, Kendal.

**Ms. Owens-Cody** As we are pivoting, we're at a unique point right now. In the end of November, we'll be pivoting to year three. We've had some time to reflect on what year two was about and what did we experience. Kendal did just share her lessons learned from the public health continuing education side. This is a snapshot of the work force of the public health infrastructure workforce team. It does consist of the unit that Kendal just

reflected on. We do have program leadership and management staff. We have liaisons that are working directly with our academic institutions, our local health departments and regional offices. We have a community engagement team that is up and running. We hired our director, I think, in the midst since the last time we met. We have the Health Wealth and Wellbeing Unit. In terms of lessons learned across all of these respective units, we have learned that there is unfortunately a lack of awareness of public health and public health careers when we're out in the community. We're spending a lot of time educating people on public health before we can actually get to the job where we thought we would be talking about different careers. We're spending a lot of time, which is great. We love to educate on public health, but that's one of the things that we're recognizing is that there's a lack of knowledge of public health and also the profession of public health. Kendal highlighted the training and development needs. One of the other things that we're working on is internal communication before we go external and then collaborations across state agencies. There's a lot of opportunity for us to connect with other state agencies that are doing similar work. That's another area that we've learned a lot about as well as academic engagement. When we're working and engaging with academic institutions, there's a lot of opportunity for us to strengthen internship opportunities, career pipelines, and then for us to be of service to colleges and universities across the state in terms of training and development or panel or guest presenters in some of our academic institutions as well. Where are we headed in year three? I've spent a lot of time probably with Dr. Whalen, as well as the rest of the team wrestling with like where do we see where we really need to strengthen our focus for the grant as well as where we would like your insight in your support as well? One of the biggest ones, as I mentioned, that there is a lack of awareness of the public health profession, public health overall. We have in our year three budget, we have set aside, I would say, a large investment of our grant to drawing more visibility to the Office of Public Health. When I say that I'm including website, storytelling on... You know, why do we all love this work that we're doing? What is public health about? We also have funding for branding communications. We do want your support or your ideas on how we can bring public health to the forefront and be more visible so that people recognize public health in the field. Another area that we really want to strengthen is our interagency engagement. We've had lots of meetings and discussions. For instance, I'll give an example of SUNY. We've been working with SUNY and Department of Labor on community health workers is one of the apprenticeships that exist and how do we bring that resource a little bit closer internally being that we are funding and supporting a lot of community health workers through the Office of Public Health. Another area that we've been also exploring is some of you may be working closely with State Ed, State Ed and graduation requirements are changing as we speak as well. We've been looking at how can we create a CTE or a public health pathway so that high school students are also aware of public health as a potential career. We know that State Ed and SUNY are just one of our state agencies, but there's lots of opportunity for us to collaborate with Office of Temporary Disability Assistance and other state agencies. We would love your help with that as well. There is another slide and another announcement during this, but I did want to let you know that those were the two areas that we were hoping that over year three of the grant and we can show you where our funding and our investments are going. For instance, Public Health Week, we would love to do something bigger in our state around Public Health Week. We have funding set aside there because we thought there could be a big awareness day/week opportunity for us as well.

**Ms. Owens-Cody** I'm going to pass it to Dr. Whalen.

**Dr. Whalen** Thank you so much Keshana and Kendal for all that wonderful information. I'm sure the committee appreciates the real delta in the amount of accomplishment and work

that's being done through this grant. I wanted to talk about at the department leadership level there has been recognition for this. In realizing as this engine is being built and we're seeing all the good that's coming out of it, the importance of how we look at public health infrastructure. There has been a decision made that we are restructuring within the Office of Public Health, the teams and so much of this work is as Keshana indicated, aligned with work that we're already doing. One of the things that Keshana and I have had a lot of conversation is how does the public health infrastructure grant support the work of the state health improvement plan, which is another update that we're going to be getting on this? How do we work together to ensure data modernization is something that is advanced in a meaningful way with our partners, including local health departments? How does this also tie into the mission around the state health equity plan? All of this work is essential to advancing public health in New York State.

**Dr. Whalen** Next slide, please.

**Dr. Whalen** We have made the decision to create, and this is an org chart for the Office of Public Health. If you see the third bullet over, there is a newly formed Division of Public Health Infrastructure that is headed up by Keshana Owens-Cody. Within this division will be housed in New York State Public Health Corps Fellowship, the Office of Local Health Services, Community Engagement and Outreach Unit, and the Public Health Continuing Education Unit. We know that the work that is being done within this new division is assisting with the work across the department and particularly as it relates to our public health partners across the state, including local health departments. It's very important to ensure that we have this infrastructure here. We're very pleased to have that. Also, you'll see the final bullet is the Office of Science and Technology, which I think all of you are aware of. That it's a relatively new office to the Office of Public Health as well.

**Dr. Whalen** If you can go to the next slide, please.

**Dr. Whalen** The Division of Public Health Infrastructure, you know, we talked about what that encompasses, but the work of it is going to be very broad. We really want to work to identify the intersection between program outcomes, eliminate duplicative work, promote training and development opportunities. We are fleshing out our regional offices who have provided a lot of support to our local health departments in the regions across New York State, including reedition of the Capital Region Office, which had not been in and in existence for a number of years. As Keshana indicated, we really want to utilize this grant to increase visibility of public health and careers and public health and pathways to public health and highlight and showcase the importance of the work that we do with community-based organizations, with academic institutions and workforce development institutions. We always have the work of local health departments and community-based organizations at the heart of everything we do. We're talking about dedicating fiscal resources to community health improvement planning for the local health departments, which is a good way that we can support them with the important work they're doing around the prevention agenda and then how we continue to leverage investments from this.

**Dr. Whalen** Next slide, please.

**Dr. Whalen** The final slide, I think is on the Division of Technology. Of course, this is the third important part of this grant is to enhance infrastructure from a technology perspective. There's been a tremendous amount of work that I think resulted in these practical applications that we are sharing with local health departments, including a new data hub on the health commerce system with query products and enhanced data for the local

health departments, a new prescription monitoring program dashboard to local health departments that can provide them with information on prescribing practices in the communities they serve, which can be an important practical tool new symptom monitoring system to provide local health departments a tool to monitor symptoms for individuals or groups of disease, syndromic surveillance dashboards and communicable disease dashboards for local health departments with data from New York State City's system. A lot of the work that's being done is now being evidenced across the state. We continue to work with our partners to best serve their needs in continuing to reinforce this data infrastructure across the state. That's the last slide of this. I don't know if we wanted to kind of go back to what Keshana was talking about, whether others had thoughts on the two items that we discussed or whether we just want to put that out there for future collaboration and communication.

**Dr. Boufford** I think we ought to open the floor to questions and then we may want to talk about the two areas, the public health visibility and interagency engagement that you mentioned as possible areas of collaboration with the committee.

**Dr. Boufford** I'll open the floor.

**Ms. Soto** Nilda Soto, council member, PHHPC member. I want to commemorate your collaborations with interagency in New York State, in particular the New York State Department of Education. I'm not sure if you are aware of a special grant program that's been around for about thirty years called the Science Technology Entry Program and the collegiate part of that program. There are about eighty programs. On the high school side, there are about eight of the seventeen medical schools that have this program. Right now, that grant cycle is coming up. It'll be from 2025 to 2030. One of the things about this particular program is that the eligibility requirements are targeting young people who have been historically underrepresented in the careers and also financially disadvantage. All of them have to be New York State residents. I think the opportunities and the internships and the various things that you're doing. These young people and the programs that are managing these programs will benefit from this collaboration and enhance awareness of public health as a career.

**Dr. Boufford** I saw you nodding your head, Keshana. You know about those programs.

**Ms. Owens-Cody** I do. I do. I would love support with adding public health as one of the sciences. When I'm very familiar with the program, I actually have a kid that went through. Public health isn't identified as one of the sciences, so I would love to talk more about that. Excited that you brought up that and that their grant cycle is open and would love to collaborate on that.

**Dr. Boufford** May have to not push the public. They've been trying to get another M in STEM for the last five years and that hasn't worked either but. You might want to just keep the public health on the low, low down while you're talking about it. It's the same skill set.

**Dr. Yang** Patsy Yang, council member and a member of this committee. For my own public health days just curious and very interested to know how you're messaging what public health is all about. Over the last few years, I felt it had it an identity crisis. I will still consider myself to be a public health person and a local public health person. Lack of resources, lack of respect. We can't articulate. I don't know how to articulate well the value that we bring to government society systems. You know, at the local level, it was easier on the environmental side. You know, it's the air, the air you breathe, the water you drink, the

food you eat. That's tangible, concrete value. You don't want any jeopardy on that front. Harder, particularly given the variation across even just New York State in terms of local responsiveness, yet statewide ness and value. When you get into communicable disease, chronic disease, maternal child health, health care systems access much less when we start talking about the prevention agenda, the even loftier stuff. It's with the changes in reimbursement and sort of the networking of health care providers and the expansion of Medicaid and the reach out by health care providers, medical providers into the softer stuff, the facilitators stuff, and then more upstream with prevention how you're trying to pull that all together in a... Not in a package with a bow on it, but to be articulate that knowing and understanding how different across the state of New York progresses towards that side when you get into the medical care side. I don't know if I'm helping.

**Dr. Boufford** I mean, I think that what we want to do is if we take this public health visibility, which is what you've been talking about, the nuances of it, and similarly, the interagency part. We're sort of talking about the interests of this committee, because I think hopefully.... I mean, one message would be we'd like to work with you certainly on the visibility and the messaging for sure. I think there's a curiosity on the interagency work. I mean, you mentioned the Department of Ed yourselves, but we just kind of take these as comments on these two areas. Maybe before we end just to know, Keshana, if we've been overtaken by events in this work is already done or if there is an opportunity in these two areas for us to collaborate.

**Ms. Owens-Cody** These are the ones that I came up with that I would love to collaborate on. I would say we've started. I got to or I arrived at these two. We have the funding set aside to do lots of different things. Even to the question of like how are we articulating what public health is? When we've gone to like reverse site visits with the CDC, they've been emphasizing doing more storytelling. I'm hoping that that's one way that we can portray what public health is. I look to all of you and the team that we have within as well as OPH to help us come up with what is our visibility plan.

**Dr. Eisenstein** Thank you for the presentation.

**Dr. Eisenstein** Larry Eisenstein, a council member and committee member. Like Dr. Yang, I think of myself as a local public health person after all those years doing that. Thank you, Dr. Whalen and team. My question goes back to A1 of your presentation on the workforce. We, as many of us in the room know there have been numerous grants and staffing opportunities dating back to the CDC apprentice program where health departments got local people. it's changed names over the years, etc.. one of the things that never changed is that it wasn't sustainable historically. We'd get people for a year or two. They'd work on a project. If they were good and there happened to be an opening maybe we were able to keep them. I don't know of anybody that's been able to structurally expand their staff based on these grants or programs. I guess my question is this is great and if there's a way to do it, I would love to hear it. I know you have long term outcomes. How do you make sure these people are able to be kept if they're good? What's the long-term result? I wouldn't hold it against you if you haven't solved it, because I had fifteen years and couldn't solve it.

**Dr. Boufford** I think it's a really critical question. It's true of the waiver and everything else. What happens when the grant ends? I think that's a really important question. It may also to the degree that there's a need for some kind of legislative advocacy agenda that might be also something we could work together on. That was one of my questions very concretely, I guess. How long is the grant? Is it renewable? Getting to Larry's question,



what are you thinking about relative to being able to maintain, especially on the staff side? I see a lot of the other stuff is one time cash but staff.

**Ms. Owens-Cody** I'll be honest, we have not heard from the CDC if this is renewable or if we're going to get any extended funding. What I am doing, being that we're almost at 100% filled is starting to... My hope for next year is to start asking the questions on the roles that we've hired, how they are supporting each one of our centers, our local health departments. Start to pull the stories, but also looking at the cost of each of the positions, the salary grade. Now that we're almost a year three, I'm going to start to analyze. I can even bring those things to you as well. Also, I've been starting to have conversations around what grants are trending. Are there any additional workforce grants that we know about? I would say that's where I'm starting right now. Who have we hired? Where have they been placed? The improvements that they are making in each one of our areas or the gaps that they're closing so that we can start to build that story.

**Dr. Boufford** I think that's really important.

**Dr. Whalen** If I could just piggyback on what Keshana just said. We recently were at the NYSACHO Conference presenting on the grant and hearing from local health departments about some of the challenges that they face. It won't come as a surprise to Dr. Eisenstein, and certainly didn't come as a surprise to me. There is a lot of concern, not necessarily from the health departments, but from their leadership, from their county executives about sustainability. We are seeing people utilizing the funding for staffing, for retention, but it's very difficult for them to create new positions if they don't know what the pathway to the future is. I think as Keshana indicated, the first thing we're really trying to get information from the CDC, whether this is something that is going to be continued. Of course, all of us know that that may be decided in part in November. In addition to that, I think that this really does call to importance the information on how we elevate public health and the awareness of what public health does. Because in telling those stories, in highlighting the health departments that have successfully been able to convince their leadership to create new partners, what the value is in that. Also, by setting the example that the state is now setting, creating this office, creating this workforce within the department and stating, we think it's that important. We're hoping that that filters down, but there is definitely work to be done on that because those challenges are very real at the local level.

**Dr. Lim** Sabina Lim, committee and council member. Going back to actually the interagency collaborations and speaking of the waiver. I wonder whether it's worthwhile to talk to either the Office of Medicaid or the actual organizations that have been awarded the WIO sort of contracts. Because that's the workforce investment component of the waiver. I know that's focused on clinical workforce, but I do wonder whether there can be over time a broader definition of what kind of workforce is included. It's a way to make sure that the waiver continues to stay directly integrated in some way with the work that DOH is continuously doing. Just a thought.

**Dr. Boufford** It's really important, I think is there is money there and presumably that perhaps is arguably more renewable in some ways than the grant.

**Dr. Yang** I think it was an earlier meeting on prevention agenda. I know we're going to get to that. There was a moment where came and presented and promised us additional data. How are you in your reimbursement strategies and plans waivers and non-waivers proposing to fund and support the direction of the prevention agenda? That definitely includes workforce, especially as the medical system starts reaching out into other

spheres and broaden its scope of practice and all of that stuff and brings in other titles and disciplines that that becomes part of the reimbursable world.

**Dr. Boufford** It's really important. I think the interesting thing obviously there was... I guess it was \$1 billion put into the clinical workforce by the Governor's Office last Spring, and presumably that will become part of the overall ongoing budget, although I will create other issues other elsewhere. It's not our problem. I think this issue of is there an opportunity? I mean, obviously we may be a little late for this cycle but building the case with you all through this grant to get something analogous, obviously not that large, but something that really sort of inform a process that would get funding into the public health workforce. I think the thing that back to the messaging question or the advice on narratives. I think is useful, having talked to several local officials about public health there. The question is sort of what is it? The priority is always the local hospital or health care delivery system, understandably from a political point of view. I think giving people examples and maybe even looking for examples in local sort of elected districts and other things where they're outbreaks, where there are problems, water/air pollution. I mean, taking it to their home districts. That's worked for us in Age Friendly in New York City when we did it by Council District. They said, "Oh my goodness. I had no idea that so many people over 65 living there and that they were poor and there was no walkability." Some strategy around mapping public health emergency. Sadly, that's probably the most thing that's visible locally and how being able to prepare for and avoid and or respond would be in their interests. Certainly, as elected officials, I think it begins to elaborate a bit on the strategy.

**Dr. Boufford** Mr. Perry wanted to jump in and then back to you, Dr. Yang. I have my eye on the clock. This is our big issue for the year. We'll go until 2:00pm here and then we'll squash the other two in.

**Mr. Perry** Stanford Perry, I am a committee member and council Member. My question relates to the division, public health infrastructure, specifically your community engagement and outreach component for people with intellectual and developmental disabilities who are highly underserved throughout all of our communities in New York State and often are totally underrepresented in terms of health equity. Will there be any specialized tailoring of information or materials to reach this specific audience so that they too can be included as it relates to your educational outreach component?

**Ms. Owens-Cody** Absolutely. Our community engagement unit is really going to be focused, I would say, on the front end. They will be looking at all of our different populations that live in New York State and how can we engage and make sure that we're meeting everyone where they are. Yes, absolutely.

**Dr. Boufford** Mr. Perry, we promised him that he would be able to get visible in a lot of these presentations the issues of concerns of people with disabilities, because he's a great resource. I already know that having called him for one of my colleagues. He's very wired into this network. From an intelligence point of view can give you that background.

**Mr. Perry** Just as a follow up. At some point then we will see exactly what mechanism you intend to use to reach the IDD population?

**Ms. Owens-Cody** Absolutely. Actually, next time I present, I'll bring my Community Engagement Unit Director so that they can share a little bit more about what their strategy is and what they're working on and how they intend to reach all the populations within our state.

**Dr. Boufford** Dr. Yang, you want to come back?

**Dr. Yang** Just to be mindful of time, the picking up on what you were just talking about. I think an area that's really, really strong, in my opinion is the surveillance piece. Public health, particularly at a state level has that unique position of being a neutral body that doesn't have a fiduciary self-interest in getting laboratory medical provider health care systems data at a population level to identify for doing surveillance. That is whatever the political environment is needs to know data. Needs to know the surveillance of disease patterns, whether it's chronic or outbreaks. It doesn't have to be an emergency, although that's critical. Everybody wants to be ahead of that and to know where their investments are going. That is something that nobody else can do, right? Hospitals can provide the care. They know what's in their network and in their facility, but not on a regional level, not on a county level. I think that is something that is unassailable and nobody else can really do that. I think you have a unique position.

**Dr. Boufford** I would maybe tee off of Patsy's comment and then I had a couple of other comments/questions. I noticed that you're talking about a new syndromic surveillance dashboard, which if it's really new and it's working with emergency departments. Because I know everybody's now trying to retrofit their infectious disease surveillance dashboards for NCDs. If you're dealing with the sort of place-based approach to some of this relative to working with local health departments and you're starting something or building something out that hasn't been dramatically comprehensive, you might think about trying to do both at once. I know in New York City they've had infectious disease outbreak surveillance for a long time. They have like 2,000 primary care practices networked into the health department on that. Now they're thinking, well, the big killers are cardiovascular disease, cancers, etc. We have to go back and think about how we get those into the dashboards, into the charge to collect. If you're starting with something new is trying to figure out, at least on the big killer's cardiovascular cancer, probably the big ones would be really an important opportunity I guess. We talked about the grant duration, which was my other question. One of the things you mentioned, Keshana, last time and you didn't mention it today is the time it takes to process people through the system to give them the job once the offer has been made for them to start working from anecdotal evidence from people who have waited to the point where they take another job. I wonder if that part of it is on their admin fiscal side as being or HR side is being streamlined. You mentioned the issue of sort of advertising, hiring, getting people into interview, but once they get offer how long it takes to get somebody on board.

**Ms. Owens-Cody** Yes, we continue to work on that. It's actually one of our performance metrics for the grant is the timeliness. We also have a work group similar to what Kendal mentioned in terms of the Public Health Continuing Ed. We have a recruitment and retention work group as well that's looking at the recruitment cycle and identifying different parts that we can improve.

**Dr. Boufford** Two or three other quick ones. I notice on the foundational competencies area. I had mentioned this before a while ago when you all first got the grant. I'm delighted at what you're doing. I think there's a great investing in the infrastructure. The essential public health functions, there is a self-assessment tool that CDC has developed and been using. New York was actually one of the pilots. Local health departments can really assess their level of competency on these different foundational, essential public health functions. It might be something to think about doing during year three and sort of teeing up the argument for either renewal of the grant or additional funding, because I know a lot of them

the data area was a real problem. Surveillance systems were a problem. Some of these others. It's being used globally, which is the reason I know how it's happening and throughout Latin America. I don't think we've used it again since the person that created it left CDC a long time ago. It's very quick. I mean, it's pretty easy to do and not a big deal. I think if people thought, and you got trends saying we really need to continue investment in Area X or Area Y. I think it could be powerful because it's kind of a tool that's been out there for a while and quite organized and very specific. It's sort of like here are the criteria for saying you need X, Y, Z, that sort of stuff. It's documented. The other thing I wanted to ask was you mentioned the collaborations with academic institutions on continuing education. I mean, one of the longtime concerns has been that so few people in public health jobs have actually have public health training. I wonder. Are some of the sort of more maybe more extensive modules or programs going to perhaps give people opportunities to have credits toward an MPH or a certificate in public health more formally from the academic institutions you're working with?

**Ms. Owens-Cody** Kendal, I don't know if you want to speak to this, too, but one of the things before Kendal speaks, if she chooses. I've been looking at our trainings. I'll be honest. What we've been producing and not only asking if any of this questioning, if any of it can also be counted towards academic credit, but also even when people are applying for positions that some of the trainings that we're also creating also can support career mobility. Those are things that we're definitely having discussions on. Kendal, I don't know if there's anything you want to add to that with some of the trainings that you're working on with institutions, if it relates to the connection towards MPH degree as well.

**Ms. Pompey** We haven't had those discussions yet, but again, in the discussions that we've had as part of strength and diversity of the workforce within our strategic plan, we're having more of those conversations as we discuss through our internships and different pathways. I work with Cornell in Albany through their programs. I think more of those discussions are going to tend to happen at an HR level and internally as we start to look at the different processes and identify where the gaps are and how we can help bolster those to move towards those pathways and those credits. We're definitely having those conversations.

**Dr. Boufford** I know in the federal government there were if somebody had been a long-time employee for a period of time there was tuition support for them to get an MPH actually. Things like that are really... You know, since the salaries are not going to go soar into the atmosphere in terms of being competitive. Something like that is really helpful.

**Mr. Perry** Thank you.

**Mr. Perry** Something you just said made me think about one of the problems I always felt in public health is that we kind of have our own language. We're trying to connect with the public speaking a language that we all understand and just assume everybody understands, but they don't. Even words like surveillance and health equity. We could write a book just in those words. When you ask the average person in the public, they don't know. Even health equity, the words health and equity don't necessarily together mean the sum of the parts is... Well, you get the expression. The point that I'm making is maybe a recommendation... I was shocked when I got to my hospital system and looked up. I'm not advocating for this. It's just the tool that worked really well. American Hospital Association has an equity roadmap that you don't need to understand the terminology to be able to follow the road map. I've been able effectively to use that to grow equity in our system and to teach our system about it. I think one of the things, again, that they did so well is they

use everyday terms that anybody, whether you're a medic in medicine or not or an advocate or not can understand. I think maybe that's something good just to reference. It'd take you ten seconds to look at it online, to see how they did it with the different steps and where's your system? Where do you want to be? When I first looked at it, I thought would have been good to have this when I was leading a local health department. That came from your idea on resources and how to go forward.

**Dr. Boufford** Before Johanne Morne became first Deputy that the Equity Unit did a lot of lit review on how to construct the health equity index for the hospital. There may be really sort of good information there. You're absolutely right. I think it's a great idea. My last is a lobbying point, which and I've been... This may be done a couple of ways. Theoretically, we are looking for people in a leadership role in public health to have advanced training in public health. The DRPH program has absolutely no financial support almost anywhere in the country from universities, even though PhD students get full rides and stipends. I'm sort of trying to start getting myself activated to do something about that because it's really... It's just crazy. I just want to mention in your workforce, in your leadership development work, and I know when I was.... When I was at the Wagner School of Public Administration. This is an example because I just want to put it as a story to have it in your brain. I mean, when the New York has a number of... has workforce legislation and we found that in the workforce legislation scholarship eligibility did not extend to students getting a public administration degree, but it extended to business school students. Obviously, somebody was much better lobbying than the people in public administration. One avenue might be and I'm happy to talk about this offline is just trying to get. I don't know when the next round of renewals and workforce is there but getting the word public health in there. I think it was actually. Getting it in there, I maybe the Master's and Doctor level training in public health in that legislation and or thinking another way to do it because this is... Ridiculous is too weak a word that that happens. In fact, a lot of universities are abandoning the degree because the students are mostly working in public health. Surprise, surprise, they don't make a lot of money. They can't afford the tuition. It's a really sort of really sad issue. I just want to raise it in that sense.

**Ms. Soto** Well, I'm referring to Number 6 on our slides. There's a tuition exploration.

**Dr. Boufford** That's why I'm saying DRPH as well.

**Ms. Soto** Would it cover something like what Dr. Boufford is mentioning?

**Ms. Owens-Cody** DRPH is actually on my list in my explorations. I would love to have that conversation with you. That's when we were exploring what the current program covers. We caught that DRPH is one of the...

**Dr. Boufford** Sometimes it's not even there.

**Ms. Owens-Cody** It's not on the list. There are other programs that the Certificate of Health Disparities Maternal Health is also not included. Those are the areas that we're currently looking at is the DRPH and some of the certificate programs that are focused on advancing health equity and eliminating health disparities.

**Dr. Boufford** What I'm hearing is that the committee likes both of your ideas relative to collaborating on the public health visibility, messaging, etc. You've got some pretty seasoned experts around the table here in public health who have been doing this for a while. The issue of messaging being available to talking about a focus community,

certainly in terms of Black, Hispanic and other sort of underrepresented communities, but also disability communities, I think we've heard that is important and would be willing to work with you on it. Obviously, really sort of connected to the visibility question is working with the other agencies. Obviously, education has always been a bit of the difficulty. I wanted to raise two other agencies in that context. One, because a lot of the visibility on public health for the prevention agenda period has been through the partnership with NYSOFA and really a lot of the technical assistance that the Department of State had the webinars and stuff that were provided to the local health departments which were funded by the Department of State. NYSOFA and the public health sort of get it together as a tag team because the concerns about people, older persons. This gets back to the sort of agenda for all ages of the prevention agenda. Whatever is going on in the workforce area linking public health to that with an older population has a lot of traction. Because local people vote, older people vote locally, and they buy local. It has the local economic development piece. It gets people's attention from that point of view. There may be options if public health becomes more entwined. Many of the people in NYSOFA have public health backgrounds. It's another way for visibility. Having just come back from a conference that every single meeting was on climate change. I think the Department of Environment is another area. These are things where people get it. When you start talking about environment, Patsy mentioned the ones we've been working with traditionally, but also a lot of other issues like heat and sort of water pollution. You know, a lot of stuff. Rising water levels on cities and stuff are all areas where public health is super active but may not be as visible as it could be. That interagency piece could be a really good connection there. What do you suggest for next steps for us? We have another meeting on December 3rd. I know you probably have a timetable that's driving you faster than that. How would you like to take this forward?

**Ms. Owens-Cody** We actually find out from the CDC, hopefully by mid-November if the work plan that we submitted, which includes this was approved. I think that the December 3rd meeting, we would be able to provide you an update on if there were any changes that had to be made. I think maybe we can discuss this a little bit more offline, but then figure out if we need to have like a separate committee or how we want to start getting to work on specific areas.

**Dr. Boufford** Because what we did with the maternal mortality when --- was talking about it is we would have a set of meetings as part of the Public Health Committee and sometimes for the PHHPC. They're all public. There's a large audience waiting for their CONs. It's an opportunity to give people information about things that they may or may not have heard about that before.

**Dr. Yang** You're hooking in with the Center for Environmental Health when you talked about environmental. It is climate change, but so many of our local health departments, our septic systems, subdivisions, development, led, all of those things. It is the regulatory arm of local public health. That is that the enforcer and the implementer. That is so concrete when you're trying to message what public health is at a local level, the value it brings to communities.

**Dr. Boufford** There's a really good environmental unit in the department. Be interesting to know. I know Paul Buyer, who's involved in the Masterplan on Aging and others has been part of our Ad Hoc Committee. The environmental justice area is another area in the Department of State. It would be interesting to know what the Department of Environment, if anything is doing that may be different from what your own unit is doing within the department.

**Dr. Boufford** This is great. Thank you so much. You can see this is wonderful background information. We really appreciate it. Everybody's fired up.

**Dr. Whalen** I want to thank everybody for such a robust discussion, but I want to also be mindful of the time that we have.

**Dr. Boufford** I want to move now to prevention agenda, if we can.

**Dr. Whalen** I actually would propose because I know the maternal child. There's a longer presentation there. I'm wondering if you would consider changing the agenda to have them go first. It's your preference.

**Dr. Boufford** No, it's fine.

**Dr. Boufford** It is a very long, potentially long presentation, but also really, really instructive and detailed slides. The presentation we could highlight some of the detailed information and not go through all the slides with all the detailed information because then I think we would never finish, but maybe we could think of leaving twenty minutes for the update on the prevention agenda. From now until twenty minutes of for the maternal mortality group to present.

**Dr. Whalen** That sounds great.

**Dr. Boufford** Because I know we're super interested, but some of the slides were so self-explanatory that I think if you can especially hit the sort of big picture issues and then questions that you might have or any other activities, anything you want from us that would be great. People can look at the details and if we have questions for Kristen or others later we can do that.

**Dr. Whalen** I will just put it right over again in the interest of time to Kirsten Siegenthaler to provide the presentation for us.

**Ms. Siegenthaler** Hi, everyone. Thank you for inviting me. I'm Kirsten Siegenthaler. I just will hit the highlights, as you mentioned. Let me just share my screen. As you mentioned, we wanted to provide you information. I know that you are all very interested. I will start with highlighting a brand-new grant that we were the recipients of. It's a federal grant from the Health Resources and Services Administration. You can certainly read the federal aim and focus in the first slide. We received \$2 million per year for five years. New York as one of thirty-five states nationally that has been awarded. One of the keys is innovation, since that's in the name of the title of it. We are tasked with doing a few specific things. One is establishing a Maternal Health Task Force, which we have done and convened. They are individuals who are on a number of our different task force in areas related to maternal health. We did take the opportunity to really broaden and make sure that we had good community representation in it. The goals of the task force are to really review our needs assessment, identify gaps, to develop a strategic plan, to take that plan and engage their partners. To continue to convene and monitor progress annually. You know, identify any new priorities and update the plan accordingly. We will be working to align the task force to our maternal mortality and morbidity efforts and really promote the innovation. The other part of that is really capacity for data. The second goal is to improve state level maternal health data and surveillance. We're able to actually hire additional staff within the department to look deeper into the data and to do some more novel matches between

data sources to try to enhance our knowledge of the data and of the state of New York and ways that we could leverage and implement changes to improve maternal health. Within the actual innovative efforts, one of our first opportunities is to really test a universal virtual home visiting model. It's a postpartum home visiting model right now being tested in rural communities in St. Lawrence and Shenango. It's a partnership between a hospital and our Perinatal and Infant Community Health Collaborative, which is our community health worker model. Every individual who gives birth, regardless of their insurance or their income will be invited and eligible to participate in this. While they're in the hospital, there will be staff to check in on them to explain it. The individual could opt out of it. Presuming they continue, they would be eligible for up to three postpartum visits. Those visits would really focus on things like safety in the house, accessibility to food, postpartum depression, screening, breastfeeding support. If an individual needed more support, then they would be referred to an in-person home visiting program so that more intensive support could be provided. Really trying to engage in that early postpartum period within 72 hours of birth to check in on the family and make sure everything is going well. We will be evaluating this and thinking about scalability of this first in the rural communities. This is definitely a model that could serve anywhere. We do know that there are many people who would prefer a virtual telehealth visit over in-person. We always want to partner with an in-person opportunity in the area. One, so they know the community, but also so the families would have additional support. You can see sort of what the follow up structure would be like. We're modeling this after other home visiting programs, one of which is in North Carolina and has been adopted in New York City and in some of our rural counties like Essex. There's really a kind of a checklist that each of the visits to really follow up on the different topics. The other innovative effort is going to be a perinatal project. You can see here what the model is. What we're going to do is work with the University of Rochester Medical Center and Westchester Medical Center, which are established Project ECHO sites. The only other one is Albany Medical Center. They were not able to participate in this. They were all sort of invited/engaged. We will be working on this to really build up our clinical capacity to address maternal health and improve outcomes. There will be support both for our community partners, but also our clinical partners because we feel like the two together is really important. These are not limited to those two hospitals, but rather broader to the larger perinatal community the project ECHO. Right now, for the initial pilot of the Universal Home visiting it will be in those two specific hospitals. I just wanted to highlight that as something new to share with you. We're very excited. It was a competitive grant application. I think we were able to demonstrate an innovative as well as having the infrastructure to implement it. We just finished our first year on that. We are really just beginning now to implement the Universal Home visiting and the Project ECHO. We had to get contracts in place and staff in place and begin data and the task force. We're moving into the second phase, which is really implementing the innovations in this year. We'll have more to share in the next year. I know you're always very, very interested in data. I wanted to share some data just to give you a scope too. I think we talk a lot about rates, which are really important because they even things out when you look at different areas, right? That have very big populations versus very small populations. One of the things I feel like you lose is the scope of it. We have had a bit of a decline in the birthrate, rebounding a little bit in 2021. There are about 24 births per hour, so 575 or so per day. Just during your meeting today, there will be close to 100 births that will happen around the state. We are unfortunately seeing an increase in maternal morbidity. The rates are increasing themselves. I'll show you a little bit more data about that. Maternal mortality has unfortunately increased as well with some of the bigger increases related to pregnancy associated deaths as opposed to pregnancy related deaths. Pregnancy related are very much directly tied to the pregnancy impacting the mortality, whereas pregnancy associated are completely unrelated. Think of a motor vehicle accident six to nine months after birth



versus some that are associated but not clearly related. Those can range from some mental health and substance use that were present prior to the pregnancy. It's not really clear that the pregnancy eventually led to the death. It's a very difficult area. We have clinicians who work hard to differentiate between the two. We're, of course, interested in care about all of them. Just to sort of share that there might be different techniques required, you know, opportunities to affect them. They're often reported separately. Our infant mortality. You know, we've seen a decrease overall, although a slight increase from 2020 to 2021. Again, to get into some of the rates. You lose the volume of it. You can at least get a sense for the scale over each year being the rate is more equal. There's a line here because of ICD9 international classification of disease changes. Either way, there has been an increase in maternal morbidity. Some of the state maternal health innovation work is actually explicitly focusing on maternal morbidity because we have been looking so much at mortality. We have really included morbidity as an important component of our new state maternal health innovation, because we need to better understand what is driving this increase in morbidity.

**Ms. Siegenthaler** You've seen this before. Were started 46th in the nation. We're 16th. We've kept barely even. Obviously, there's been year over year fluctuation. Unfortunately, the rate in the United States has doubled in the last twenty years. The work we have done, of course, has reduced that impact. In other words, New York hasn't seen the increase that other states have seen. Where we haven't made strides is in our racial/ethnic divide. We continue to unfortunately see stark divisions between maternal mortality for our Black birthing people compared to white birthing people. Looking at the overall leading causes of death. You know, you've seen some of this before, but mental health and 90% of those individuals with mental health also had a substance use disorder associated with it. The two are strongly correlated to each other. Cardiovascular hemorrhage, embolism. Those are definitely strongly associated with pregnancy related. For the first time, and I included the six is we've seen infection, which hasn't been an issue in decades has reemerged and they're related to COVID in 2020 and in 2021. We see infection emerging as an underlying cause for pregnancy deaths. Just in summary, Black/non-Hispanic women had the highest pregnancy related mortality among all races at every education level. It's not an issue of Black/non-Hispanic women having a higher degree, and that decreases the likelihood of mortality. It's significantly higher at every education level. It's not a matter of losing weight or not being overweight. At every body mass index, they are greatly at risk for mortality over compared to their white birthing people. For both vaginal and cesarean deliveries, as well as regardless of their insurance type. The absolute highest mortality was seen among those who are 40 and over who receive Medicaid, cesarean section and in New York City has the highest rate. Sort of different ways of looking at risk factors. The other thing that the Maternal Mortality Board has reviewed and which we are really trying to think hard about is that three quarters of these deaths are deemed to be either likely or very likely had been preventable other actions have been taken or things that were missed were not missed. The Maternal Mortality Board develops reports every two years. They list out recommendations that the state, the legislature, health care systems providers could implement to reduce maternal mortality. It's all posted on our web page. I mean, the other things we know about are we have health professional shortage areas. You can see the very dark counties are the ones where the whole county has a shortage area. They have seventeen counties with fewer than six obstetricians per 100,000 population, which is making it increasingly difficult for individuals to receive care in their county. The need is to travel very far, which is a barrier and a burden. We continue to have higher cesarean rates. We're working on a quality improvement effort right now with hospitals to try to lower our low risk, which is called NTSV, which is defined in the bottom left corner. These are low risk births where we have the greatest capacity, we think, to impact the rate of

cesarean section and try to reduce those rates. You can see we're well above the United States consistently year in and year out. We look at sort of go overall cesarean versus low risk. We have a lot more cesarean deliveries than other states. We break it down by our race ethnicity. We see that Black/non-Hispanic birthing people have the greatest likelihood of cesarean delivery. That is part of our work is not only to reduce NTSV, but specifically looking among Black, non-Hispanic birthing people. Why is there a greater rate of cesarean delivery when we know that is associated with a higher risk of mortality and morbidity? I think what's interesting, we've really just sort of started to understand and use this as a national data set from a Maternal Vulnerability Index. This really has, I think, a stark call to action for us on social determinants of health and physical environment. If you look at Montgomery and Bronx County, which have the highest vulnerability indices, really the drivers of that are social determinants of health and physical environment. Again, those are educational attainment, poverty level, food insecurity, social support, as well as physical environment, violent crime rates, housing conditions, pollution. These are big topics. These are going to be important as we think about the prevention agenda and other things, which I'll talk about as to what the Department of Health's role in these areas. Traditionally, we have obviously focused within the health care system. If we really want to impact health care, we need to look at the broader context.

**Ms. Siegenthaler** I won't go through all of these. You can see that we have a birth equity improvement project I was already talking with you about. We're getting patient reported experience measure. These are the types of questions that are being asked. We are seeing improvements across most of these areas. We're still seeing, I'm sure, flat line not yet seeing positive movement, not negative, but not positive around dignity and respect and stigma and discrimination. The reports by Black birthing people are pretty consistent and haven't yet improved. We're really looking at these data to try to address communication and supportive care that's being provided. That's really being delivered with dignity and respect and without stigma and discrimination.

**Ms. Siegenthaler** We work with our regional perinatal centers. Here's a list of them. We have our home visiting programs. There are links to see more about our two major home visiting programs that are evidence based, maternal infant, early childhood home visiting. These are the ones both the department but also the department and the Office for Children and Family Services Support. We do work closely and are expanding our community health worker model. It's on the last screen and this screen. The paraprofessional model is the Healthy Families New York out of OCFS as well as our Perinatal Infant. That first one is the one that we're pairing up with our hospitals to try out to evaluate the universal home visiting. We've run a few times now Hear Her Campaign. We delivered a lot of materials in many languages that are available at no cost for community members and partners, health care systems to use this and hang these posters up or share them with their birthing community to let people know that what they think, and feel is important and that they will be heard. More broadly, we try to remind people that pregnancy is a moment in time. If we can really help people prepare and sort of enter that period of time in the greatest sort of healthy space that they can that that's our goal. We have a significant investment in family planning and reproductive health care services. We have a number of youths basing activities that work on healthy relationships, financial security, financial literacy, as well as our sexual violence prevention, our abortion access, infertility reimbursement and surrogacy program. Our sort of mantra is really that we want to meet people where they are. We want them to have the information they need, as well as the access and ability to make choices and feel supported in those choices for a healthy outcome. All of you are very familiar with our maternal mortality review. We have a large board managed by the State Department of Health. New York City has its authority

over cases within the city. The two boards meet in parallel and then the state takes all of that data, combines it into a shared report with recommendations and all the data, as well as information for the community to try to effectuate change.

**Ms. Siegenthaler** I added one slide that isn't in your deck, but it's really just our website. If you go to the Department of Health, we have a Maternal Mortality web page where you can get access to a lot of the materials that I have shared today if you're interested in reading more or seeing more information. I went quickly because it seemed like...

**Dr. Boufford** We were running out of time.

**Ms. Siegenthaler** Hopefully, I hit the highlights.

**Dr. Boufford** Thank you.

**Dr. Boufford** Over the years, you've been such a stalwart in this area. I know. It's really great, great work in general with you and your team. I had a couple of questions.

**Dr. Boufford** Other members of the committee have questions?

**Ms. Soto** I have a number of questions, but I'm going to limit it to your program that you were doing the universal virtual home visits. It's like three parts. Who are the professionals who are doing that? Are they nurse practitioners? Are they physician assistants? You have identified some communities, some of which I've had the pleasure of visiting Canton and all of those fifty miles from the Canadian border. Are you encountering individuals who don't have access to I don't know what medium you're using. Are you using cell phones? Are you using iPads? Do they have access issues as to whatever mechanism you're doing these virtual visits?

**Dr. Whalen** Sure.

**Ms. Siegenthaler** I invited Laura Madison, who we have brought on as our Project Director for this new state Maternal Health Innovation. Just to clarify, you know, for the first question, the community health workers are the individuals who are doing the virtual visits. These are individuals who are representative of the community. They have received training. They are engaging with the individuals who've given birth in the postpartum period and really going through screeners, as well as encouraging and making sure that individuals have access to and can get to appointments with for clinical care. There is no clinical provision of services during this activity, but rather more of a postpartum supportive care for all individuals. There is a lot that community health workers are able to do in these settings. In terms of the access, that is something that we haven't yet started our postpartum visits yet. We have just implemented the contracts. One of the areas that we are evaluating and thinking about are what are the needs to make sure that individuals are connected not just to our community health workers, but in general in these rural areas. We're looking at what supports are needed in terms of cell phones and Internet connection during the postpartum period. These will be assessed by the community health worker ideally before the individual leaves the hospital. Because as I mentioned, there's interactions at the hospital. We have a contract with the hospital so that somebody before their discharge is already kind of beginning the postpartum discussion. There are the calls after the fact. We will be evaluating that and determining what are the needs. I don't know, Laura, if there was anything else that you wanted to add to try to answer.

**Ms. Madison** Thank you for that.

**Ms. Madison** We have had a soft launch. We've done some visits. We're still in the very, very infant. Not to do a play on words, but we're in the infancy stage of our Infancy Support Program. We have not encountered any barriers as of yet in our very soft launch. Almost everybody that we're encountering has a phone of some sort. Whether it's virtual being a Face Time or an app like a WhatsApp or a telephone call itself. We've been okay to date with making that connection that there is not the access issue.

**Ms. Soto** Well, it was, and I didn't ask it. That was language and culture in terms of the people that you're trying to reach. You know, what training, what awareness in terms of people's different language access and also cultural preferences, beliefs and so forth and so on.

**Ms. Madison** Excellent.

**Ms. Madison** We know that in our North Country area there are Indigenous people, and their communities are up there as well. I know that the organizations that we've partnered with, the two organizations, North Country Perinatal Center Council and Mothers and Babies. Their community health workers utilize language line services. There are language line and translation services available and easily done over the phone. Again, as Dr. Siegenthaler mentioned, they are from the community as well. Very often they are women of color that are employed as community health workers. They are women who have experienced the same things that the individuals that are being referred to us have experienced. There is that lovely connection.

**Dr. Boufford** I have two questions. One of them one of the questions Nilda asked about who's doing the post-partum visits. Because I think one of the issues is I understand it anyway. Again, you probably have this data that a number of so-called maternal deaths occur within thirty days or so of delivery. I mean, are the patients being triaged relative to high-risk women and there is a nurse perhaps? I mean, I was thinking of nurses from the local health department or visiting nurses from the hospitals seeing those patients or being involved directly with those patients. I know you mentioned mental health, but a lot of the focus here is on social supports and community conditions and the family community, etc. For those women that are at risk, is there a triage going on relative to people doing the postpartum visits that are a little bit more trained, nurses or midwives or others?

**Ms. Madison** Sure.

**Ms. Madison** I mean, the community health workers are ensuring that individuals who have any risk factors or when they screen have any symptoms are going to clinical care and making sure that those visits are happening. The deaths are happening because individuals don't understand or know that that symptom really requires immediate follow up. We've looked at the data and the workforce that would be required to have a nurse visit 200 plus thousand births.

**Dr. Boufford** That's why I asked about triaging.

**Ms. Madison** There are some local health departments that have nursing services, but the typical path would be connecting the individuals at risk for people who are having symptoms to go to their health care provider. The health worker is working to make sure that transportation and childcare and other issues are not the problem.

**Dr. Boufford** I guess that would be something to watch relative to the data in terms of this.

**Ms. Madison** We are evaluating all of this.

**Dr. Boufford** I remember from the last time we went through this, and it may be included. One of the real issues around especially the high-risk women were the early onset of NCDs. I mean, you know, not cardiovascular disease, kidney, you know, others starting sometimes in the mid teenage years, moving into the 20's. You mentioned a couple of those really in terms of causes. You have the list of cancer, which was interesting that that shows up as powerful as that. The other thing that we had talked about before, which is tricky. Again, I want to know if it was part of the plan was this issue of somehow getting women at risk early enough in pregnancy so that they're plugged into some specialty OB services, even though it may be online or it may be different because I know there are even fewer of those folks around, but sort of high risk pregnancies identified as early as possible so they could get some special attention before the delivery.

**Ms. Madison** Sure.

**Ms. Madison** It's not part of the state maternal health innovation grant because that one is focused on the postpartum period. More broadly, the department does have investments in community health workers and nurse family partnership. The goal is really to engage with individuals at risk and get them connected to the care that they need. We invest \$4.5 million in our regional perinatal centers who are working very closely with their network of birthing centers to really be available when there is a high-risk issue and so that they can support the local hospital and or have the referral made to the regional perinatal for individuals. I mean, can we do better? Of course, there is a shortage of individuals who are trained who can support a high-risk pregnancy and the workforce work that needs to be done.

**Dr. Boufford** I guess the other thing that would be missing. We don't have time to talk about it today, but that had come up was the degree to which sort of the whole arc of pregnancy delivery and postpartum care was paid for adequately relative to certainly Medicaid or others. That had been an issue. I think there's been changes made in that. Again, this sort of cost of the financing of this, because it's not an accident that a lot of folks are closing their OB units and their Peds units and the things that aren't paying as well as the other areas. Maybe we can talk about that next time.

**Dr. Boufford** Well, thank you so much.

**Ms. Madison** We'll have to invite our Office for Health Insurance Program.

**Dr. Boufford** One of things we were able to do is bring them in and talk about this. I took it back as an issue. Anyway, maybe we'll catch up with you again in six months or so after you've gotten your pilot underway and then have another conversation. Thank you very much for this really great, great information. Appreciate it.

**Ms. Madison** Thank you for inviting us.

**Dr. Boufford** Over to you, Liza. We were talking about some of this material is familiar. We were going to talk about the more granular implementation strategies at the local level,

how that's going, and then just sort of give us a preview relative to the interagency work and maybe we'll come back to the community benefit at the December meeting.

**Dr. Whalen** Sounds great.

**Dr. Whalen** Thank you for that wonderful presentation.

**Dr. Whalen** Now, I'm going to ask Zahra Alaali to get started on our prevention agenda update.

**Ms. Alaali** Thank you, Dr. Whalen.

**Ms. Alaali** I will really go quickly over the timeline. We started the planning over the last nineteen months. Currently, we do have a vision. We do have twenty-four priority areas. Currently, we are forming working groups to develop the action plan for each of the priority areas.

**Ms. Alaali** I'll skip this slide just to save some time. If you want to look at the priorities, here's your reference slide.

**Ms. Alaali** Over the last two months, we sent a survey asking for volunteers to participate on domains work across the workgroups. Members will be contributing to develop the action plans for each of the priority areas. Basically, they will be tasked with defining goals for each priority area, identifying objectives and selecting indicators. Currently, we are working with a contractor. They are all here. They support the planning and facilitation of working group meetings. They are creating some training toolkits to facilitate the discussions and get the work across. This effort was originally estimated to be concluded by November 2024 or beginning of December. However, so far many of the members has expressed concerns about the timeline. We are exploring the possibility of a time extension for this important effort.

**Ms. Alaali** I have a timeline and the next slide.

**Ms. Alaali** Basically, the working groups, we have a total of 250 participants divided among divided among eleven working groups. Each group has an on average twenty-three participants. Watch work group will focus on priority areas listed on the table. So, for example, if you look at Domain 1, we have Working Group 1 will focus on poverty and employment.

**Ms. Alaali** This is the timeline I was talking about for each component of the action plan. As you can see, this is really aggressive timeline in which we expect that the members will be working on each of the components, for example, for the goals like within one week or one week and a half. We expect them that they finalize. That's why we are exploring the extension of the timeline, because it seems like it is not feasible really to dedicate one week for each of the components of the action plan. For constructing the plan, members will start by defining the broad goals for each priority area focusing on the desired results or outcome. Once the goals are set, they will identify interventions and after the interventions, they will set smart objectives defining the baseline and identifying the targeted results. Finally, they will select key tracking indicator to measure the progress for each of the priority areas. We have different levels of membership, but I will skip this. We have members. We have the working group lead to facilitate the conversation with the members. We have the domain leader who will make sure that the working groups work is

aligned with the overarching goal for each domain. Created a training toolkit to guide members in developing the action plan. All the information is available for the working group members on a Share Point site.

**Ms. Alaali** Here are some examples. Basically, there is different materials, but this is an example of a standardized worksheet. The worksheet provides instructions on each required elements of the action plan. This worksheet can be also used to write down the members on board or even for the final action plan. Resources also include explanation of smart, objective framework. Previously, we used the smart objective framework for the current cycle of 2019-2024. We shifted, which added two component, inclusive and equitable components. We also provided some examples of key objectives on the Share Point site. Other example for guidance documents found on the Share Point. The document outlines a set of criteria for selecting indicators and provides guidance on applying each criterion. All these resources are available on the Share Point site, and here is also another guidance document to select interventions. For the next cycle, we will continue to maximize the impact with evidence-based interventions. Again, we provided some criteria and resources for the members to utilize during this planning process.

**Ms. Alaali** Moving to the Community Health Improvement Plan and Guide. Before I jump to the new guide for Local Community Health Improvement, I just want to go over some common terminology I'm going to use, which is the Community Health Assessment or the CHA, which is the assessment plan that identifies the health issues or critical health issues in the community. The second one is community health improvement planning or the CHIP. It is called CHIP at the local health departments, and it is called also community service plan within hospitals. The CSP basically is a long-term systematic effort to address public health problems based on the findings from the assessment.

**Ms. Alaali** Jumping to the requirements from law from New York State's hospitals and local health departments are leaders in local community health improvement planning. These entities are required to conduct community assessment and develop improvement plan. In New York, State, local health departments and hospital used to submit their plans every three years. Until this current cycle, they have been submitting every three years. However, starting next cycle local health department will submit their plans every six years instead of the current three-year cycle. Hospitals will continue with a three-year cycle to meet the requirements of the Internal Revenue Services.

**Ms. Alaali** This is where you can find the guide. It is available on the Prevention Agenda website and the Community Health Plan and Guide and Step. We tried our best to make the timeline very clear. We have the number of years, which is six years per cycle and then when is the due date for the submissions. For the next cycle provide it's a provides more flexibility to local health departments in which they must submit their assessments by December 2025 and for our improvement plans no later than June 2026. Last cycle or the current cycle, they used to submit the Community Health Assessment and the Community Health Improvement Plan together. We provided more flexibility in the next cycle. Since local health departments are switching to six years cycle, they will also be required to submit a mid-cycle assessment in year four. This is something new. The mid-cycle assessment update will ensure alignment of priorities and also which will ensure active collaboration with hospitals up through the six years cycle. Hospitals, on the other hand, will submit both assistance and community service benefits by December 2025 and again a three-year plan by the end of the year four, which is December 2028. Both hospital and local health departments are required to submit the annual progress reports. We are still working on the details of the progress report, but we are aiming for less write in some

reports. The progress report will ask partners to include highlights of efforts and progress for each selected priority supporting data about their progress, evidence of stakeholder engagement and continuous quality improvement activities. This is just to visualize the timeline and submissions for both local health departments and hospitals. It's a good visualization to see that although local health departments will switch to six years, there is some sort of alignment with the submission and collaboration.

**Ms. Alaali** Encouraged local health departments and hospitals to work together and to work with other regional partners and to develop one joint Community Health Assessment and Community Health improvement Plan. This has been done in the last cycle. we will continue with that with highly encouraging a joint plan between the county health department and the hospital within the same county. We also encourage hospitals to submit schedule edge of the Internal Revenue Service's Form 990, which contain information about health improvements, investments or activities related to the community service plan. Hospitals were also encouraged to increase their investment in community health improvement and community building activities. Within this guide and for the next for the new cycle hospitals and local health departments are asked to select at least three priorities from the prevention agenda list. We have twenty-four priorities. We ask hospitals and local health departments to select at least three priorities. The selection of the priorities should be informed by the Community Health Assessment. One of the selected priorities should include social determinants of health factors such as poverty, employment, nutrition, security, housing, stability, etc.

**Ms. Alaali** I will pass it to Dr. Whalen to talk about the Interagency Working Group effort.

**Dr. Whalen** Thank you.

**Dr. Whalen** This is something that we've discussed before. The new iteration of the prevention agenda was designed to have this additional component to promote a culture across government that prioritizes health and equity and incorporates health and equity into state agency practices. We had some conversation about this internally. What we ended up doing is realizing the fact that we have within the state DOH the Office of Health Equity and Human Rights, or we call it OHEHR, which has a similar interagency task force that was established last year. Their goal is to improve health equity and reduce disparities across racial, ethnic and socioeconomic groups while leveraging data to inform policies and improve health outcomes. I reached out to the organizers of that group and talked to them about whether this would be an appropriate forum to utilize the framework for our Interagency Prevention Agenda Task Force. They were very excited about this. It really aligns with the work that they're doing. They have a broad representation across all of almost all state agencies. This is already established. It would be a significant time and labor saver to utilize the existing framework. We're going to have a planning meeting on this in this quarter to flesh out again the mission of this work group vis a vis the prevention agenda and then look forward to a meeting within the first quarter of 2025, as was originally scheduled. That's where we are with that.

**Dr. Boufford** We'll look forward to hearing about that in December at our next meeting. I had a couple of questions. Anyway, thank you for the presentation. It's very clear. I think it begins to answer a number of the questions we had about primarily around the implementation with local health departments and the sort of measurement issues which I know are emerging. We have two representatives from the Master Plan on Aging sitting on both sides of me. Thank you for coming. Andrew and Jean, one of the issues here has been I know the language says that you're going to be applying these across the life



course, but I think there's nothing. One of these that struck me was relative to the Slide 13 selection criteria, indicators or guidance. There's no mention of adults over 65. I think it has to be that explicit or over 60/over 65. I know the last round we had thought there were going to be older adults. It ended up being 50, because that was probably the age break you had. I think the question would be seeing... At least trying to see how the applicable objectives and priorities could apply to individuals at least over 60, if not over 65. Some of the social determinants I think NYSOFA probably has that data or as a result of the Master Plan on Aging and or agency work. I'm looking at Andrew who's managing this project now. He may want to say something. Those agencies may be able to with some specific questions provided the information and the broader social determinants areas like housing and some of these other areas or poverty, some of the other areas they're going to try to tackle, which I think would not be the case for your equity group probably.

**Mr. Lebowhl** It was very instructive going through this in terms of the data that is accessible on an interagency basis. First of all, I'll say the more specific question you have, the better chance you have of getting it answered. Recognizing, of course, that sometimes you need a certain amount of data even just to be able to articulate exactly what the question is that you need. Second, that sometimes a lot of the data that you think is out there actually hasn't.

**Dr. Boufford** That becomes important for us to know because we're putting ourselves on the line here relative to a big shift. If there's no way to kind of see what the result that needs to be noted that we start so that people are not expecting something that can't be delivered.

**Dr. Heslin** Dr. Heslin, Department of Health.

**Dr. Heslin** I'll just add to what Andrew had to say. We took a little look at the data from Department of State. We also looked at SOFA, State Office of the Aging Department of Health data. We've also taken a little peek at OMH data as well as OPWDD/OCFS. None of those data sets match, nor do they talk to each other. There is no common denominator in any of those data sets that you can actually cross walk once you get beyond anything that has anything to do with privacy. There's a lot of data out there in the world. Just none of it talks to each other. None of it's formatted in a way that it can talk to each other across any of the state agencies. Just to put a pin in Department of Health, we have 418 different databases, and many of them still don't talk to each other.

**Dr. Boufford** Thank you for that encouraging statement.

**All** (Laughing)

**Dr. Boufford** I appreciate that.

**Dr. Boufford** On the other hand, one of the ways we solve this problem in New York City, when we started Age Friendly New York City was using a place-based approach. Using county level data is better than no data. Pretty much every agency keeps at least county level data. You can't match it to neighborhoods. You might not be able to match it too local. But since your actors here are county health departments and presumably hospitals serving at least one county, if not multiples, or multiple hospitals serving one county. Could I suggest that you think about that in terms of especially the broader determinants of health, social determinants that you want to deal with? You probably have all the other stuff, but I know just Department of State can help with a lot of that. I mean, Greg Olsen

has used this economic analysis from the first time I ever heard him speak to market to the importance of older people of the State of New York. I think that a place-based approach at county level could give you some baseline. Again, I agree. We had this discussion before. It's probably not going to track needle movement. I mean, what you'll do, track needle movement is probably in your smaller objectives and priorities within the department. I think to give that a shot, at least with the interagency group. It may be that the MPA interagency group I know because over the last two years, they're the data people in each of those agencies working on the MPA are accessible, have been identified. We know who they are. It may be that if you said... You know, I think you've got some subsets of how you want your five socially determinant areas to look. That's a pretty specific question. What can you give us around these? You could do it yourself, Liza. New meetings versus people who have been talking to these folks for the last year or two.

**Dr. Whalen** Yeah, I think that's very helpful.

**Dr. Heslin** Liza I share a wall so we can just knock on the wall and chat about it.

**Dr. Boufford** That's important.

**Dr. Boufford** The other issue, as you know. I think that this is something that it could work to a point. The county health indicators data out of University of Wisconsin is national data. People have used it to make change in the way they're doing business. There is a New York State report for that by county. You can pull that right offline. A number of those issues are educational levels of the population. Do people have jobs or not? That kind of stuff. I think it's another instantly available by county in New York thing that could supplement on the social determinants piece. The other issue, I guess, and we talked it says... I'm going to Slide 21, which has my most unfavorable word is encourages the hospitals and health departments to do all these things. I know you can have the local health departments do this. Liza, we talked at one point. You're encouraging them to submit their IRS forms form 990s with attention to the Community Health Improvement Committee building categories. We had gotten further than that in that the Health Commissioner had actually sent a letter out with before COVID when everything got interrupted to the CEOs of hospitals asking them to send it. The reason that's different is then you can track who didn't answer his in this case email. I mean, it was very effective. It sort of gets people's attention. It's not like that's new. They had been asked to do it before. I think the other dilemma, as I recall from trying to look at those categories in the past is very often they just put a dollar amount in there. There's no useful description of what they're doing. One question might be, I know the guidance has gone out, but I gather yours is still maybe a little bit more being thought about is whether even in a parallel play, a letter from the Commissioner asking for their 990 and then a little bit more granular information on those two categories could come out in a letter from the Commissioner. That wouldn't be too different from what they're used to. I think that was one of the dilemmas before. Because we have thanks to the information from one of your former employees whose getting his PhD at the city of Albany. He has the level of investment by category within the 990's for the last eight years I think by hospital across the state. The dollar amounts would be great in those two categories. He has that already. You don't have to worry too much about that. If they were asked to submit to you, at least let you know what they're counting in CHI and committee building so there are some subsets of narrative or how they're aligning with the prevention agenda criteria.

**Dr. Whalen** I mean, as far as I know, that has not been done since COVID. That would need to be reconsidered.

**Dr. Boufford** I just encourage it. This is part of the conversation we had before you started, Liza, that didn't really get moved ahead. Only to say that the letter from the Commissioner had been done in the past. I think because you're not making them, the only thing it adds that you're asking them to be a little bit more granular. If they do answer, if they don't answer is a little easier to track who answers and who doesn't.

**Dr. Yang** You're more pragmatic than I was at the data. I thought the data would be a great thing for your interagency task force to start tackling.

**Dr. Boufford** The master plan people have been sort of beating this question to death for the last two years. The equity platform is great. It's just that it may be time savings to focus on the ask from our colleague sitting here for those agencies.

**Dr. Yang** Siloed data is from their perspective.

**Dr. Yang** It's sort of going back to the earlier conversations that we had, which is, you know, if the CHIP at CSP is sort of roadmaps related to prevention agenda with measurable objectives and outcomes, that rather than it sort of being an exercise of just what has been taken seriously or less seriously or more seriously. It is an opportunity to pick those things that you actually have interventions that will be measurable, that will show the value of local public health and local community building towards something that's going to make a difference to the people who have the investment in the future of their communities rather than just picking things that are somewhat... I'm not saying everybody does it, but that is the tendency, right? It's an exercise that we have to do.

**Dr. Boufford** I think all the local health probably did breastfeeding, for example, which was something they were already doing.

**Dr. Yang** I think it is in the intersection of the CHIP and the CSP an opportunity to articulate better where public health on the clinical side, not the environmental side. The clinical side is with the health care delivery system, right? Those things sort of stick out obviously. I am still curious about what a local health department or health care system will do on poverty and unemployment and housing stability and security. I'm curious. You're saying they need to pick one of them, one of their three, that they have to come up with interventions with measurable outcomes and objectives. That's great. I'm just not sure what that will look like or if it walks you back into that vagueness of we're not sure what our value is coming. It's aspirational.

**Dr. Whalen** We do have a lot of community bench strength of people that have been working within that space that were not traditional public health employees before they came to work for DOH. Some of them are within the Office of Public Health Infrastructure. I mean, it could be as little as can you implement within your health department a kind of connector to employment, to feeding employment? I mean, so much of the work they're trying to do is to increase educational opportunities and increase funding for people to get gainfully employed. This is a strategy that could theoretically assist in reduction of poverty and improve standard of living for people. We have to look at these things from a couple of ways. We have to look at what's out there that's already evidence base that we could utilize. Can they partner with banks or other agencies that can kind of introduce capital into these efforts? We'll be able to share more of this after the planning committees have met and come up with these evidence-based interventions. The other thing is that for those areas where there are evidence-based interventions we'll utilize them. For areas where

we're looking at promising practices, this really allows us an opportunity to be creative. I think that cross-sector collaboration and looking at a larger level with other state agencies across the spectrum of public service really allows us time and effort to kind of develop systems that can help to move people out of poverty. I don't think it's impossible.

**Dr. Yang** I don't think it's impossible either. I think the partnership piece will be critical. Your objectives are still process ones that it is not unilaterally process. It's not just the local health department submitting the application. There is some process, out process measurement on the receiving agency. Because you're never going to get to an outcome measure until you can get the other side. We're filling out the application and sending it over to another agency and then it sits. There isn't that outcome. All you're doing is just measuring tasks process. I know you know that. I'll just stop.

**Dr. Boufford** I wanted to ask you on your working groups are greater New York and HANYS giving you members from the hospital industry?

**Dr. Whalen** Yes.

**Dr. Boufford** Oh, good.

**Dr. Boufford** The other question was whether the Community Health Center folks had they reached out to. They were in passing just informally the New York State Association of Community Health Centers has been involved locally in a number of places, but not everywhere. They obviously have access to the most vulnerable groups relative to primary care access, which would be an important part of the social determinants. Who's the executive director of the New York State Association of Community Health Centers. Sorry, I get their names wrong. She's a member of the Ad Hoc Committee and maybe could be reached out to explicitly to see if you've got community health center reps on some of these committees as well. If they didn't answer your call, I know you asked Ad Hoc, but if they didn't answer. It's a system that can really contribute as much as the hospital systems can do.

**Ms. Alaali** We have a presentation on the working groups. We have community-based organizations. We have even physicians, which I think didn't happen before. We are trying to identify underrepresented organizations at the moment.

**Dr. Boufford** You can't do better than community health centers in terms of providing primary care to underserved populations. That's their raison d'être. I just think it gives you some access without having to sort of try to find out things that may be harder and take more time. They may have partners, but community health centers as well.

**Dr. Whalen** Do they encompass federally qualified health centers as well?

**Dr. Boufford** That's what I'm talking about.

**Dr. Whalen** That is the same thing.

**Dr. Boufford** They probably have community-based organization partners as well that they could make available in this process. They would probably be eager to help. They had always wanted to be more involved than they were in the end at a local level. Bringing them in now would be really, really good, I think. Help you and save a lot of effort at the state level.

**Dr. Boufford** Any other questions?

**Ms. Soto** Along with Slide Number 21 about submissions one, reading this, I realize that a lot of this is wordsmithing and because of the words should... They should select three priorities and they should be informed by the CHA. My question basically is what are the outcome and consequences one of noncompliance? Is there such a thing as a poor rating? If a poor rating is given, what steps are taken to improve that particular institution's rating?

**Ms. Alaali** Just for clarification, the selection of three priorities is a must. I apologize for the error. So far, like I have been working here for two years and I haven't seen anyone noncompliant. Hopefully, this doesn't happen in the future. I don't know if you want to add to that.

**Ms. Soto** What if the institution has a poor rating? They submit something and whoever the reviewers are and saying, "Well, no, this is not meeting the level of expectation. What happens in that case?"

**Dr. Boufford** Historically, there was a group of reviewers of each of these plans, and if it wasn't adequate, they were sent back for revision. It was sort of as simple as that.

**Ms. Alaali** We have you have been doing this. The team are the one who is reviewing all the plans. As I mentioned, the last submission happened in 2022. We haven't seen anyone who was not compliant. All the plans were actually fulfilling the requirement. After the review, we sent them feedback about how to strengthen their community health assessment and improvement.

**Dr. Boufford** If that process is still in place, it should be fine. It should work well.

**Dr. Lim** I just want to jump back to and continue Dr. Yang's train of thought, I think. If we can just get sort of hypothetical and concrete for a hospital. They have to choose one of the three SDOH priority areas. Let's say that they choose either the housing or food and nutrition. Most hospitals or all hospitals are required by various entities to, at the very least, do screening and referral. Part of the role, the role of the hospital would be to do screening and referral to assess whether they need housing, whether they need nutrition services, need medically tailored meals, what have you. That as part of the way that they would meet the objectives is they would screen and refer perhaps to the social care networks set up by the waiver. The hospitals don't necessarily have to be the entities that set up the housing or set up the sort of food and nutritional services. They don't have to create new. I mean, they could choose to if they want to. Is that sort of what you're thinking sort of concretely down the line what you would envision the hospital's role in this in terms of what their actual participation is to drive the priorities?

**Dr. Whalen** Either of those things would be acceptable. Obviously, given the fact that this is unfunded. We can't expect that hospitals are going to say, "We just bought an apartment block and that's how we're going to do this." Unless, you know, that was what they were already doing. A lot of this work is amplification of work that exists or enabling kind of cross-sector collaborations and collective impact by choosing to work together. Whether it is working with a local housing authority to ensure that high needs patients have needs met. It really is looking at how those collaborations can occur. Yes, if something is being amplified it involves a collaboration. Obviously, you can't say, my plan is that I know this

guy down the block is doing something that is aligned with what you want. They have to be part of the collaborative. They have to be contributing to it in some sort of meaningful way. Either of those kinds of efforts I think would be acceptable.

**Dr. Boufford** Thank you.

**Dr. Boufford** There were some stories in some of the earlier preliminary trails presented over the last few months of examples of things hospitals were doing. I think the key is, is it in the area on the prevention agenda priority?

**Dr. Boufford** Any other questions?

**Dr. Boufford** Thank you very much for a very rich meeting. You gave us a lot to think about. There's energy in the room for collaborating and working with you all. I really appreciate it. Please tell everybody that we appreciate the time that went forward, and we'll look forward to seeing you in December, if not sooner.

**Dr. Whalen** Sounds good.

**Dr. Boufford** Bye.

**Dr. Whalen** Bye, everybody.

**Dr. Boufford** Bye.