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TRANSCRIPT

Dr. Boufford Let me call this meeting of the Public Health Committee of the State Public Health and Health Planning Council together. I'm Jo Boufford, Chair of the Committee on Public Health. We're delighted. We have a tough and skeleton crew today from the committee, Lindsay Farrell and Dr. Eisenstein. We've got the hardcore. We're delighted to have staff that are visiting with us, and Elizabeth Whalen will be leading the discussion today with Zahra Alaali from the staff. I want to just provide context. This is the meeting that we had delayed from December because of the lag in the timetable for the SHIP, the State Health Improvement Plan development, which we had agreed would be extended into March -ish. We're delighted today to hear about very, very considerable progress that has been made, and then just to remind the committee that we're really talking about, we are going to be following three things in relation to the State Health Improvement Plan. One is the sets of domains and objectives and the progress in defining those and mapping them out between the Health Department and the local departments and hospitals, sort of what I might call the internal elements of the State Health Improvement Plan. The second area we're tracking is the interagency engagement going beyond the Health Department, within and beyond the health department agencies to align them in their work relative to the broader, sort of broader determinants of health that have been identified as key domains for focus, and then the third area we're looking at is community benefits. We're going to be looking at all three of that kind of regularly as our standing agenda, and today we'll get an update on all three of them. All of those items are going to be covered in the presentation. We talked a little bit about dividing it up, but it didn't make a lot of sense then. They're all pretty well connected to each other. We'll encourage, since they're just a small group of committee member any time you have a question, I'm sure Dr. Whalen won't mind interrupting or asking those questions. We'll sort of pause between the three parts of the presentation, even though the dominant area will be in the State Health Improvement Plan objectives and domains. The other thing I'd mentioned is the other standing item for the Public Health Committee is the Public Health Workforce, progress on the Public Health Workforce. We're delighted that Ms. Owens-Cody is here today, and we'll maybe call on her towards the end of this session if you can stay until then. Just to give us a quick update, we were going to do it today, but thought there probably wouldn't be enough time, but we'll certainly feature that next time. Part of what we'll ask her is to bring us her thoughts about one or two areas in which the committee could work with her office and with the department in supporting advancing progress on the Public Health Committee. Without any further ado, let me invite Dr. Whalen and Zahra Alaali to start the presentation. Why don't we ask Keshana to just speak while we're waiting for the media. I mean, this is not formal. I just whispered in her ear about five minutes ago. Maybe just give us a sense of how things are going. Hopefully, we can have another Public Health Committee meeting, you know, certainly before later in the Spring, and have you been the featured presentation, maybe even communicating with the committee before then. Just give us a sense of how things are going, whether there are any concerns about the CDC grant. Anyway, you have to be realistic here, and then similarly kind of where your thoughts are in terms of how we might work with you.

Ms. Owens-Cody The grant, I would say, is progressing. As I mentioned before, we have three pillars of the grant. One is focused on recruitment and retention. The other one is focused on strengthening our foundational capabilities. The third is on data modernization. Data modernization, we did hire a Data Modernization Director. We're really excited. They started last month. We're already starting to plan out some activities and trainings to support our local health departments, but also within the Department of Health as a whole. In foundational capabilities, right now, I would say in the midst of strengthening or executing our contracts that we have for training and development with the School of Public Health or Center for Integrated Health Studies now, as well as Cornell University to continue to offer trainings to local health departments, as well as the Department of Health as a whole. Our Training and Development Director has assessed training and development needs across the entire Office of Public Health. We'll be presenting to HR, our HR, HRI and HRMG, the results and deciding how we want to roll out different trainings across the Office of Public Health, as well as to our local health departments. In terms of recruitment and retention, we did hit our target, I would say, for last year, which was we had 100% of our hiring. We still have more hiring to do, because we did... Being that we had some carryover funding, we did ask throughout the Office of Public Health if there were other positions that we wanted to hire for. We do have some more positions to fill in that space. In terms of the ask, I'm excited about this. Because one of the big things that we talked about, I think, last time is around making public health more visible. That's kind of a running theme within the team is to make public health public. We have dedicated funding in our communications area of the grant so that we can... And we're partnering with Public Affairs Group, who's the one that manages our website, as well as other social media and things like that. That's one of the positions we're actually bringing on because of the carryover is a web developer, someone that's focused on social media, as well as a health media specialist, just to help us with making sure that we're one of the places for people in the public to go to for trusted public health information. We'd love your support in that space of, what is public health? How do we educate the public on what public health is? How do we also continue to build pipelines and career pipelines into public health? That's a big focus, I would say, of the team is working on that and then continuing to strengthen pipelines. We've been out in the community, presenting different careers in public health, raising awareness, working with HR on different places to post positions. How do we attract the emerging public health workforce? That's another area that I can see you all definitely helping. How do we paint the story of what does it mean to be a public health professional? We hope to maximize Public Health Week as well. We did dedicate some funding there to help local health departments as well as the Department of Health as a whole with making it a celebratory around Public Health Week as well. Workforce is one of the days. We are starting to go on APHA's website. They just started putting out information on what the themes are per day. That's going to be another focus of ours that we'd love your support with as

Dr. Boufford Great. That makes a lot of sense.

Dr. Boufford I see Dr. Eisenstein leaning forward.

Dr. Eisenstein Hi. Larry Eisenstein, council member. One recommendation I have having worked at a Health Department now out in the private sector and having taught public health at multiple universities for many years. I've raised this on curriculum discussions regarding public health. I think there is a tremendous disconnection between academic public health and what happens in the real world. I would just encourage. I say this to the schools where I teach at. Having adjunct Professors who are practicing in the outside world is helpful, but it's got to be incorporated into the curriculum that people who are

training in public health get more of an experience than just what's in a textbook because life outside of the university is very different. That's just a recommendation having lived multiple sides of this.

Dr. Boufford I just want to add to Dr. Eisenstein's comment. It was exactly where I was going with this. I'm also at the NYU School of Global Public Health. There are career fairs. I think I actually made sure we had a table for the state health department the last time we did that. We have another one coming up. I think we had tried to mobilize. There is as to my knowledge still no statewide public health dean's group as there is for medicine and nursing and dentistry. I think that is an area we ought to look at. I think Larry is exactly right. One of my frustrations... I'm going to get to my second point here is the issue having been in the practice world is trying to insert practice. The incentives are unfortunately not really there for faculty. The faculty incentives historically have been around research and getting tenure in publications and others. I think it's a real challenge. That would be a great thing for us to talk about. I think the committee is well positioned to be helpful in that sense. The other piece I wanted to mention is I think I mentioned this last time but in my relentless effort to keep talking about visibility is the DrPH degree. I'm very interested. I don't know what the status is. Maybe you could help us look at that of sort of workforce legislation. There have been programs in the state. The last time I looked, I'm not even sure public health was mentioned as eligible for scholarships and fellowships. I know public service was not. Public administration was not. Even though business schools are. I mean, it's bizarre the language. Maybe you could take a look at that and see how we might address that because the irony in this is a national issue being involved with this network of DrPH directors that the DrPH students who mostly are working and going to school part time or full time and they're in public service and don't have high incomes get zero support from the university for their matriculation for the DrPH degree. The most that I've heard of is some of the schools have managed to get a donor that will support part of the tuition costs. Those are our doctoral level practitioners that we're trying to bring in and we're not really supporting them at all. The last thing I'd mention is that just because I have to look at these things. The Association of Schools of Public Health just put out a new set of competencies for the DrPH and the NPH, which are I think even more. This is their dialog with the practitioner world. It literally just came out I think a couple months ago. It would be worth taking a look at that again and seeing how it might give us a window. I think this would be a really exciting link that the committee could be very helpful and the PHHPC for that matter. We look forward to the discussion. We'll work out a date sooner rather than later anyway.

Ms. Farrell It's a time of real disruption, and so perhaps that presents an opportunity for the New York State Department of Health right? If other states and the federal government are indeed shrinking, perhaps there's an opportunity to get some true talent from around the country that might not have access at the federal level for example. It's just something to think about.

Dr. Boufford Let me let me pass it on to Zahra and Dr. Whalen.

Dr. Whalen Good morning, everybody. Thank you so much for being here today, especially on this cold day. We're very happy to discuss the updates for the State Health Improvement Plan. I'm going to turn it over to Zahra to start the conversation and we'll be kind of going back and forth with the presentation.

Ms. Alaali Thank you, Dr. Whalen.

Ms. Alaali I believe you need to put it on the slideshow.

Ms. Alaali I will start with a refresher and background about the prevention agenda.

Ms. Alaali Next slide, please.

Ms. Alaali The prevention agenda it is the New York State Health Improvement Plan, or we call the SHIP. It is a six -year plan that aims to improve overall population health and reduce disparities with a stronger focus on prevention on primary and secondary prevention. In general, the prevention agenda sets priorities for our public health system and provide a list of interventions to address these priorities and think about it as a roadmap for local and state efforts where we set the priorities and provide an action plan to address these priorities. Our local partners also at the local level local health departments and hospitals they have similar plans, and they utilize this prevention agenda model to create their own plans. We will talk about this in later slides. The linkage between the state and local plans enhance collaboration reduce duplication of effort and ensure synergy of resources. At the state level, we have the prevention agenda. At the local level, we have the community health improvement plans by hospitals and local health departments. Both plans are linked. This basically reduce the duplication of effort and create a synergy of resources to address those priorities.

Ms. Alaali In the next slide, you will see some acronyms. I believe everyone has a copy. In case I use any acronym, and I didn't spell it out you have here this slide as a reference. Here also a refresher I know all of you has been part of the planning process for the prevention agenda. We started almost two years ago in March 2023.

Ms. Alaali I'm just concerned people on Zoom they don't have a copy.

Dr. Boufford That's true.

Dr. Boufford Can we post it in the chat so people can open it if they need to?

Ms. Alaali Perfect.

Ms. Alaali The planning effort started two years ago in March 2023 after two years of extensive assessment data analysis and partner engagement we have identified twenty-four priorities for the prevention agenda of 2025-2030. Currently, our team is working on finalizing the action plans for each of those priorities. As for implementation, it will begin on March 1st, 2025, and it will continue through December 2030.

Ms. Alaali Next.

Ms. Alaali This is the prevention agenda for 2025-2030 in a nutshell. At the top, you can see the vision. the vision statement shifts the focus from being the healthiest state as in the previous iteration of the prevention agenda to focus more on achieving health equity. The framework is built on four foundations that focus on health equity prevention across the lifespan and cross sector collaboration and also local collaboration building. The framework has five domains that focus on social determinant of health in alignment with Healthy People 2030. We have twenty-four priorities grouped under each of those domains. The priorities include social determinant of health, such as poverty and employment and opportunities for continued education. Other health factors and outcomes such as maternal and child health, healthy children and others. You can take a look at the

priorities. It listed on black font under this slide. Each of the priorities has a statewide goal and the framework overall has measurable objectives. Half of the objectives focus on general population. The other half are inclusive of population that experience disparities. We have forty-four SMART objectives and forty-six SMARTIE objectives. There is a total of ninety indicators to track progress. There are other general indicators we are including also to help local health departments and hospitals and their assessments. Those general indicators exist in the dashboard of the prevention agenda. They will be carried on the new dashboard as well. We have a list of evidence informed interventions to maximize impact of the state and local action for the prevention agenda evidence informed intervention. We prioritize the evidence-based interventions best practices and innovative practices.

Ms. Alaali I will hand it now to Dr. Whalen to talk a little more about the new action plans.

Dr. Whalen Thank you, Zahra.

Dr. Whalen If you could go to the next slide please.

Dr. Whalen I believe the last time we met; we talked a little bit about the work of the domain work groups. We gathered a tremendous amount of people together from the state, from other state agencies, from the community, from hospitals, from local health departments, community-based organizations and pulled them together under each domain to form work groups. Their purpose was to identify the goals, objectives, indicators and interventions for each of the five domains that reflect the social determinants of health. As I said, these are individuals who are experts in social determinants of health, health equity, health disparities and community member. If you go down and look at this timeline, you'll see that the work groups really started to come together to do their work. In October, a little bit earlier than that, but around October they were oriented. They spent a lot of time discussing as a group priority goals then coming up with interventions and intermediate measures. They worked with our office of science to determine what the data would be used to track each and every one of the indicators. They came up with interventions, intermediate measures, implementation, partners and resources, objectives, outcomes and indicators, targets and priority narratives. All of this came together to create the state health improvement plan. What I thought it would be helpful rather than go through everything is to take a little bit of a deeper dive into one of the domains and talk about how this marches out in the document itself. The first domain as you know is economic stability. I think it's actually important that we're highlighting this domain when we follow up with this group. This was a concern around the new framework of implementation. How are we going to address things that historically haven't been in the domain of public health, but we know utilizing a public health framework could assist in change and growth across the state? Economic stability. As you see, the domain goal is all people in New York have financial security and support needed to thrive. Let's take as an example the priority. You can see the four priorities that are in that first domain are there. We'll look at the priority of poverty and then go and look at the action plan which consists of a priority narrative. Why is poverty important? Priority goals, objectives, indicators, and interventions. As Zahra said, all the proposed interventions that we are working on are evidence based or evidence informed.

Dr. Whalen If you look at the next slide, you see the narrative that was discussed.

Dr. Whalen Each priority is introduced with priority goal and a narrative as to why it is important from particularly from a public health perspective. I'm not going to read this. It is

pretty dense reading for one slide, but it does give an idea of how each of these domains or how each of these priorities are framed within the document itself.

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

Dr. Whalen From there, we go to objectives and indicators. As Zahra talked about, this plan uses SMART and SMARTIE objectives with the SMARTIE objectives focused on inclusivity and equity. This is one example of a SMARTIE objective reduce the percentage of people living in poverty from 13 .6 to 12 .5 percent and reduce the percentage of adults 65 Plus living in poverty from 12 .2 to 11. If you look at how this is presented within the document itself, there is the general statement about the desired result. There is the indicator. There is the data source that will be reviewed to track the progress, the population that this will be focused on, and the baseline and the target. This lays things out pretty in a pretty straightforward manner.

Dr. Whalen If you go to the next slide, you'll see some of the interventions that could be utilized to meet these objectives. Again, interventions were really selected using rigorous criteria, strength of evidence base, alignment with state and national health initiatives, and feasibility. A lot went into determining these. If you look at the key you can see what level these changes can be implemented. There's one for local health departments, one for hospitals, and one for others, which is usually the community -based organizations, other state agencies, and educational institutions. For each of the featured interventions there's evidence rating and there are direct outcomes that can be directly observed and evaluated using the tracking indicator for the priority area. Again, I won't go through all of these, but if you look at the first one, featured intervention is implement a comprehensive measure of poverty for county health needs assessments following the guidance of metrics similar to the ALICE screen, Asset Limited Incomes to Constrained Employed. As everybody knows when you're looking at something through a public health perspective, you start and kind of finish from the data perspective. We really have to look at how our partners are looking at tracking poverty in the areas that they live. Developing those systems is going to be very important to making a change in the outcomes.

Dr. Whalen If you go to the next slide, it's also incredibly important to ensure that we have the correct partners and resources that we're working on. We consider state government agencies that will be working on poverty and many, many other partners. There are implementation resources that are things like Promise Neighborhoods, United Way, and New York State OSC Poverty Trends for Data. I will say that the list of partners and resources is always going to be dynamic because throughout this process we are hopefully going to be soliciting the input of more people that want to get involved in this work and want to work together with their community partners, hospitals, and local health departments in this work to augment the work that they're already doing.

Dr. Whalen The next slide please is all of the work that we're doing across this is of course framed in health equity. The 2025 -2030 prevention agenda prioritize health equity in many ways including addressing the root causes of disparities, defining the SMARTIE objectives, prioritizing evidence informed interventions, and cross sector collaboration, which we'll talk a little bit more when we talk about the interagency task force and leveraged expertise. These are the primary guiding principles of this. That's a little bit of an idea of how the SHIP will look for any given health domain. I think it's going to be a very helpful resources for our partners when we get it out hopefully by the end of March.

Ms. Alaali Next slide, please.

Ms. Alaali The prevention agenda list of priorities, objectives, goals and objectives and intervention can be basically implemented by a wide range of public and private partners at the state and local level. This include but not limited to hospitals and local health departments. We already mentioned that hospitals and local health departments are leaders in the implementation of the prevention agenda and leaders in local community health improvement planning. This also includes state agencies. In the previous prevention agenda cycle we collaborated and worked very closely with different state agencies including Office of Mental Health, OASAS, Department of State among others. We will continue this collaboration also in the next prevention agenda cycle. We are looking toward collaborating with health care providers, health care plans and other organization in the next cycle of their prevention agenda. We will talk a little bit more about this in the next few slides. Again, giving the complexity of the prevention agenda priority areas, cross sector collaboration is always a key. The prevention agenda goals cannot be accomplished without working with other partners.

Ms. Alaali Next slide.

Ms. Alaali Currently, we are working on identifying other organizations that plan to support the prevention agenda, priorities and goals and how would they support it. Our team created an online survey, and the survey will be distributed to the Ad Hoc Committee members, domains working group members who are external to New York State Department of Health, and they participated in creating the action plan, so they are familiar with the work and the priorities and the goals. We are aiming to include them in the implementation. We are planning to send this survey also to the Interagency Task Force. We call it the Social Determinant of Health Interagency Task Force. Dr. Whalen will talk about this interagency and I think it is an exciting news to everyone.

Ms. Alaali Next slide.

Ms. Alaali Here is the main way of implementing the prevention agenda. Again, it is the community health improvement planning. As you know, local health departments and hospitals in New York State are mandated to create community health assessment and submit community health improvement plans. It is called CHIP or the Community Health Improvement Plan at the local health department level and community service plan at the hospital level. Hospitals will continue with conducting these plans and submitting them every three years to meet the federal government requirement for tax exempted hospitals. However, starting this cycle starting March 2025 local health department will switch to six years submission and after receiving feedback from local health departments in the last cycle they basically shared with us that implementation takes time and seeing results takes time and three years planning and implementation is not enough. Starting March 2025, they are switching to a six-year cycle.

Ms. Alaali In the next slide here, you can see the submission timeline for both hospitals and local health departments. The first submission will be in December of 2025. Hospitals are asked to submit both assessment and community service plan by December 2025. However, local health department has more flexibility. We're asked to submit the assessment by December 2025 and their community health improvement plans maximum by June 2026 which is six months after submitting their assessment. Since local health departments also moving through the six -year plans they are required to submit a mid-cycle assessment update to ensure priorities did not change and to ensure collaboration

also continues with the hospitals and this will happen in year fourth of the implementation timeline.

Ms. Alaali I will hand it back to Dr. Whalen to talk about some exciting news about the inter -agency working group and the community benefits.

Dr. Boufford If we could just pause here... Because I think there may be just a couple of questions. I have a couple and maybe our colleagues do until we move into this other part. Like we said, it's all connected but maybe just these are more technical. I want to just to emphasize the decision that was made, and I think it's important because we have an opportunity to keep an eye on how this goes is that we continue to encourage hospitals and local health departments to work together. The cycle is more or less especially because in the past we had hoped there might be an integrated needs assessment that would be done by hospitals and systems with local health departments. I know these are being contracted by others by other hospitals etc. Even though the plans are a little bit off that could be a focus for collaboration. I think we got to about 40 to 45 percent collaboration in the first this most recent cycle of the prevention agenda and equal want to keep our eye on that as these reports come in in December to see whether this sort of continued voluntary effort or encouragement is having increased results because I think it's one of the issues obviously for local health departments is resources and I know in New York City a number of them. I don't want to take any money away from nonprofits, but a number of nonprofits are being contracted by hospitals at a significant financial level to conduct their community health needs assessment. To the degree this might be integrated into a community plan, I think it's something to keep our eye on for the next cycle of the work. The other thing I wanted to raise in this context and I'm sure you all are thinking about this or will think about it even more because this is still a work in progress. One of the issues the feedback we got from the local health departments in the last round of the prevention agenda was the sort of need for greater technical assistance. There are a lot of resources in that bucket. I think there was a between the Department of State and NYSOFA in support of the fact that we were working on healthy aging which we're still working on at the same time as a prevention agenda for largely sort of webinars and not a whole lot of onsite TA. I want to raise that you put some potential sources of that technical assistance and support on the implementation side. You're providing a lot of resources, which is great. The other area they also indicated would be important. We're looking forward for the next nine months is this issue of documentation of collecting data and being able to document. Some of it was just bandwidth having not having people to do that and the other was sort of in the expertise area. I want to raise those as things we'll want to look at going forward but also at one point there had been I think conversations. I didn't see them on your implementation resources with the regional offices the regional departments regional offices. I wondered if that's still in play or if that's still a possibility or how they might have fit in. I know it was in passing and wasn't necessarily related to this but the idea that your regional offices might provide might be a basis for some technical support and or assistance in some of an implementation on this thing.

Dr. Whalen Certainly, our regional offices are going to be aware and part of this process. They know well the work that the local health departments in their regions do. We also have the Office of Local Health Services. We do look forward to being able through the Public Health Infrastructure grant to provide some technical expertise to the local health departments that we had not previously been able to do.

Dr. Boufford That's really helpful, important going forward.

Dr. Whalen Any other questions?

Dr. Boufford They're happy. We'll move on then.

Dr. Whalen Great.

Dr. Whalen Thank you.

Dr. Whalen I'm going to talk a little bit about the Social Determinants of Health Interagency Work Group. We thought with this iteration of the prevention agenda given the fact that we are focusing on the broad range of the social determinants of health that really establishment of a separate and more kind of leadership focused work group would be very helpful for us to look at things on the macro level and make sure that we're working with our partners that are working on some of these agenda items already. To this purpose the Social Determinants of Health Interagency Work Group has been established to lead collaboration efforts at the state level. The purpose of this group is to promote a culture of health equity and integrate health and equity into organizational practices and facilitate collaboration to identify shared goals and opportunities to enhance performance.

Dr. Whalen If you go to the next slide, we'll talk about the who. There is already established the New York State Association of how New York State DOH's inter agency task force on health equity and diversity equity inclusion. This group is going to be serving as the base for the Prevention Agenda Implementation Planning Group. They consist of experts in social determinants of health, health equity, health disparities, economics and vulnerable populations. We're really looking at a high-level discussion and what is going on in other parts of the state and through other agencies that could assist and raise and provide collaboration for the work that we're doing through the prevention agenda. We had an initial meeting with this group which was pretty much going over what prevention agenda is, what the state health improvement plan will look like, how we are focusing on the social determinants of health, a presentation we've given to this group a number of times. The next meeting we're going to really start to delve into particular domain workgroups. I'll talk a little bit about that.

Dr. Whalen Next slide lists the task force members. These are a list of some of the organizations that are represented in this task force. This is an extensive list, but it is not exhaustive. Again, when we start to focus on particular domains of the SHIP, we want to ensure that we have the appropriate partners. Our idea was to really start to focus on particular domains and bring in high level leadership across the state and those that are working in the community through hospitals et cetera to discuss these particular domains and link kind of the work that's already being done with the work that we want to implement through the prevention agenda.

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

Dr. Whalen This group will be asked to establish sub workgroups as needed. These will be for the domains. We will be incorporating staff from the New York State Department of Health, state agency members, local health departments and hospitals, community members, including individuals with expertise and lived experience related to groups facing high illness and death rates and those knowledgeable about equity within public health and healthcare. What we want to do is bring this workgroup together and try to in the first couple of years develop a compendium of activities and funding across the state. While our workgroups for the SHIP came up with a list of evidence -based resources,

potential ways to affect changes in our goals, this group is going to identify what's already going on that we can plug into with maybe agencies that are not the state health department and how can we build those partnerships so that we can build momentum with these broad efforts.

Dr. Whalen Next slide, please.

Dr. Whalen For each domain the agenda members will develop recommendations and strategies to reduce health inequities, enhance collaboration resource allocation, improve data collection and analysis track progress and strengthen partnership and engagement. We want this group to inform the work that is being done locally with local health departments and hospitals. We want there to be kind of cross sector communication so that as implementation starts to roll out we can share promising practices that are occurring across the state. People will find a way to create additional resources around the goals that they have, create iterative experiences, and again utilize the strategy of collective impact so that they can come together to do this.

Dr. Whalen That's the last slide before community benefit spending. I thought you might want me to pause to see if there are questions on the inter-agency task force.

Dr. Boufford A lot of work going into this.

Dr. Eisenstein Thank you.

Dr. Eisenstein Thank you, Dr. Whalen.

Dr. Eisenstein You and I have been colleagues in local public health. You addressed a lot of the questions that were coming to mind. I would think a question, you would answer it. Just raising it as a concern to think about going forward. We've seen this in public health before where the initiatives are addressed at a level that's way too high and not boots on the ground. You did say this is not a comprehensive list, but having worked in local public health and now at a hospital doing the lead on the social determinants of health, health equity work very few of these agencies know exactly what the day-to-day work is and difficulties are. Philosophically, we all can talk about poverty is one of the main drivers. Everybody gets that. The actual work that's happening having many of these agencies talk about how to fix it as a collaboration might be helpful. But without that I'm not so sure. What's disturbing to me a little bit is that you start the presentation by showing that the main responsibility is on local health departments and hospitals. That's where the legal responsibility is for a Community Health Needs Assessment yet they're just a little dot on the second page of many big agencies. My concern is that the groups who are the boots on the ground responsible for this are not necessarily represented here in a way where their needs can be heard. I just want to make sure that the people who are trying to get this done at hospitals and at health departments aren't washed away by Commissioners and other leaders of these other agencies which are all vital agencies but might really not be in touch with the day-to-day problems. I could tell you having been a Commissioner of Health; it was very easy to say well these hospitals should be doing this and that. I'm at the hospital and I see why it wasn't so easy to do it. It's not. Simple things like collecting data which was from the first section. Collecting data is hard work.

Dr. Whalen Absolutely.

Dr. Eisenstein Especially, in a hospital where people literally come in dying it's not the priority. We have to try and find a way to change the culture that those things that are hard work are not just brushed aside but they're funded and resourced and the value of them is prioritized. I have no issue. You did a lot of work getting to this. I think this is great so far. I just want to make sure that LHDs and hospitals obviously that's what I know so that's why I'm supporting that are not just as we've seen in numerous initiatives before not just the kind of sub bullet, and they get pontificated to by people who really don't know what's happening on the ground. That's my only concern with the way this was laid out. I want to be fully supportive.

Dr. Whalen I appreciate that, Dr. Eisenstein. I think you know that local health departments have a very special and large corner of my heart. We know that what we want to do with this task force is help the work that they're doing. They're going to be intimately involved, but the thought is to link them. What we're always talking about is breaking down silos and utilizing a public health approach to these large-scale problems is doing what local health departments do best which is really building partnerships with the communities that they serve and making a difference. We know different state agencies even with their local partners don't always connect the dots. What I'm hoping to do with this group is to really start to come up with a hey did you realize that maybe your DSS does A, B and C. These are all county agencies so they're very important to the local health departments. How can they be aware of programs and services that they could partner on within their own counties to do this work? I think that that is helpful for the local health departments. Certainly, we want to hear from them in terms of what would be helpful. Coming up with a compendium like this... You know, on the one hand we give them the SHIP, which says here are all your evidence-based resources. Here's the twenty, thirty, forty things you could choose to do based on your evidence-based resources. The next piece through the Interagency Task Force is... Well, what do we have locally that we could kind of bring together to support this work? How can we connect those dots? It's a different level. Though it sounds like when I'm talking about leadership it might be at not a boot on the ground level. The idea is to be able to make these connections so that the boots on the ground can say this is the importance of the collaboration that we didn't even know was in our own backyard.

Dr. Boufford Ms. Farrell

Ms. Farrell I have a question.

Ms. Farrell I've been to so many of the local meetings. It's fun. You see all your friends. We do this couple of years. The folks that are typically missing are the plans. I'm thinking about the Department of Financial Services as well as DOH and the Medicaid providers. Those are the guys with the deep pockets. I'm wondering how we might be able to align them. Obviously, you need to aggregate the health care delivery system. Typically, it's hospitals. I think the piece that's missing right as care is moving out of the hospital and it's moving out in a significant and substantial way. It's the payers that are directly involved in the delivery system and the aggregation of health care resources and Lord knows they're... The last thing they want to do is be paying expensive hospital claims. Is there a way to better align the plans through... I'm not talking just Medicaid. I think Department of Financial Services plays a significant role and obviously as Medicare Advantage becomes sort of the more normal approach to Medicare in the country it would be the DFS who's licensing all of those plans. I would imagine you would have some leverage there. Is there a way to sort of better align them and all of this?

Dr. Whalen These are great questions. They're certainly things that we're interested in exploring. I've started to explore to a large degree. We have had a lot of interest from HANYS. They're very willing partners and have asked us to come and speak to their association about the prevention agenda. I previously worked a short amount of time about three years in managed care. I saw firsthand the amount of public health that is going on through many of our better managed care organizations. I think there is a strong volition. As you point out, there should be a return on investment which is a strong motivator for this work from their perspective. There is a tremendous alignment between public health and the quintuple aim of health care. I think that that is something we're very interested in continuing to explore. We also... You know, from the state perspective have had ongoing conversations with our Medicare/Medicaid team as the new waiver is rolling out we know that it's very... They have an important focus on the social determinants of health. It makes sense for us to do this work together. We are continuing to have those conversations. I agree with you that this is an avenue when we are looking at something that is historically an unfunded mandate. We want to look to where the resources are and where it makes the most sense from a mission and a pocketbook perspective. The agencies that you referenced; we will be doing outreach.

Ms. Farrell New York is a not -for -profit health care state. We have not -for -profit plans. We also have for -profit plans. There's tension between obviously both sectors. Not -for -profits tend to be more regional and much more connected kind of at the local level. There might be an opportunity using your not -for -profit plans in the state to really align the work. I truly believe our interests are aligned

Dr. Whalen I agree.

Ms. Farrell They want to manage that spend and they want to work upstream to be able to do that. My recommendation would be to somehow work through. I don't know whether it's the state attorney general, whether it's Department of Financial Services. Obviously, you have all the Medicaid plans at your disposal through the Department of Health, but I think it would be important to go beyond that

Dr. Whalen Thank you.

Dr. Boufford One of the elements that can bring this in, and we have this meeting next Monday of the Ad Hoc Committee. Historically, actually the New York State Association of Health Plans had been a member of the Ad Hoc Committee. I think you're absolutely right. The payers have been a missing link because it's such a provider driven state in terms of health policy. It's a real opportunity. I know the membership of the Ad Hoc Committee has been revised and revisited. We've had good showings at the previous meetings. Hopefully, whether or not we're standing we'll have another good one here. We can be online. Everybody can be online for that as well. I think that issue of these... Part of the Ad Hoc Committee structure, and I say this because Liza's more lately arrived in this role, but part of the Ad Hoc Committee idea is to invite in state level associations, professional associations, advocacy groups, membership groups into the conversation on the prevention agenda. I think that's where we'll want to see who comes and who is missing from the Ad Hoc Committee as well since it's a structure that's already kind of set up. It's been working the last year or two hearing about this reinvention of the prevention agenda. It's a really good opportunity.

Ms. Farrell I just want to note there's a transaction that's happening with respect to a local not -for -profit plan and typically when there's a transaction of plans there's significant

resources that are available. Could those resources be made available in support of our prevention agenda, or will they just fill some other hole in the state's budget? It's a health plan and those dollars should support the state's health care agenda, which is to assure healthier New Yorkers. It would be important to kind of get an eye into that. I'm assuming that's at the level of the state attorney general. I suspect they're completely disconnected.

Dr. Whalen Thank you.

Dr. Boufford A couple of other agencies again that have been active historically in the Ad Hoc Committee is AG and Markets, which has been really. They're not on this list. I think our veterans and being working with us in the department of state which has money. They run the sort of empowerment zones in the sort of city. I keep using that term. I know it's dated. The different initiatives. They have budgetary initiatives for economic development as well as the environmental justice activity. They've been very loyal members of the Ad Hoc Committee and been coming. I think one of the issues would be whether some of those other agencies through that could be linked up into these processes. I want to speak to your point, Larry. It says in the document here one of the goals of the inter-agency group is trying to align the work of other agencies with the prevention agenda work and similarly as Liza mentioned. We've seen this in previous iterations mostly with mental health and OASAS and Aging. Through pass through from the federal government they have local offices, the area offices on aging. Mental health has a local infrastructure. Try to connect those dots. Those people move on, and they lose their connection. I think one of the really interesting questions to think about and maybe in the survey or in some of your earlier meetings identify which of these agencies have local infrastructure. They won't all have it. I mean, it's kind of interesting to think about that. Which ones have local infrastructure that could be the highest candidates to partner with local health departments in some local problem-solving priority setting? We know those other agencies have had that. I think in some counties it's been really successful. When you were in Albany it was. I think other counties have had a lot of success and were connecting the dots. Some of the rural counties actually have pulled together as multiples to work together as local health departments and to bring these other folks it. That alignment. I love the way you said that which is to sort of say what are they doing now that's aligned? It isn't like saying you must do what we in public health think you must do. What are you doing already that could add value to the prevention agenda especially in this broader social determinant space like issues like housing and job creation and education and other areas? It's a longer-term agenda for sure, but it's a really, I think a really good start and ambitious start. I also want to mention I see the executive chamber as number 19 there. How do you keep people coming to the meetings, events convening events? I like seeing the executive chamber on any list of interagency engagement. Congratulations for that. I think that's great

Ms. Alaali I just want to mention that the survey has a question asking the external agencies what kind of support they could provide to advance the prevention agenda. Is it through funds, program support among others. We are actually asking the agencies to give more details about what kind of support instead of saying there is only just an alignment between the prevention agenda priorities and the work and the initiatives we are implementing. This is one. For the list of the members, we will definitely expand the membership. We are planning to ask the Ad Hoc members. We have a presentation from NYSACHO. You don't see NYSACHO here in this list. We are definitely planning to extend the membership to include more representation for local health departments, hospitals among others.

Dr. Boufford I think that's great. I think the trick in getting other agencies is part of it, some of its interpretation. Having shown up at the doorstep of other agencies talking about a health initiative and their first question is why are you here you're a doctor? Why are you here you're a health department person? I'll just give you one anecdotal story with the Department of Parks. When I was at the New York Academy we went to talk with them about physical activity and food in the parks. She had all the physical activity. She got it. Just spoke about it right away. We have bike lanes. We're doing this. We're creating this. She said, "I have no control over the vendors in the parks. It's part of another state agency responsibility." She knew exactly where the problem was. Part of the beauty of this kind of things is sort of identifying those opportunities and if the people maybe. I think it was the Department of State at the time was managing those contracts. Do you know that if you began to focus on healthy foods or AG development upstate, you know New York bringing healthy foods to the table is complicated. Do you have any way to support this? You may want to be more explicit. Do you have local infrastructure at the county level? I mean, you want to know that at some point. You might want to add that question specifically and then have them kind of look at what they're already doing. That's always the trick. Having been in government a couple level city and federal, the first question when you get that answer is you want my money. The answer is.... No, we don't want their money. We just want them to spend their money in a way that makes the healthy choice rather than the alternate if they can. They may not always be able to do that. It's complicated but exciting.

Dr. Eisenstein Quickly to follow up, and in full agreement. It's coincidental that Dr. Whalen and I both have experience working in local health departments, but this meeting could easily have happened without anybody at the table who's worked in local health.

Dr. Eisenstein That's the point I'm going to make.

Dr. Eisenstein There are fifty-eight directors and commissioners. It's not only that. It's every hospital and hospital system now has invested in people to work on social determinants of health because we've had to under the requirements. None of them are here except coincidental that's my role at my health system. The point that I'm making is I don't... I think that if they're going to be a partner they have to be at the table. I don't know that they understand the significance of a meeting like this. They're not here. I'm not pointing fingers. I'm defending them and supporting them. What I'm suggesting is maybe we both as a Planning Council and for this initiative need to make sure they're at the table with us. We went through the frustrations together, Dr. Whalen of the first where we were the experts in public health in the room and we were not invited to the table. Now, not only are we inviting them to the table... We need them here if this is going to be successful. I think the approach on bringing the partners in beyond that list of senior leadership tying back to my point before is to say to them look this directly impacts you. If you want to have a voice we need you at the meetings. This is when they are. Today certainly wasn't a long enough meeting to have long public conversation, but I just want to make sure that the people who are going to be the key players in this have a voice at the table.

Dr. Boufford We might want to add to the slide set because you have the structure working with you as part of the PHHPC is the Ad Hoc Committee. It's not here, and I think it might be good. It speaks to your concern, Dr. Eisenstein, which is the HANYS and Greater New York Committee are they are both members of the Ad Hoc Committee. They are very involved, as you can see, when they leap up out of their chair when we talk about the next topic. Anyway, I think it might be good to add a slide on the Ad Hoc Committee. As you decided to use the interagency structure that was set up previously, which is

always smart because you don't have to start something brand new, and then you have the Ad Hoc Committee and want to keep an eye on it. We have the same conversation on Monday as who's missing from this conversation, who needs to be part of this so that they're definitely involved. Anyway, so that's a really good discussion.

Ms. Farrell Is the Department of Education involved?

Ms. Alaali The Department of Education originally were not involved in the Ad Hoc Committee. However, we were able to have a contact in the domains action plan members, and they have been participating in creating the action plan. We are planning to extend the membership to them also in the Interagency Working Group.

Dr. Boufford They're listed here.

Ms. Farrell I mean, they're such sort of big players in the local community and also have responsibility for licensure of health professionals, right? I think they too would be really important. Who's got the resources in health care? It's the plans.

Ms. Alaali I agree. I'm calling this interagency as mapping initiative at this point. We are really trying to map who should be involved in the effort of the prevention agenda and extend the membership to them first. Mapping also what kind of activities and initiatives they are working on that is aligned with the prevention agenda. This will happen in the first two years of the implementation of the prevention agenda. And then after two years, we will start the implementation effort and aligning the initiatives.

Dr. Boufford One of the things that we didn't do and talked about, and you have the opportunity, I think, with the Interagency Group. I believe having been in government; I would be very surprised if every agency didn't have to report to the Governor on annual basis what programs are in which counties in the State of New York. One of the things we found... I mean, in terms of an annual report that wouldn't make them do it. Part of this mapping effort is they probably are doing it anyway. I think the county level programming, one of these things was really interesting. The last cycle of the Ad Hoc Committee was we had people talking about obesity was one of the issues and cardiovascular disease prevention was one of the issue areas, which it shows up again, obviously, because it's so pervasive. A lot of the local health departments did not know that AG and Markets had green markets in their county. They weren't aware of it. AG and Market people came in and said, look, these are all these little dots. We have a great map where we just put the AG and Market programs in the same counties. The local health directors could connect with them to get healthy foods and fresh fruits and vegetables brought in. I think this county level mapping of what the departments are doing anyway and then deciding using that as a basis. I just can't believe it's not happening already. You could decide what's related. I mean, unfortunately, in health, everything's related. You could figure out what their priorities are. It might be a question to ask them is the last time they submitted perhaps a report to the Governor on county level programming.

Ms. Farrell I'm just thinking of all the meetings that I've been to through the years, they're fun, but it's always the same old group. Perhaps the role of the State Department of Health would be to encourage local health departments to reach out a bit more broadly. Like the schools should be there. The schools should be there. They employ. They're the largest employers in small communities. The hospitals are obviously going to be there. You can have such impact when you're working with young families and the schools are sort of the

community focal point. The farmers markets, of course. They should be there. They're not typically the people that show up at these meetings when we're thinking of our priorities.

Dr. Whalen I really want to say how much I appreciate all the thoughts on this. I think that there is excitement behind. There are a lot of ways that we can inform our work with your suggestions. I want to apologize before I said HANYS when I think I was talking about the New York Health Plans Association. HANYS, of course, and Greater New York are wonderful partners as well. I was talking about the Health Plan Association.

Dr. Boufford They're on the Ad Hoc Committee.

Dr. Whalen Yep.

Dr. Whalen All of these suggestions, I think we will bring back, renew our discussion and focus with. It is still early days. We're just getting started. They're going to be quarterly meetings. We can determine subgroups from those to kind of get this broader focus. Having this ability to draw this network of where things are already being done in counties where they could be augmented or amplified, I think is a really important and key focus of the prevention agenda and the work of the prevention agenda.

Dr. Boufford Speaking of money.

Dr. Whalen Speaking of money, let's go to the next slide.

Dr. Whalen I think most of you are aware, and it's been discussed previously. I know it's a favorite topic of discussion for Dr. Boufford, the community benefit, which nonprofit hospitals in New York State are required to report for their tax-exempt status. There is a new proposal in the fiscal year executive budget, which includes a community benefit spending proposal as an amendment to Article 7 legislation. It really is at this stage a reporting requirement that specifically asks about coordination with the local health departments and aligning community benefit spending with the prevention agenda and how such community benefit expenses support the priorities of New York State as outlined in guidance, including but not limited to the New York State Prevention Agenda as developed by the department. It specifically calls attention to the prevention agenda. I think that that's important. It is kind of the first step in the accountability that will enable us at the department to be able to get a little bit more information on how this money is being spent.

Dr. Whalen If you go to the next slide, you'll see that this is an executive proposal. It's not a done deal yet. It requires approval from both houses, but it has the potential for a lot of public health impact, including eliminating social determinants disparity related to the social determinants of health, improving health equity, preventing certain diseases and promoting wellbeing. This is funding that we believe could be instrumental in supporting the work or the prevention agenda that many hospitals are already doing. It will give us at the state an opportunity to really see more about the collaborations that are occurring that could be highlighted throughout the state for other counties that may be not utilizing funding to the same extent. I can provide a link in the chat, but Dr. Boufford was interested in the language of the amendment. I'm just going to kind of pass around print copies of that if anybody wants to get a little bit more in detail on that community benefit legislation proposed letters.

Dr. Boufford A couple of comments, I think just contextually for members of the council and others, the as Dr. Whalen said, community benefit really emerged more from the sort

of... I hesitate to say Obamacare, but this Affordability Act national and the reporting requirements, which are really what have been discussed. They're sort of the foundation of the Prevention Agenda. Unlike surprisingly for a state that's as highly regulated as New York State, we don't do much in regulating community benefit or requiring certain kinds of... Recapturing shall we say, funds from community benefit. Other states do that. We've looked at some state comparisons like Massachusetts, Rhode Island and Maryland and others. I want everybody to be sure that this kind of voluntary reporting is a very important step, but it's a very early step. It's been something that we... Part of what we'll see. I think we've talked about it again in the next cycle of the Prevention Agenda is during this next couple of years is how much collaboration we're seeing between hospitals and health systems and local health departments and their partners on the ground and investing a community benefit level. Just to indicate that the community benefit tracking has been done. It is done at the national level and has been supported by Edward Johnson to set up a system at GW. We're very fortunate that one of the former Department of Health employees here who's getting his PhD at the University School of Public Health in Albany is doing this for his Doctoral Thesis. We actually have every category of community benefit. There's sort of eleven. I think it's eleven areas that are required on so-called schedule H to IRS where hospitals tell IRS what they're doing in the community benefit area. We know what every hospital is doing in every category. I think going back at least five to seven years. The data is available. The other thing I want to mention, and I know being now at a hospital Dr. Eisenstein is going to be asked to look at this. We're not talking about unreimbursed care. The community benefit is there. We're not talking about graduate medical education. We're not talking about any of these other things. We're talking about two categories community health improvement and community building. There are very explicit categories for the schedule age. The definition is almost exactly the definition of what we're asking hospitals and health systems to do in the Prevention Agenda. In 2019, which is the last data I have looked at in the community health improvement category, hospitals were indicating an expenditure of about two hundred million dollars a year. I mean, the other is like a trillion if you count everything else in New York State. This is not trivial money. It's not to say hospitals aren't spending it. This was never the issue that they're spending it in their communities. Some of them are not evidence-based intervention. Some of them would have much more power if they were aligned with other partners in the community. What we're hoping to see with the Prevention Agenda is more conscious awareness of how this funding is being spent aligning with community health needs.

Ms. Farrell Sometimes it feels like the large institutions, hospitals, for example, are sort of supplanting existing activities in the community. It's like the last thing you want to do as a primary care provider, as a federally qualified health center is competed with your much better resourced hospital. Just to sort of make the community better understand how it works sometimes. You know, rather than having a hospital set up its own farmers market on Wednesday wouldn't it make sense to have that institution partnering with the existing right programs that aren't particularly well resourced? It would be helpful if the more collaborative approach was the one that was taken. The last thing we want is unnecessary duplication, unnecessary administrative expense. In many communities there are a lot of stuff that's happening that doesn't necessarily get recorded on that schedule.

Dr. Eisenstein That's what I was going to talk about, if I may have perfect segue. One of the things that's been biggest eye opener for me, having now spent a little more than two years at a hospital system, coming from the public health side is the complete misunderstanding of what community benefit means. I don't mean among hospital leaders

who practice this. I mean, just in general, people don't know, Dr. Boufford, that the charity care that hospitals provide is not part of this.

Dr. Boufford It is part of it.

Dr. Eisenstein I know.

Dr. Boufford It's not what we're talking about.

Dr. Eisenstein That's my point. There's very strict regulations and rules as to what does count and what doesn't count. If something is done during work hours versus not work hours, the same event might count, or it might not count. I support strongly what we're doing here. I think in order for it to be successful, there has to be an education that comes with it so that people understand what we mean by community benefit. Not just the definition in a room of executives, but on a day-to-day operations, what is community benefit and how to track it, because it's more difficult than you think. I would love if there's a system that somebody's developing to make tracking this a lot more easily. I see everyday community benefit that is just missed, that doesn't get reported, that happens because the people doing it didn't know or the reporting somehow fell through. I'm not talking about my system in general. This was an eye-opener for me and I think a great area of opportunity. I agree with collaborating with partners in the community, and that's what I'm hoping to totally change the topic here. That's what I'm hoping comes out of the Medicaid waiver. It behooves hospitals to not have to do what was just described, to not have to be the one to set up this, that, and the other. In order for that to happen, though, the agency that we're partnering with, we have to have confidence in. There's got to be strong community-based agencies and organizations to partner with. I'm hopeful that all of these initiatives and the Medicaid waiver, for example, work to strengthen that partnership where hospitals have a strong community-based partner team to rely on. It doesn't help if a patient's sitting in a hospital because there's no safe place for them to leave to. That costs everybody. Much better if there's housing and social services that are available for the handoff. I think we have great opportunity here. Just the term community benefit, there's so much that can be done. I'm excited that it's a key thing. Just like I said before, collecting data is hard work so is this. You know that. That's just something we've got to make sure that, again, that we're just not preaching to ourselves the same ten people sitting around the table. Thank you for that.

Dr. Boufford Thank you.

Dr. Boufford I would say that this conversation has been going on in the context of Prevention Agenda for about the last seven years. We're not springing anything on anybody. I always have to say that because I think it's just really important because it is complicated. We don't want to be naive about the fact that changes need to be made, and information needs to be provided that has not been organized quite in that way. I think the timing is great. All the pieces that have been set up here look like it really gives us that opportunity.

Dr. Boufford Do you want to do monitoring evaluation?

Dr. Whalen Yep, I'm going to turn it over to Zahra for those comments.

Ms. Alaali Thank you.

Ms. Alaali Moving to monitoring and evaluation of the Prevention Agenda. The Prevention Agenda Dashboard, if you are not familiar with it, it is an interactive platform that provide an overview of the progress of the Prevention Agenda objectives. It will be updated with the new indicators and the 2030 targets. The dashboard basically provides overview of the most recent data, trends and provide nice visualization of all the indicators. All the data will be updated with the new priority areas, domains and indicators. It will take time to get the data, access to the data and then coding them. Hopefully, we will see the breadth of the Prevention Agenda Dashboard end of Summer/beginning of Fall. We have the county dashboard, which provides data at the county level and sub county level to provide maps, graphs and comparison across counties. For monitoring local level progress, the Prevention Agenda team will also continue to review and evaluate the submitted community health assessment, community health improvement plans and community service plans from LHDs and hospitals. Our team basically review each of the plans and identify where and this is something back to your point, Dr. Boufford. We review those plans, and we identify which hospital and local health departments collaborated together in the assessment and in the implementation, who submitted one joint plan and who submitted a solo plan. We also look at the selected priorities and the selected interventions. We evaluate if the selected interventions are evidence-based practice or promising practice. Another thing is the next iteration of the Prevention Agenda will continue also with requiring annual reports from local health departments and hospitals and their implementation. They normally provide updates on the implementations of the interventions and the progress they have made toward those interventions. This is regarding the local level planning. We also encourage hospitals and local health departments to extend monitoring and evaluation activities as feasible at their counties.

Ms. Alaali Next slide.

Ms. Alaali Before we open the floor for questions, I just want to take a moment to express my gratitude for all the support we got from the committee members here and from the Ad Hoc members as well and the domain working groups and our colleagues from the New York State Department of Health, the Prevention Agenda team and the Office of Science and Technology. This work wouldn't be done. We wouldn't see the Prevention Agenda new cycle without the support of everyone. Thank you, everyone, for your support.

Dr. Boufford Thank you very much for your leadership, Dr. Whalen and Zahra. This has been an interesting year or two, but I think the resolution is great. We're excited about it. It is more of the long haul. If we can really succeed in pulling these pieces together in the way the committee's been talking about, we'll have pretty dramatic results, I hope. I'm sure it can. I think the degree to which the Governor's Office has been interested and involved in is really important relative to keeping interagency work going as a priority area. We've been having our discussion along the way.

Dr. Boufford Any final, any other comments from either of our committee members?

Ms. Farrell Again, I'm worried about the future, given everything that's happening with the inauguration of President Trump. I suspect that economic disparities will grow. There are concerns about Medicaid cuts on the order of magnitude of up to \$900 billion in the United States. I suspect that New York State will be impacted rather negatively as a result. To the extent that the department has the ability, if indeed resources are shrinking across the state to assist local health departments, local institutions in prioritizing in a smart way, I think that will be really important as we attempt to navigate the coming years.

Dr. Whalen Thank you for that.

Dr. Whalen I agree wholeheartedly with that. And of course, we are all very carefully monitoring what's happening in the federal government. One little spark of hope that I see is that there seems to be a level, a potential level playing field when we talk about chronic diseases. When we talk about how the social determinants impact chronic diseases, you can't not put that in the equation. I mean, there's just simply no body of literature that says it doesn't matter if you come from poverty or if you come from wealth that it doesn't matter. Your health outcomes aren't affected. That's just not in the literature. If we're looking at this, I try to look at it from the hat of managed care again from a fiscal perspective. We're talking about putting money into prevention so that we can save those downstream costs. The mission doesn't change, the language might. The language really has to be about how we are focusing on the quintuple aim of health care, how we want to improve the quality of a patient care experience within a hospital system, within a local system and decrease costs. I think that that piece where public health generally hasn't really messaged so much about, hey, we've got to decrease health care costs. It's what we want. It is what the goal of any preventive effort should be in part. Of course, we want to improve health. We want to improve health. I think that the mission to improve health now has to be very carefully balanced with how that is going to impact other systems at play that we want to really try to work on reforming.

Dr. Eisenstein It's funny you say that, Liza, because I was going to make my final comment almost identical in the sense that, you know, we're going to be and we're... We really always are in an industry that is just like others in one sense. Show me the money at the end of the day. We can always talk about the success of the WIC program. It's always had tremendous bipartisan support because, in my opinion, the data shows that for every dollar we invest, we save two, three, four dollars depending on the study you look at. Every one of them shows that investing this money saves us all taxpayer money. We in public health have always believed that preventing somebody from becoming diabetic or stopping them from smoking saves the system millions and millions downstream for us to be successful. This goes back to the comment on collecting data. I think we need to show that more. I think that resources, research, maybe Dr. Boufford coming to public health academia research that shows that addressing social determinants of health and putting a monetary value on this. It's very easy to understand how a hospital system or an insurance system or even a community-based organization if they hire somebody that does a procedure, and they get paid X amount of dollars is a very quick and easy return on investment to show to the board. We have to show to the boards all of them. By that I'm not only talking about Board of Directors. I'm talking about the leaders of all the agencies on that slide and our political leaders, our elected officials that this work is not only the right thing to do. Feeding the hungry is the right thing to do, but it actually impacts health outcomes to the tune of X numbers. I just hope going forward that we use the numbers and the data as our protective weaponry to say, look, this is not just a nice thing. There's a financial reason to do it, even if you don't buy into the social reasons to do it. It costs us money to not do it. I think when we do that, we stand. It's unfortunate it comes to that, but I think that's to a large degree what it takes to stand in a stronger position. I would advocate any kind of funding for showing that or partnering with universities to do the research to show that that research takes time. We don't have a lot of time, but that's just what I would advocate for as well as part of all of this, even on things like community benefit. You know, understanding the money involved in it more than just a term.

Dr. Whalen Agree.

Dr. Eisenstein Thank you.

Dr. Whalen With that, it's important to look at intermediate metrics and long-term metrics. Because if you're talking about prevention, if you're talking about taking a child and putting them in an education system that is going to promote their health and an environment, you might not get the return on investment for that for years. If you're talking about potentially hiring community health workers that are going to ensure people get their screenings, you can demonstrate something that happens out of that relatively quickly. Again, I think the role of the plans is important here to kind of get that data on return on investment for shorter term programs and then to look at it with a long eye as well.

Dr. Boufford The thing I wanted to add just again as a sort of concluding remark, I don't see any members of the public. I will formally invite them to speak.

Dr. Boufford I see none.

Dr. Boufford Seeing none, we'll declare that part of the conversation over.

Dr. Boufford I did want to say that I think in addition to the things we've been talking about, especially bringing the other agencies in is really the opportunity to change the environments, the health conditions in communities that make people sick in the first place. We don't want to forget that. I mean, the cost of care issue is a proximal and in this state it's crucial. I think the emphasis on it is totally appropriate. One example where the cost to the provider system showed that it was valuable to do this. There are other examples like this. The New York Academy of Medicine worked collaboratively with Little Sisters of the Assumption in East Harlem, which had a very good program of basically coming in. I don't want to say decontaminating. That wasn't the point. Going into housing units and identifying risks for asthmatics looking at the mold, looking at insects. There's an official term for it. Those of you that are closer to the technical world will think of it before I finish talking. Money was provided by the Federal Housing and Urban Development to fund the nonprofit to do this work in three units of housing. Working with Mount Sinai it showed reduction in Emergency Room visits and reductions in hospitalizations among asthmatics. It was cheaper for the hospital to invest in that kind of intervention than to hire patient navigators for asthmatics. It's a booth and question. I think what part of the challenge for us in the Prevention Agenda is keeping both of these areas very much to the fore. I mean, part of what we're talking about with these other agencies is changing community conditions, which is fundamental to really dealing with broader social determinants in addition to the social services that are needed for individually sort of patients that are at high risk.

Ms. Farrell I'm so glad you mentioned that example, because the term that I haven't heard and maybe it's overplayed is using innovation, right? Innovation, most people think, oh, using technology. It's not necessarily technology. It's just thinking about an easier way to get something done more quickly, for example. I would hope again that we would be looking to innovative approaches to accomplishing what we need to accomplish. I think the resilience of the sector is going to be really important with all of these headwinds that we expect to be experiencing. Leadership and encouraging innovation. It's probably not going to be the same old, same old. We're all going to have to be in great fighting shape so that we can feel great about what we are able to accomplish going forward.

Dr. Boufford Absolutely.

Dr. Boufford Curtseying resources from other sectors outside health to promote health, which is really part of the design here.

Dr. Whalen One of the ways that we want to use the Interagency Task Force, once we kind of have the work groups established, once we get that infrastructure supported is we really want to use it as feedback loop. If we start hearing about innovations or cool things or collaborations that are occurring across the state, we really want to highlight that so that people hear about that and get inspired and think, how could something like this happen in my community? Sharing that with this group and the Ad Hoc Group, I think, is going to be important as we start to get into implementation not necessarily this year, but maybe next year and going forward.

Dr. Boufford Great.

Dr. Boufford Next steps, Monday, we have the Ad Hoc Committee, 10:15am to 1:15pm, I think. It's a three-hour meeting. Some of that will be the agenda that we always want the Public Health Committee to have the agenda first and get comments and feedback so the modification can take place. It's based in Albany, although everybody is able to, because it's not an official decision-making body of the council, you can join in by Zoom, if you wish. I'll see how many of our Ad Hoc members are coming from Albany. I'll schlep up here just because I feel like we should be honored the fact that people are. We're doing these things in both segments. Similarly, the next time we have the Public Health Committee, we'll maybe ask Keshana to expand on how we can, and we may talk a little bit before that meeting to see whether part of what we can do here is have the sort of platform for a public conversation about things that you might or might not have. If they're a particular area like to talk about how we get Public Health Board visible, how do we get public input into that process, I think is a really important agenda. We can take that on. Again, the other area I'll mention just for the committee's purposes. There is current language in the acute care Certificate of Need asking them to explain how they're addressing priorities in the Prevention Agenda. Something the PHHPC did. It's about four years/five years ago, I guess. We've had some conversation, thanks to Dr. Whalen's work with Doug Fish, and that's their department there to talk about. We've been talking about revising that language actually since the COVID epidemic. I think now with the new model, we really will be challenging looking at how that language could be updated to reflect the new Prevention Agenda. Similarly, we had had at one point a conversation about looking at CON related language both in community and ambulatory care, even in some of the specialty areas and in long-term care, which we didn't take forward, but it had been part of a conversation in a PHHPC retreat a couple of years ago. We'll be exploring that further and have more to report to you in the next meeting.

Dr. Boufford I think we're done.

Dr. Boufford Thank you all very much. Thank you for a great job. We're excited. I hope you'll get your rest between all these meetings. It is a lot of work. It's really terrific. Thank you so much.

Dr. Boufford We stand adjourned then.