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PUBLIC HEALTH COMMITTEE
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TRANSCRIPT

Dr. Boufford Good morning, everyone. I'm Jo Buford. I'm the Chair of the Public Health Committee for the New York State Public Health and Health Planning Council. I'd like to call this meeting of the Public Health Committee to order. Just a couple of remarks beforehand just to lay out the agenda for you. As you will recall, the Public Health Committee is sort of tracking three core issues. Our statutory responsibility is providing oversight to the prevention agenda itself. Related activity for the prevention agenda is an interagency advisory group, which exists. The idea was to use the group that's been convened by Johanne Morne for the equity index. The third item that we were tracking regularly was community benefit, which can be related, ideally would be related to the prevention agendas, but it need not be. The other pieces of the agenda today are updates on the maternal health initiative, which has been something we've been tracking once or twice a year. We want to get a progress report and understanding that with all that's going on in the federal level, we want to be sure that New York State is maintaining its support for reproductive choice and addressing the continuing problems of maternal mortality. The committee also every year identifies one particular issue that we're work on, and Public Health Workforce was the one we picked for this year. That's why that is here on the agenda. Let me just summarize, I think I'll do that, Liza, and if you want to correct me, you can. I want to just indicate just as an overview to get started. The prevention agenda, the draft of prevention agenda is still under review and is not publicly available as yet. Therefore, the Interagency Group will probably not meet until September. Those two items are really not... That's the status of those items at this point in time. The community benefit item it's actually quite exciting because you have this very small print attached to you. Language which provides gives the Commissioner authority, statutory authority to design language that requests hospitals to report on their schedule age submission to IRS is in this language. This is in the budget language. It was approved in the budgets. It's very exciting, I think, for us going forward to really think about what suggestions, recommendations we might have for what that language should look like and also tracking that activity. That is moving forward. The other two are on hold at this point. I've talked with Dr. Whalen, and we'll have a meeting probably of this committee if it gets to be too late in the Summer, we probably won't do it. We might. We have met in July before. We might as soon as the prevention agenda is released to the public. Let me just see if Elizabeth has any.

Dr. Boufford Do you have anything to add to that?

Dr. Whalen No, I think you summarized everything perfectly. Thank you.

Dr. Boufford We're very fortunate to have Johanne Morne joining us. We got her on the cusp of analyzing the impact of all the federal activities on public health in the state of New York, and so we're going to hear from her today with something very good timing that we were able to snag her for this meeting. As I mentioned, we'll have updates on the Maternal Health Initiative and the Workforce. It's my pleasure now to introduce our new Deputy Commissioner for the Office Public Health, Michelle Davis. Everybody I've mentioned your name to says I think I remember her from before, so she comes to us from the federal government regional office. I'm going to have her introduce herself so that we don't miss

any details and Liza and Michelle, and I had a lovely transition call about ten days ago. Liza will continue working with us on the prevention agenda. Michelle will pick up the rest of the public health portfolio

Ms. Davis Thank you so much, Dr. Boufford.

Ms. Davis I'm very pleased to be here today, everyone. This is my actual return to the New York State Department of Health. When I was a little child, I worked for the Department of Health way back when as a Research Scientist in the Division of EPI. Yes, as Dr. Boufford just mentioned, I have spent time with the federal government with the Centers for Disease Control and Prevention as well as in the Office of the Secretary with the Health and Human Services in DC. I'm very proud to also have had experience at the local public health level, in particular in DC as well in Philadelphia, and then also with several state health departments during my career. One position that I'm very proud of as serving as the Health Commissioner for the U.S. Virgin Islands, which allowed me to get some Caribbean territorial experience in addition to my volunteer work in Africa. I'm very pleased to be back with the Health Department as the Deputy Commissioner for the Office of Public Health. We have a great team. They're doing wonderful work in all of the units and divisions and bureaus there. I'm here to support the Department of Health's mission to protect and promote health and well-being for all and building on the foundation of health equity. I know we're going through a transition from the federal level, and Johanne Morne Will be talking more about that, but I'm working very hard with the executive team in the Department of Health to get us through this transition and to prevent as many individuals from being laid off as possible. We're trying to be very creative, innovative, to keep all of our programs going and to keep staff in place. Once again, I'm very fortunate to be here, to lead a great team, to support a great team and to work with all of our partners external to the health department throughout the state in the cities and counties and local communities and to partner with others in the United States to move public health forward. Thank you very much.

Dr. Boufford I think it would be great to have the committee members introduce themselves since you will get used to them, but this is your first meeting.

Dr. Boufford Why don't we start down at the other end?

Mr. Perry I'm the CEO of AHRC-Nassau. We provide, along with the family of organizations, a wide array of services to people with intellectual and developmental disabilities on Long Island.

Dr. Eisenstein Dr. Larry Eisenstein, we've met. I am the Vice President of Community and Public Health for the Catholic Health System, six hospitals on Long Island. Prior to that, I spent more than a decade as the Commissioner of Health in Nassau County.

Dr. Soffel Denise Soffel, I am a long-time consumer advocate, especially around Medicaid issues in New York State. I'm actually a consumer representative to the Public Health Council.

Ms. Soto Nilda Soto, council member, retired from Albert Einstein College of Medicine. I was an Assistant Dean at the college.

Dr. Watkins Kevin Watkins, Public Health Director for Cattaraugus County Health Department. Been a member of the PHHPC Council for many years.

Dr. Torres Welcome and congratulations. Anderson Torres, President and CEO of RAIN, a not-for-profit organization focused on the elderly and home care council member and Co-Chair of this wonderful committee.

Dr. Yang Hi. I'm Patsy Yang. I'm currently Senior Vice President of Health and Hospitals, specifically for Correctional Health Services on Rikers, and before that, worked in hospitals and health departments in Westchester, New York City.

Dr. Boufford Do you know all the staff members? The indispensable Colleen you've met. Any other colleagues?

Dr. Boufford Well, welcome. We're delighted to have you. Delighted to have you. I think Johanne Morne is supposed to be next, but she isn't joining us. My guess is there may be.

Dr. Boufford Is she on?

Dr. Boufford There she is.

Dr. Boufford Johanne Morne, our Executive Deputy Commissioner for Health, we're delighted have you, and when Liza mentioned that you had we were prepared to help us analyze the impact or potential impact and the threats and opportunities, I guess, with the federal changes. We wanted to snag you. We really appreciate your speaking to the Public Health Committee.

Dr. Boufford Without further ado, let me have you go forward.

Dr. Morne Oh, thanks so much.

Dr. Morne It's such a pleasure to see you. A huge thanks for the invitation and Dr. Whalen for finding the time to walk me through as far as understanding what we wanted to talk about today. So glad to join all of you. You know, the truth of the matter is, I know all of you are paying very close attention to the impact that the federal transition is having not only on the Department of Health, but certainly on all of our public health work across New York State. While there are multiple, multiple sources of information, we here at the department work really hard to focus on the facts so that we can make informed decisions. I have to say that in spite of all the risks and in spite all the threats that have come, I am very, very, what's the word that I want? I feel so strongly about the work of the department and the way in which we are facing these risks. I say that because we have been very thoughtful in how we think about a loss of funding or how we about the potential as a result of loss of money on the staff and our colleagues. Certainly, with our stakeholders and partners across the state and really looking at and working towards understanding how we continue to prioritize and ensure that the essential components of public health are what we are focused on as we face a lot of different questions during this time. Let me acknowledge all of you because I know in your own spaces, you too are walking through and trying to understand what the federal transition means to the work that we do across our state. I think for some of you, you may hear things twice. Dr. McDonald certainly is known for making very specific statements that quickly become quotes because, in fact, they are probably some of the best ways in which we can speak to the experiences that we've been having more recently. One of the things that Dr. McDonald has stressed is that as public health funding is facing unprecedented upheaval at a federal level, we must be careful not to allow that to distract from our mission. I think that's really significant, in

particular, because our mission, if you were to look at the New York State Department of Health mission, speaks to the continued protection and promotion of New Yorkers, as well as the wellbeing, but we maintain our foundation of health equity. We know that there are many discussions that speak to the reference of health, equity, diversity, equity, inclusion. We know that there are many conversations that do not necessarily align with that mission. However, it is more important than ever that we maintain the mission that we have in order for us to continue to advance in our public health work. I won't suggest that it won't be without challenge. Many of you probably have seen in past presentations by a member of the DOH. It's an image of individuals under a tree. It speaks of the distinction between equality and equity. The distinction is that with equality what we do is we give everyone the same resource in order to be able to achieve whatever goal or challenge they have in front of them. Equity speaks to giving people the tools that they need appropriate to their individual situation in order also reach that goal or challenge ahead of them. The work that we do and the conversations that we have as we think about the risks that we are facing is really essential in making sure that we continue to find those opportunities in which people are given the tools that they need in order to individually continue to advance in their health and in their wellness and overall life satisfaction. What are the risks? What are the threats that we're looking at? We're looking at the potential of individuals losing health coverage. Over 730,000 potentially could lose health coverage on the essential plan. We're looking at about a million Medicaid enrollees or 15% potentially at a loss of their insurance coverage. We're looking at the unknowns related to the changes, the vast changes to the Advisory Committee on Immunization Practices or APIC, which speaks to immunization and vaccination. We're looking at certain risks to areas that we have dedicated many resources to in an effort to save lives, such as with our opioid overdose response, our prevention work, and our continuing response to the crisis through harm reduction. What did we do? What are we doing? What have we done? We are continuing to learn. We are continuing to understand as we move forward what it is we need to look for. What are the questions we need to ask? How do we continue to promote what so far has been working effectively for us in the department through collaboration, through communication, through the prioritization of facts, and the effective use and protection of data? We know that many of the risks that we have faced over the last few months, in fact, have been temporarily placed on hold or placed on a hold through a preliminary injunction. This is due to the work of the New York State Attorney General in collaboration with multiple other states, jurisdictions, and other attorney generals as well. An example of this shows a temporary restraining order that came from Rhode Island. May 16th of this year, the court issued a decision granting request for a motion of a preliminary injunction denying the federal government's motion. Status quo will remain, meaning that we continue to do the work that we do. This is related to areas of diversity, equity, and inclusion. This is related two areas of health equity as well. As we have preliminary injunctions, as we had temporary restraining orders that allows us to continuation. I want to stress and be clear, the threat still does remain as we have seen with the attempted termination of multiple federal grant awards. To date, in spite of the fact that those multiple risks have presented themselves, we have been fortunate through some of these legal actions, also through some actions taken by the federal government to offer cost time extensions. I have to acknowledge and some of the areas still receiving a notice of award, even though there is question as to how we will continue to advance or if the entire funding cycle will continue. Recognizing that we have funding cycles that may end in 2027 or 2029 based on multi-year awards. Communication. The work of the department is both internal and external. We have worked very hard to ensure that we maintain internal communication so that the staff across the Department of Health have the facts, recognizing again that there are multiple outlets in which people can receive information, recognizing that while people are working through the challenges and the risks that we are

experiencing, they also, too, are at risk of their own employment. The reason for creating the space on a routine basis to ensure facts is one, to make sure people are informed and have the correct information so they can make informed decisions, which is a similar practice to what we're doing with our partners and our stakeholders in ensuring that people understand when grant funding may be at risk for them and what that means to the activities that they provide to some of the most vulnerable areas and communities of our state. We also are looking at opportunities and continue to take opportunity to correct misinformation and to again, remind people through again, a history of the work that we do to point to those areas of public health that are significant and that based on facts, science and evidence we know are in the best interest of people's health. That is why you see public campaigns as it relates to vaccination. That is why, you see Dr. McDonald in various different spaces in public media, speaking to the work of the department, and most importantly, speaking to the science and evidence of the work that we continue to do on a daily basis. We know that we have risks as it relates to areas of our funding related to the 1115 waiver, which we know this 1115 waivers not new to New York State. We have had a history of waivers and some of you may know that in the past as MRT, most recently the 1115 waiver is based in a framework of health equity and promotes areas such as social care networks. It looks at improving the integration of primary care, behavioral health, and social care. It does a number of different things with a very significant multi-billion-dollar investment from the federal government. We know and we anticipate that as we move forward to 2027, what has been allowable in the initial approval of this framework will more than likely not be allowable moving forward. This will have a significant impact on the 1115 waiver. That impact continues to be assessed as we continue to learn more about what may or may not be eligible. Again, what I'm pointing to is a foundational, foundational investment across New York State, again, with the intention of engaging some of the most vulnerable individuals and communities for the purpose of maintaining access and sustained involvement in care.

Dr. Morne I reference data. Data is a really significant part of this discussion. Again, if we're working from a place of evidence we're working from the place of data. We have spent many years looking at the intent and the purpose of data collection, so that it has a meaningful purpose and not just for the purpose of saying we collected it. The reason for that is because we want to ensure that we are our resources, and we are focusing our work in the areas that have the most need. Along with the data, of course, comes responsibility and looking at the ability to continue to safeguard our data and safeguard the information behind that data which is representative of human lives. We have continued work as it relates to this continued, safe, reasonable, and purposeful collection of data. We also, in an effort to maintain communication and provide data to internal and external partners have developed a global health report. That global health record provides public health trends as well as infectious disease outbreaks. It looks at the impact of what is happening in public health globally. In the absence of communications from different federal agencies, this is the opportunity for us to maintain and ensure that we are keeping our eye in emerging areas of concern so that in New York State we can continue to be prepared. Recognizing that we're not alone in this conversation. The nation is experiencing the impact of the federal transition in many ways. One of the things that we are doing is working across the Northeast area, so that we can look at collaborative opportunities in which we can share those experiences, share the responses, and look at the ability to replicate in those areas that make sense. This is a fairly new collaboration, but what it does do is convene public health officials and allows us to at least have a discussion about the benefits of looking at shared resources, data, and other areas that can help us impact how we move forward. I do want to point to the state as far as thinking about what are the key areas of support that we need. We all know that we just actually, I think today's

session is starting to come to an end. We did have an executive budget that now has passed. We have some pretty historic investments that have come from the state, around \$34 billion in the Medicaid investment, a billion dollars in capital, \$300 million in operating funds, specific to the safety net transformation program. The opportunity of looking at over a billion dollars to expand access and increase reimbursement that rates for hospitals, nursing homes, assisted living programs, physicians, and other areas of care across our state. The state investments certainly speak to our continued ability, not only to maintain the services, but to continue to advance, understanding that we will be balancing that with the potential of losing access to federal dollars. We do not have the specific detail to that. We certainly will not know what the exact impact will be until the federal budget in the Fall is released and we know exactly how we are going to advance in the areas that we're going to look to. Certainly, you know, New York State, we continue to be a progressive state. The safeguards that have historically been here as it relates to reproductive health access, as it relates to women's health, as it relates to the protection of individuals and the access to care, particularly in services that benefit the LGBT community and individuals who seek services such as gender affirming care. These are conversations that through the federal transition, we know have been challenging yet New York State continues to provide the protections through legislation, through policy, and through access to care.

Dr. Morne The one other thing that I'll say, and then I'll stop for questions, is that it's another term that Dr. McDonald uses. It's that our jobs have always been. Our jobs are hard for any number of reasons, right? When we're faced with adversity or when we are faced with risks, what we have to understand is that it's less about the job being harder and more about the jobs and our roles and the importance of what we do being even more significant in its importance. Our responsibility to New Yorkers across the state is significant. Our need to look at what is essential and prioritize those essential services that will result in the highest levels of health and wellness are significant in this conversation. It is challenging to think about changing anything that we do. However, when we are faced with particular risk it is important for us to have collective conversations with community input in order for us to determine how do we advance, how do we prioritize, and how do we leverage the resources that we do have available to us as we move forward to ensure continued safety and care for all.

Dr. Boufford Thank you very much.

Dr. Boufford I'm sure our committee down here will have questions.

Dr. Boufford Let me start off while they're putting their questions together. I want to go to the vaccination question because there have been a lot of maybe confusion and maybe it's just lack knowledge about the sort of degree to which the committee's decision about vaccines affects a state's ability to continue to mandate or manage its own vaccination programs the way it wishes, and especially for physicians to be reimbursed for those vaccines. I think this has been a question that I've heard a number of people asking about. Can they change the way New York sort of manages its own vaccinations program and its own reimbursement for vaccinations?

Dr. Morne So, that is a really key question. It's one that we are currently looking at from a legal perspective. Understanding, for example, if it's decided that the vaccination is now a shared decision, understanding what is the impact to New York State regulation and expectancy, particularly if you think about school aged children, you know what impact may or may not come of that? We are currently looking at that. We are trying to answer those questions so that, again, we can provide informed information as we move forward.

Dr. Boufford No, just to follow up. I was just thinking, let's say, for example, measles vaccine is determined to be ineffective. I mean, having sat through some of these committees in the past at the federal government level. Does that matter to us relative to providing the vaccine and or paying for paying people to provide it?

Dr. Morne I think the question of doesn't matter is absolutely. What I would say is that New York State has always stood by the science behind the example you shared, the measles vaccination. I think what would have to be discussed is how do we advance with that, recognizing that when it comes to vaccination there's a whole continuum that has to be taken into consideration beyond the role, the historic role of an ACIP committee and determining what should advance and what's not, the role of the FDA. There's also the fact of how we've been access, like actually access those vaccinations. Does that process change? What does that mean? How do we establish those relationships? These are all things that have to be taken into consideration, understanding that the impact would be great, but the science is greater.

Dr. Boufford Thank you.

Dr. Boufford Dr. Yang.

Dr. Yang Just thank you for that, Jo.

Dr. Yang The question is, in my mind, is sort of if there's no preemption, no legislative preemption on the part of the feds, the federal government, sorry, not the fed's, to say something is not legal, but it's left open for guidance and recommendation. We do have state law, for example, for school age entry, which most recently includes pertussis and stuff like that. There's state law. There's certainly the State Health Department with Medicaid to mandate coverage in that regard to work with the Department of Finance to acquire commercial insurers, also to cover those things in New York State, if that's a pathway that you see is currently viable or at least not unviable, to keep that threshold in New York State intact.

Dr. Morne What I would say is that that pathway is the exact conversation that is currently underway in understanding what the legal parameters are that we have and also understanding the resources that would be needed in order to advance. Those different areas of government that you've mentioned as far as the insurance, Medicaid, et cetera, are all part of that dialog.

Dr. Yang Thanks.

Dr. Boufford He's fingering his microphone, so I think he wants to say something.

Dr. Eisenstein Hi, Johanne. Nice to see you. Larry Eisenstein. You know, you brought up the Medicaid waiver, and I'm responsible for this on behalf of my health system, but, you know, when this started as a three-year waiver, I think we all understood that three years alone isn't going to be able to achieve what the goal is. We're building an infrastructure for the future. We're now fifteen months in out of thirty-six. We're still, certainly on Long Island, from what I've heard across the state, still in the very early stages of implementing the waiver. I know on Long island and our social care network still less than 1% of all the eligible Medicaid patients attributed on Long island have been screened. Less than 1%, fifteen months in out of thirty-six. This is not for lack of effort. This is the waiver started and

we all started doing our work, but the tech had to be built, and the infrastructure had to build and all the contracting between all the community-based organizations and the social care network has to happen. This is billions of dollars of investment. I'm in a position where I'm wondering should we continue the investment that we're doing as a health system for a waiver that as you stated in your comments earlier is likely not to be extended? We certainly want to build out the public health infrastructure, but the time frame of the waiver is not practical to achieve the original stated goals. It's just not going to happen. I don't think anybody who's actually doing the work, boots on the ground thinks it will, despite everybody's best efforts. There's nobody doing the wrong thing here. It's just a matter of a program that we thought would be extended beyond three years looks like, and as you stated, probably won't. There are still billions of dollars outstanding. Has there been a discussion or a plan or what's the future of this and should we still be investing for something that's not likely to survive, I guess is the question.

Dr. Morne A couple of things. I want to say first that my intention wasn't to say that I don't think the 1115 waiver would or would not be extended. What I want to speak to are some of the specific activities as to whether or not those activities that were once eligible will continue to be eligible. There is a distinction there. The second thing that I'll say is that the conversation you raised is one that's been raised from the very beginning. Because of the fact of the timing of when the waiver is re-initiated under this new framework and understanding that it was through 2027. I think what's really significant is to take the opportunity through the work that's being done to determine is there a new path? Is there a new way? Is it an innovative opportunity to think about how we provide care on the ground? When I look at, for example, social care networks, which for me not working directly within the Office of Health Insurance Programs, the social care networks are an area I'm most familiar with and most often speak to. There is benefit in understanding what the potential outcomes of a care network can do for an individual and for a community. Regardless of the length of time, every day in which we are working in these frameworks is another day to learn what actually is the best path forward, whether it's funded through a waiver or whether it is funded through another means. I don't have all of the answers. I know this conversation is long standing from the very beginning, but I think that like with any, if I think about from my program days with any grant funding, we always knew there was a three-to-five-year cycle. What did we gain through the time in which we had the resources is to be able to create something innovative. What will be key is to ensure that whatever is being created can be scalable and can be replicated. That is what will allow us to have a successful conversation moving forward as to how do we intend to continue the points of access that have been created and the levels of support that have been provided through these dollars.

Dr. Boufford Other questions?

Dr. Boufford Dr. Watkins.

Dr. Watkins Thanks, Johanne. I appreciate your presentation. You spoke about the loss of health coverage. I think if we can concentrate just a little bit on that. If there's a loss of health coverage, what role will New York State Department of Health play to provide the health care needed by residents in New York State? How can local health departments assist in this effort even as direct patient care has been removed from our major deliverables?

Dr. Morne Thank you for that question. Good to see you, Dr. Watkins. Let me start by saying first of all that we have to acknowledge the role of the local health departments and

the relationship and partnership that we have there. Certainly, understanding that the local health departments with their regional perspective and understanding what some of the niche needs are within each of your communities and areas is what allows us to make sure that we are not just creating policy and or looking at funding allocation for cookie cutter if you will, but rather looking at what the actual needs are in each of the local health department regions. Let me just acknowledge that partnership. What I would say is this, I think that we have a very complicated conversation when we think about the history of insurance in our nation, right, and the impact. When we look at of the risks as it relates to areas of the Affordable Care Act as it relates to the impact for individuals who are undocumented, and as it relates to continued funding for the existing levels of access to care and formulary, both within Medicaid and within our New York State of Health Essential Plan. The risks here are great. I don't know that I can offer you all the answers today. I think that these are the conversations that we need to have collectively as we look at how we continue to provide care, as we looked at public health impact across communities for individuals who may not have the same level of access, and as we also look at the responsibility of providers, regardless of insurance coverage to provide access to care for individuals. I think this is a really large question that you ask, and I think it's one of the biggest risk areas that we have right now as we think about how we advance, should we find ourselves in the position of losing access, as I indicated earlier, to insurance coverage for millions of people? This is a significant point of conversation.

Ms. Farrell Thank you so much for your presentation.

Ms. Farrell There's so much language about fraud, waste, and abuse when it comes to public programs for health coverage. Additionally, I'm concerned about the potential for work requirements, which is articulated in the big, beautiful bill. How is New York State thinking about those two aspects of what I fear could become our reality?

Dr. Morne I've said this before, and I think other people have said it too. I think all of us are certainly on board with the idea of looking at how we ensure that resources are utilized in the most efficient, effective manner. That's not the question. The question is how is that implemented? How do we take into consideration the impact on individuals when implementation is done in such a way that it's harmful? Certainly, across the department, I can say to you that we too are looking at prioritization as we think about if we were to find ourselves in a situation with less resources. How do we prioritize and ensure that the foundational elements of public health are continued to be met? It is an essential conversation for all of us. That part, that part we can certainly agree to. What I want to say, and I'm sorry, can you just, the second part of your question?

Ms. Farrell Yeah, work requirements. Again, other states have attempted it. There have been lawsuits, but it very possibly could become part of the way we need to work in the future.

Dr. Morne I think, at least for myself, I know that I've worked in public health long enough. I remember work requirements in the past. I think it's really interesting when you listen to different people speak. When you listen to different people speak what you what you recognize is this. Work requirements as opposed to access to training, educational promotion, and the ability, the ability to help people gain the skills that they want and need, because most people are not opposed to. It's implementing it in a way that acknowledges all of the other social determinants of health that most often are the reason why people are challenged to engage in these areas, right? It's looking at how do you establish a structure that responds to the need for childcare? How do you establish a structure that responds in

a need for elder care? How do create a structure that responds to any of the multiple needs that individuals may present with? I think that there's a way to look at work requirements in a way that's meaningful and can actually impact public health as a whole. There's another way to work requirements as something that seems to be presented self as sort of in a that to me is not effective, has proven in the past to not be effective and ultimately it's just not successful, neither for the system, nor for the individuals who are impacted.

Dr. Boufford I think we have time for one more question. I'm just keeping my eye on the clock. It's a really, really important discussion.

Dr. Boufford Anybody have one more questions?

Dr. Boufford Dr. Yang has another question. She can have her second one if nobody's stepping forward for another one.

Dr. Yang I'm sort of sitting here weighing what will actually happen, which is going to be, in the best-case sort of less bad than my worst scenario. And just because we're the Public Health Committee, I know you have the legislation and what is required for community benefit. Whether they're thinking at this point, you know, I think of the prevention agenda, right, which we had tried to tie community benefits to. That is so broad, so lovely, and so aspirational. I wonder whether there's time and anticipation to narrow that down and try and hone that a little bit more tightly to what is the core essential of what we think is going to come down the line. I think the health care providers will need to make their own business decisions if that's a way to put in more guardrails to ensure things like the responsibility, the ethical responsibility to care for whoever. The role of public health departments to be more the facilitator, the informing, the helping people stay and get the essential stuff, and whether there's a way to narrow that down and tie it into what is now law and community benefits. I know that's a little off topic, but it stems.

Dr. Boufford One thing to clarify is the community benefit requirement in New York State, surprisingly is basically voluntary. I mean, the only requirement is the federal requirement for under the sort of Obamacare Act. Sorry for using the name, but the other one didn't come to me right now. Part of what this budgetary language does is I think it opens the opportunity for the department to look at where this... There is money. I mean, the IRS reporting. We actually are fortunate, I think, during one of our Ad Hoc Committee meetings, person who's getting their PhD, who used to work in the health department is getting their PhD from University of Albany who knows the community benefit contributions by category by hospital for the last eight years. It's not like not having the data. I think part of the conversation will. That's a challenge. I love your question. I think it really is a challenge to use this language. I think the prevention agenda is what it is going forward, and then the question would be how this budgetary language, statutory language, can be structured in a way to take advantage of what is a significant amount of money? I mean, when we, again, I always, when talk about committee benefit in front of this committee, I want to clarify we're really talking about one category, the community health improvement category, which is really quite small at this point in terms of the investment, 0.8% of the overall trillion-ish dollars of the community benefit investments that hospitals are reporting to IRS. Even in that category, there's the last time I remember looking at the numbers, which was 2019. It's probably maybe lower now. I don't know for sure. Just a little bit south of \$250 million a year. That is significant public health funding that is being spent. But your point is, can it be aligned with public health need or with health need in communities?

Dr. Yang I think there will be business decisions that have to be made, it's viability of essential providers, right, and I don't envy that kind of decision, but there is definitely going to be a population that falls out and services that fall out. I think the question of what the facilitative role is, the informational and the coordination piece outside of the provider community and just hone it down to get a little bit more focused, I think. I think we're all expecting not great news.

Dr. Boufford Well, I hope this committee can be a part of that discussion.

Dr. Boufford Dr. Whalen, do you want to comment on that? Before we move on to, or I actually, sort of, Ms. Morne, I just tried to call her Morne. Ms. Morne, if you'd like to coordinate, to comment, or Dr. Whalen, and then I just wanted to get Gene Heslin to get a chance to make a comment before we move into some of the special areas, the two special areas. Liza, or Joanne, why don't you go first, and then since you've been presenting this, and the question emerges from your presentation.

Dr. Morne Thank you for that.

Dr. Morne You know, I certainly am interested in what Dr. Whalen, Dr. Heslin have to say in response. I know that the comment was specific to the prevention agenda and the benefits. Overall, this is a discussion that we have to have. As I've said, we're having within the department. What are the priorities? What is it that's essential to ensure that we continue to advance in the best health and wellness of individuals? Certainly, we don't want to lose ground on any of the achievements or milestones that we've made. At the same time, I think there is space in which we can build upon those while also acknowledging we may have to do so with less resources. In order to do that, that means we have to really focus on what's at the top of the continuum of impacting change.

Dr. Boufford Dr. Whalen, you want to make any comments here and then moving to Dr. Heslin before we wrap up and move on?

Dr. Whalen In terms of the discussion around community benefit, I think there is a tremendous amount of potential here just for development and discussion and looking at how monies are being directed to public health in a time where we are looking at these national resources potentially and practically being really winnowed down or have decreased. Working with our hospital partners is always an important mission for public health. This is new for us. There's a lot of discussion to be had about how this reporting will be enacted and what it will entail. I think there's a lot of potential in this, and I look forward to continuing discussion with the group.

Dr. Boufford Dr. Heslin, final comments.

Dr. Heslin It's easy to agree with all of the above, but I think we go back to what the mission statement of the department is to protect and promote health and well-being for all building on a foundation of health equity. I just want to remind people that that is our mission. Now, the department, as Dr. McDonald has said, rightly so, has been around since 1901. Public health is going to be around long after what we are currently going through. I encourage people to continue to be flexible in the way they think. Hospitals have been around for a long time. Most importantly, people and patients have been around for a lot of time. We're going to be here. We're not going away. We're going to change the way we do business to react and respond to what the community needs are. We always have. In times when things are tough, I tell people to be strong in their families. Choose to

support your family. I and the department choose to make our family the Department of Health and New York State. That means that we're going to live by our mission, stand steady with what we're doing, understand that there's lots of noise in the world out there, but people are going to be people. They're going to have needs. We're going to continue to meet those needs with the tools we have. We've never had the tools that we've wanted, but we have the tools we have, and then we figure out how to utilize them to get to the best answer. This committee has always been great because we don't only think in the future, we also think in practical. What we need to do is to take what we do in the practical and continue to apply it to what our future state will be. Thank you.

Dr. Boufford Thanks, Dr. Heslin.

Dr. Boufford Johanne Morne, thank you so much for coming, joining us. We hope to see more of you as the year goes on, but this is super helpful, really helpful for context as we move into, as everyone has said a challenging period. Thanks so much coming and being with us.

Dr. Morne Thank you.

Dr. Boufford We'll move on then. I think we have at your places, you have a Power Point presentation from our Maternal Health colleagues. Jennifer Boutin Mane is the Director of the Bureau of Maternal and Child Health Policy of OHIP. They're the ones who have the money. We're going to find out what they're paying for and what the issues are. This has been an interesting issue over time, just a little bit for some new members or others that are not as familiar. Part of the reason this agenda item is on our ongoing agenda is that probably seven or eight years ago this committee and the PHHPC really developed a white paper, if you will, really calling us prior to the Governor's Commission on Maternal Mortality and various others after exploring in some detail the issue of maternal mortality and reproductive health and access to family planning in the state, had a series of meetings and conversations including OHIP, including those relevant activities across the department, which resulted in our white paper. We like to think we had something to do with the later Governor's commission and the ongoing, I know the group in the department has always had attention to this, but more visibility. That's what we want to do is maintain the shining a light on this issue of maternal mortality and this issue of reproductive health and reproductive choice in the state. That's why this is on the agenda. I want to welcome Wendy Wilcox. Sorry about that. I've known Wendy for a long time. I should have gotten that right. Wendy Wilcock who is our OB GYN colleague and strong spokesperson, strong advocate always has been for women in this state, women's health in the state. We welcome you. You're just in time for this presentation, so this is great, absolutely. Anyway, so let me invite maybe, I know we're on for the Power Point, but either before or after that, maybe I could invite Ms. Mane to introduce her team. I see there are people up on the screen. I'm imagining they are part of a MCH team or OHIP team or part of the workforce team. I'm going to invite you to introduce them before after your presentation.

Ms. Mane Good morning. Do you want me to get started?

Dr. Boufford Yeah, please do.

Ms. Mane I will clarify. It's not it's not my team who's on. I know you see a lot of Department of Health staff and members who have joined the meeting. I'm in Medicaid. I think I might be the sole individual from Medicaid.

Dr. Boufford That's great. We're always happy to have anybody from OHIP come and talk to us because you all have the money.

Ms. Mane I think otherwise you're probably seeing people on the public health side.

Dr. Boufford We'll do those introductions after your presentation.

Ms. Mane Sounds good.

Ms. Mane Hi, everybody. Jennifer Mane, I direct Maternal and Child Health Policy for the Medicaid program, sit within our division of program management and policy over here at the Office of Health Insurance Programs. I was asked to specifically speak to our state-directed payment initiatives that have been funded through the managed care lines in the past couple years, but I've added a little more information to this because those initiatives really don't stand on their own in terms of the maternal health investments that have happened through the state Medicaid program over the course of the last three to four years. I just wanted to touch upon those. You really provide the foundation for those state-directed payments as well. The first initiative, the first kind of like big push really and the foundation for all else that came after it was the updating and re-release of what was the New York Prenatal Care Standards reissued as the New York State Perinatal Care Standards in 2022. Those were issued in July of 2022 after a full year process of engaging with stakeholders, not only across the department, but externally as well. This is our foundational guiding policy for all Medicaid providers and all Medicaid payers in the state of New York. It provides clarifying guidance and the requirements coming for participation in state Medicaid for these providers of perinatal care. Medicaid benefit and program designs then support the implementation and adherence to this broader policy. All other policies, benefits, coverage kind of came out of this.

Ms. Mane Do you have a mechanism to share the slides?

Dr. Boufford Yeah, that would be great if you can.

Dr. Boufford We have a copy, but that doesn't help folks that are tuned in.

Ms. Mane Do you see that?

All No.

Dr. Boufford We have a great shot of you, but we don't see any slides.

Ms. Mane How about now?

Dr. Boufford Something's coming.

Dr. Boufford Yes, wonderful.

Ms. Mane This is what I was just speaking out about was our perinatal care standards. There's a link there. This is again, it's our overarching policy and requirements for payer and provider participation. We included in this new in this reissue were these guiding principles for the providers as well. I have the link there. Now, like I said, this is considered our kind of foundational policy where all else then is built from and onto these overarching principles and the guiding policy with an acknowledgment that we're still kind of working on

putting all of the structure around this. It's truly foundational. We don't have all of elements to fully stand this up. What I talk a lot about with the providers is we have all the pieces out there, and now we really need to work towards the structure to put them all together in the intended way, which is that all of this happens in as much as possible, the same place at the right time for the consumers. During this same period of time, so it was about six months following the re-release of the perinatal care standards, we were able to effectuate the postpartum coverage extension, and this happened really nationally. New York State had already had one year of continuous coverage for all Medicaid enrollees. The impact of this was maybe not as dramatic as in other states, but still very necessary to ensure that at any point of enrollment in Medicaid during or before pregnancy. There was still this insurance that the coverage period would last for one full year following the end of pregnancy, regardless of how that pregnancy ends. This is a list of different benefits and coverage and expansions that went into place over the course of the last couple of years in addition to the two things I just spoke about.

Ms. Mane I'll move through these pretty quickly. There's additional information available. I can get links out to those if people need the greater detail, but we already covered lactation counseling services. What happened in the last couple of year is we expanded the certifications for the providers of those services who are eligible for the reimbursement.

Ms. Mane If we skip all the way down to the bottom of this list, we just got a minor investment in the last budget cycle where we're going to do another expansion and redesign on this benefit to make it more accessible for consumers and providers. There was an increase in the reimbursements rates for midwifery services to bring them closer to the physician fee schedule. Expansion of reimbursement for screening services such that it covers all pregnant Medicaid members and instead of special populations that had previously been defined. Remote patient monitoring services are covered for many categories of Medicaid enrollees and individuals. There's an enhanced remote patient monitoring service that's covered for pregnant and postpartum people that allows for more advanced equipment utilization and increased time for data reading and data interpretation that is associated with that more advanced remote monitoring equipment. Coverage of community health worker services went into place beginning with the pregnant and postpartum population. It has since expanded to children and additional adult populations but started with the and postpartum population in 2023. The SMA carrier screening began coverage and then medical nutrition therapy. That's services, nutrition services provided by registered dietitians similarly began in the last two years with pregnant and postpartum people and has now expanded to children and additional adult populations. And then of course, which has received a lot of kind of press and support is the statewide coverage of doula services that went into place last year. We've put a lot of effort into bringing on that new brand-new provider community into Medicaid and rolling that service coverage out. These are additional services, benefits, expansions that happened in alongside of this 2023 investment in state directed payments and just to back up a little bit for those who may not be familiar with what that terminology is, the State-directed payment. That is a payment arrangement through Medicaid managed care that's authorized under the federal government under a pre-print authority it's called. That's how we have to submit them for approval. It's literally the state directs how managed across the board has to distribute a particular payment to defined provider class in a specific way. Those can take the form of rate enhancements, or they can take that form of value but what they're calling value-based payments. We have one of each. This one falls under the category of a value-based payment because it is a performance incentive payment, so the providers are earning the payment through managed care based on hitting defined performance target. This was in effect April 1st of 23 through March 31st of this year. In that frame it sounds like it's over.

It's over in terms of the rating period is over. You'll see as I walk through this we're not done with assessing the performance. We're not done with issuing the payments because of when the data becomes available and the timeframes around when payments can be issued. Really, it's just the first year that's completely complete. The eligible providers who could, whose performance is being assessed to earn this payment is in-network hospitals, in-network, meaning they're in network with the managed care plans. They are Medicaid participating hospitals, providing labor and delivery services and who had a minimum of 500 deliveries that were covered by Medicaid managed care in our baseline year, which was state fiscal year 2022. The performance that's being assessed is their performance on a low-risk cesarean delivery rate. That is measured by the national NTSV metric. That is a joint commission national quality measure that we have kind of built that metric and replicated that metric within the Medicaid data warehouse information. Being a Joint Commission metric and in the AHRQ data, there's national sources and resources for both monitoring and for pulling performance on this, but we are calculating this rate based solely on the Medicaid managed care population, served solely at who delivered at these specified hospitals. We're replicating that metric, but we're using our internal data. Performance that we're calculating will look different than publicly available sources or even the hospital's own data sets. It is pregnant individuals with a first delivery at thirty-seven weeks of full gestation and a single pregnancy in the vertex position. This is considered a delivery which could be a prevented, potentially a prevented cesarean delivery. In the first year, the way that the performance was measured is that those who were already operating at a low level, and we determined that low level as being at or below the statewide performance. And to be clear, no hospital was set at a performance rate of 14%. That was the statewide reach goal. CMS requires us to have a reach goal so that every hospital is considered to have to meet some sort of substantiated progress or improvement in order to earn a payment under these type of arrangements. That was the statewide reach goal. Hospitals already performing at or below that just had to maintain at or below that in the first year to earn the payment. If they were not at or below that, if they were above that, they had to just decrease by a minimum of 1% to earn the payment. That was they passed the year one in the initial year that is closed out and the payments have been distributed. In the second year, which we're currently reviewing the performance data on and tracking performance data around, they had to close a gap to goal performance rate. That means from where they ended in the first year to that 14%, they had improved by 10% of their gap to that target goal. How that translates, some of these hospitals had to make less than a half a percentage point improvement. Some of them had to a two percentage point improvements. It kind of fluctuated anywhere from less than half percent to three percent was their total improvement rate that they had to achieve. The way the funding is distributed. It's a single pool of funding. The hospitals earn a portion of that single pool based on how many total hospitals earn. That kind of slices the pie, right? What their total share of the population is. If half the hospitals earned, then all of the money is going out to half of the hospitals. The hospitals who had the higher rates of delivery are going to get a larger share of that half than hospitals who had the lower rates of deliveries. The timeline's broken down here. You'll see that in this second year that I'm speaking of we'll have the total performance calculated by the end of the calendar year. They'll receive their money actually in the first quarter of next calendar year. They've already received their payments for the first year. Thirty-five of the sixty-one eligible hospitals received a performance payment through this distribution.

Ms. Mane This is just probably nothing new from the last slide there. I'll skip on to the next payment arrangement.

Ms. Mane This is a different, same authority, the same federal authority for approval here under state-directed payment, different arrangement altogether. This is an incentive payment to promote completion of timely comprehensive postpartum visits. This payment arrangement is going out to primary care and specialty physician practices that provide perinatal care services, so inclusive of obstetrics, gynecologists, physicians, midwives, family practice physicians. It is a rate enhancement. We don't have a performance target on a metric set for them to achieve. Instead, we have defined service for them to complete, which is this postpartum visit as identified by specific service coding. If that service is completed, that provider will receive their usual typical reimbursement for that service, and they will receive an additional payment, a one-time additional payment. Regular reimbursement plus one-time additional payment point being to really incentivize and encourage an improvement and follow up to care and get more people in for timely postpartum care to improve our current performance, which at baseline was under 70%. We're trying to kick that over the 70% mark. We know this is a really critical time for addressing postpartum issues and maternal health issues. A really important capture time period for addressing maternal morbidity and mortality. I've gone through this, but it's detailing the amount that they are receiving. It's an additional \$208.00 via this payment mechanism. Via the billing, they are attesting to meeting all of the ACOG postpartum visit recommendations, including postpartum depression screening. This is where we're at. In the timeframe with this one, the implementation of this one followed the first one, the hospital-based one by a year. This has quarterly distributions on the funding as opposed to annual distributions on funding. We do not yet have the first results on this. We will be getting the first result calculated on this at the end of the Summer and then making the first distributions in November of this year. And from there, we'll be making quarterly distributions. That's our information in general to contact our policy unit for questions, but I'll stop sharing at this time. I can address any questions.

Dr. Boufford Thank you.

Dr. Boufford Let me just ask a question, then Ms. Soto will start. I wanted to ask you about, you talked about directed payments for postpartum, I understand that's a goal that has been sort of neglected historically, and that's really important. Has there been any change in the prenatal care reimbursement in primary care? Because one of the issues that I think that we talked about a good bit was... I mean, a lot of obviously the people moving out of OB is a problem, but just generally the early identification of individuals that might need more complex OBGYN referral by family doctors or others that are seeing them. I didn't know if there's been any change there. It may just be my ignorance of the fact that there has been, but just wanted to ask the question.

Ms. Mane It's another very obviously critical time for addressing maternal health quality as well as prevention of the maternal health morbidity and mortality indicators. We really wanted to focus on both ends of care. We have in terms of our data collection processes, so prior to issuing this payment arrangement, we put out Medicaid policy that directed payers and providers to start coding prenatal and postpartum visits differently. Part of what we have struggled with in our Medicaid managed care data and Medicaid data in general is there is a bundled payment on services. If there's continuous care by a single provider, the provider drops one claim after delivery, and that claim is for all prenatal care, the delivery and the initial postpartum visit. What we lose then in reviewing our claims and encounter data is what the volume and timeliness of that care was. We're saying when you drop a bundled claim, you also have to drop these zero dollar claims for prenatal and postpartum visit. Because if we didn't have a way, basically, to assess prenatal care or a timeliness of engagement in prenatal care because we're not getting a claim until the

delivery. We don't know what's happening and when. We couldn't use that information to drive payment. First, we're fixing our kind of data collection so we can better assess that. We've also issued the plans, letters to issue to their providers, reminding, directing them to make them immediately aware of the identification of pregnancy in practice.

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

Dr. Boufford Ms. Soto and then Ms. Farrell.

Ms. Soto I have two questions. The first one is to have a general perspective. Statewide, what percentage of prenatal care is provided by Medicaid? How many individuals are covered under this?

Ms. Mane Currently, we have around 100,000 deliveries in ballpark year over year. It's usually in the ballpark of about 100,00 deliveries annually that are covered by New York State Medicaid. In the last couple years, we, not the last couple, but a few years back, we saw that number decline a little. In the last couple of years, we've actually seen it increase a little bit over the 100,000 mark. That's deliveries. There's prenatal care that doesn't result in delivery. There's other care along the way, but in general we tend to use that number.

Ms. Soto But to compare to people who have private insurance is Medicare covering, for instance 65% of all deliveries in the state?

Ms. Mane I think it is a little over half. I don't know if I have data people on the line from the public health side who can speak to, again, currently what we're tracking to for total number of deliveries in the state.

Ms. Soto So at least half, and the other question that I'm thinking is what impact, if any, have the prenatal and postnatal standards have had on providers who are basically receiving private insurance? Is this something that's being adhered to, adopted by other individuals receiving payment other than Medicaid?

Ms. Mane The policies and payment arrangements that I just spoke to are solely for Medicaid and actually solely for Medicare managed care specifically. You know, they don't apply to private payers, the private payer lines on these insurance companies, how these payment arrangements are impacting outcomes versus the private payer. I don't have that information yet. It is a comparison we'll be doing once we have performance collected on this post-partum initiative.

Ms. Farrell The minimum number of 500 per hospital, how did you derive that minimum number? How many hospitals did you leave out as a result?

Ms. Mane Yeah, so if we were to capture every hospital in the state who had a Medicaid managed care delivery, it would be kind of over 100. We can't really base performance on hospitals who have under say 35. Statistically, we can't substantiate that. How we got to over 500 or 500 or more is that really wanted to capture/isolate the hospitals who are serving the vast majority of the Medicaid population. With that 500, we caught 85 percent of the total Medicaid deliveries in that year with those hospitals.

Ms. Farrell I'm in the suburbs. I'm not sure whether or not our hospital where we conduct our deliveries has 500 Medicaid deliveries. That being said, so often it's the culture in the

hospital and of the OBGYNs practicing there. Again, I applaud these incentive programs, because I'm quite sure they make a difference. You have to come up against that culture, right, ultimately. I'm just concerned that you might be out one or two standard deviations in terms of the number of Medicaid deliveries per hospital. In that 15% that you're not capturing, you still could benefit mothers who shouldn't be having preventive c-sections, right? I'm pointing that out.

Dr. Boufford Dr. Wilcox.

Dr. Wilcox Thank you.

Dr. Wilcox I know you said that the 14% NTSB percent was a reach goal. You mentioned stakeholders. I'm just curious as to what stakeholders you're referring to. I can tell you that when that number landed on many of the maternal health communities in which I participate, including some of your colleagues also at the Department of Health in New York State, as well as ACOG. Can you just let me know how the 14 percent, how you guys arrived at that number.

Ms. Mane Yes, I've spoken extensively to several individuals and stakeholders, partners, experts across the state who are unhappy with the 14% goal, well aware that there was discontent with that being too low. The number reflects a number that made sure that the calculation on performance, the individual hospital calculations could maximize an opportunity for improvement for as many of those hospitals who fell into the provider class as possible. I kind of hate how much the 14% is on that one slide. We've tried to take it out of most of our policy communications and things, because there was a misunderstanding, too, that that was a goal that we were asking the hospitals to reach where it is not, again, no individual hospital was told that their target is 14%. Those that were operating under were already under. They weren't told to get under 14% when they weren't already there. We submitted an extension request, a one-year additional request to CMS just because of the current environment. We don't necessarily anticipate that getting approved, but we did ask for an increase in that statewide target and that third-year submission in response to feedback. If you isolate managed care performance on this metric managed care for Medicaid managed care performance is less than the commercial and population wide rate on this target as well

Dr. Boufford Dr. Soffel.

Dr. Soffel Good morning. I'm sort of curious about why you decided that the hospital was the recipient of the incentive rather than the physicians and or the plans. Is there any sort of sense that the hospitals have to then pass some of that through to the doctors that are delivering in their hospitals that are achieving those goals? Is any thought to how plans might, in fact, also be aligned with this incentive in some way so that they are all, so that everybody's incentives are aligned?

Ms. Mane The second payment arrangement is for the physicians, the postpartum care one is for the physicians not the hospitals. The first one that's a hospital metric. It's a hospital-based care metric, the lower cesarean and TSV. It really is measuring the hospital's performance on that indicator. The plans are the ones issuing the payment. This money moves through the managed care plans and out to both, in both of the arrangements, the money moves to the managed-care plans and out either to the hospitals or the physicians.

Dr. Soffel But it seems to me that there's an opportunity, perhaps, to think about the role of the physicians and the role the plans in moving the dial on this metric. That's sort of what I'm thinking, is it's not simply a hospital decision. It is a hospital, but it is also the decision of the individual physicians, perhaps there's a way that plans could incentivize the doctors that they contract with to further encourage them to move in this direction.

Dr. Boufford Absolutely.

Dr. Boufford Any other questions?

Dr. Wilcox Thank you.

Dr. Wilcox Pivoting away from the NTSV goal, I wanted to ask about the expansion of reimbursement for non-invasive prenatal screening. Is that including both fetal and carrier screening for Mom? I do notice that there was also coverage for SMA carrier screening. The reason why I'm asking this is because we've looked at some of our reimbursement for ordering some of these tests. Carrier screening seems to more often than not get denied. Understanding that when the tests are run, they're normally run as groups of screens rather with an individual task. Why did you single out spinal muscular atrophy as just one that would be covered rather than kind of carrier screening as a whole like as a panel?

Ms. Mane The carrier screening should be covered. I'm looking right now, because you asked for the nips and the spinal muscular atrophy. These were both done in response to updated clinical recommendations.

Dr. Wilcox Right, so normally the carrier screening is done in groups, so 3, 14, 21, just multiple tests. It seems that reimbursement and charges are issued per individual test. It doesn't appear that when the test is run that it increases the cost if you have multiple ones, multiple screens on in a draw, right? It's one blood draw, you order the test, and then there's multiple screens done. There's carrier testing for multiple tests. The payment and charges are based on individual. It seemed to me like if you could figure out a way to reimburse based on the bundle rather than the individual test that might make sense. It's just food for thought.

Ms. Mane Yes, I feel like this one goes through lab policy. I'd have to look back and to understand why that wasn't the case. I hear you. This came up yesterday too with syphilis testing and the kind of bundled test for screening syphilis and HIV as well. I will bring this one back over that conversation too. If nothing else to understand why it's not like that, but to raise that it was brought up for this as well. Thank you.

Dr. Boufford If you could let us know, that would be great.

Dr. Boufford I wanted to ask one big question before you sign off. You mentioned quietly at the beginning of your presentation that you have all the pieces together, but they haven't really come together yet. There's a process. I wanted to ask you if you could be a little bit more specific about what the constraints are to connecting the dots, as they say, because that's always the key, right? I mean, you've got a lot of the pieces together, but unless you connect the dots it doesn't work.

Ms. Mane Yeah, I mean, I don't know, maybe you can all tell me. It's helped its delivery system design, right? What's the delivery system design that if we take the perinatal care standards, and you can say all these things are covered. Everything's done. In reality, we

know that's not true. Just because you can bill individually for twelve different things doesn't mean all of those services are being provided. It certainly doesn't they're being provided in a kind of coordinated, cohesive way. What is the delivery system design that really effectuates that? What is payment design that supports that delivery system? That's our nut to crack. We are working on a couple of different pathways to that right now. It's going to be like all things funding dependent. There are different pathways to that too. We can rearrange how we currently reimburse for some services. Does that still make sense? Is there a different way to design the bundle? Looking at different payment arrangements through managed care and seeing if there's a way to pull back here to feed over here? What new funding would be needed as well, such that the delivery system is kind of built to provide the care that's intended?

Dr. Boufford No, I think that's really helpful. I think just looking back on earlier conversations five, six, seven years ago, the problem was a lot of the gaps in payment. What you're saying now, a lot of those have been filled in. The piece isn't coming together as yet. I think that's a really, really helpful Thank you so much. Appreciate it. We hope we'll have you back as well if we take this up again. Super interesting and really nice presentation. Thank you.

Ms. Mane Thanks for having me.

Dr. Boufford May I ask the DOH Maternal Child Health folks that were on before they click off, maybe they could introduce themselves. Can we get the screen for the other people? Maybe they could introduce themselves, the folks that are part of the Maternal Child Health group within the department.

Dr. Boufford I stole ten minutes from you but I'm sure you can handle it in a half hour, or we'll go over a few minutes if we have to. We know and introduce your team and then we're eager to hear. We also have at your place, you also have her Power Point presentation on health workforce. Thank you.

Dr. Boufford Keshana, over to you.

Ms. Owens-Cody Thank you.

Ms. Owens-Cody Thank you for having us. We can start with introduction. I'm Keshana Owens-Cody. I'm the division Director for Public Health infrastructure. I'm going to put my slide up because it has all of our names on the front.

Ms. Owens-Cody Michelle, you're up to present yourself.

Ms. Stefanik Hi. I am Michelle Stefanik. I am the Assistant Director for Public Health Continuing Education. I will pass it over to Callie.

Ms. Messner Thanks so much.

Ms. Messner My name is Callie Reese Messner. I am an Academic Liaison for the Office of Public Health. I'm located within the Division of Public Health Infrastructure.

Dr. Bush Hi, everybody. I'm Dr. Katie Bush. I serve as the Director of Strategic Operations at the Center for Environmental Health. I'll pass it to Erin.

Ms. Knoerl Thanks, Katie.

Ms. Knoerl Hi, everyone. I'm Erin Knoerl. I'm Director of the New York City Public Health Corps Fellowship Program. Starting on Thursday though, I will be the Associate Director of the Division of Public Health Infrastructure. I'll pass it to Jillian.

Dr. Bumpus Thanks, Erin.

Dr. Bumpus My name is Jillian Bumpus. I'm the Workforce Manager under the Public Health Infrastructure Grant, part of the Core Management Team. I will pass it back to Keshana.

Dr. Boufford Keshana has definitely staffed up since the last time we had the coverage.

Ms. Owens-Cody We'll move right into slides. What we're hoping to present to you is an overview. Just again, I always like to level set on the PHI grant just because we've had other discussions. I will ground us there. I'm going to pass it over to Michelle who's going to give us an overview of workforce development and different activities that have been happening there. I know we've spent some time talking about recruitment into the public health workforce. We'll do a spotlight on that as well as round out with some of the federal transitions similar to I guess to elaborate or give a spotlight on one of our programs that has been impacted by the federal transition. Just to remind everyone, the Public Health Infrastructure Grant, we are in year three of the Public health Infrastructure Grant. We're actually right in the middle of year three. We're in our reporting cycle as we speak. A1 is this top box here or top bubble where we're focused on workforce and increasing the size and diversity of the public health workforce. We've hired over 120 staff at this point across the entire office of public health. A1 is one big focal area of our grant. A2 is where we have our foundational capabilities work where we are working on improving organizational systems and processes as well as strengthening public health foundational capabilities. A3 is where our data modernization activity takes place, and we have a dedicated team and data modernization director that is working through all of our data modernization activities through the department. For the past three years, I know I've shared this slide in the past, but this is what our day looks like within our team. These are our strategic partners. We work very closely with the Office of Health Equity and Human Rights. We work with Human Resources, Internal Operations, working with IT. We work strongly with our local health departments. NYSACHO is one of our partners as well. A lot of different other stakeholders like in terms of training and development and grants administration and different organizations across the country, not just in our state, that we have been working collaboratively with as it relates to workforce initiatives. Our LHD engagement, as you may remember, 40% of our funding is dedicated to our local health departments. We've built an infrastructure around our local health department engagement. To date, we've had six local health departments fig quarterly meetings where we work in partnership with NYSACHO. We also have released five local health department quarterly bulletins. We sent out a newsletter to keep, because as you may remember, we did have some challenges in terms of releasing some of our funding to local health apartments. We've really strengthened that infrastructure to give updates, to provide technical assistance through dedicated staff, phone calls, as well as office hours. Most frequently, again, expenditures for our local health departments continue to be furniture, hiring new staff, training costs, software, and conference attendance. As you'll see through this presentation, they are, local health department are focused on a lot of the same initiatives that we are, especially as it relates to professional development and recruitment.

Dr. Boufford Can I just ask one question now while you're in this section? You mentioned year three of a grant and obviously a lot of hiring, which question comes, are those salaries dependent on the grant or are they partially or completely or are going to be sort of built in or institutionalized going forward?

Ms. Owens-Cody Right now, all the positions are completely funded through the grant. However, we are starting to have our conversations around sustainability. We're kind of making that pivot to having those discussions on how we move these positions to be sustainable within the department.

Dr. Boufford And it is a three-year grant, right? Is it longer?

Ms. Owens-Cody We have until 2027.

Dr. Boufford Thank you.

Dr. Boufford Sorry for interrupting, but I wanted to get that out there.

Ms. Stefanik Thanks, Keshana.

Ms. Stefanik One of the things that we're looking at with workforce development, we have a couple of resources. This is very evidence-based. We have data from the Public Health Workforce Interest and Needs Survey that we looked at in order to get us started off with looking at the needs of training the staff within public health. We also had training consultations where we actually sat down with the different parts of public health and asked them, what do you need now? What are you going to need in six months or a year? What are your long-term needs? We could really look at what those needs were across the department and see where similarities lie and where there might be differences. We actually found a lot of similarities across the department. You can see some of those things in the graph that we have below. There is a large need that was identified both through PHWINS and through the training consultations for leadership and management training. And then the second largest one, it has to do with technical skills. How do I use teams? How do I organize files? Those kinds of things. Lastly, the other large ones are some DOH or OPH topics specifically about what is DOH? How does it work? Because we have a lot of new staff and then other soft skills that we came across in that. When we look at offering trainings, we're looking at sustainability. We're partnering with other groups. Keshana had mentioned the Human Resources Management Group. We've partnered with Health Research Inc also to look at some of the trainings that they have that are available and how we can make them more available to the staff in a different way. We've started working with them to schedule specific trainings where people can come in and offer them live and in person. This seems to be a big demand right now is I want to attend a training in person. I want that face-to-face opportunity. I want a chance to ask questions and answer questions and maybe even participate in some workshopping parts of a training. They've been working with us on that. Lastly, our learning management system is being... We're looking at implementing a brand new one. We've been heavily on researching what's the best LMS for us? How are we going to replace a legacy system that we've had for the last eighteen years that meets the needs? That particular system meets the needs of the entire state health department. It's not just used by OPH. This is a large project that we're working on. In particular, if you can remember from the last slide, leadership and management was the largest request for training that we got through a variety of different resources. NYSACHO found the same thing through their enumeration survey. Some of the trainings that you can see here in particular were requested multiple times by different

agencies across the Office of Public Health. I am a new supervisor. I was promoted because I'm great at my job, but I don't really have any training on how to manage people. What do I do next? One of the big trainings that was requested was on change management and talking about managing change. We've spoken about it throughout this meeting today, right? Public health constantly has new things coming up. Grants change. The target changes. Maybe you realize that one population you are serving needs to be flexed a little bit. How do you introduce this information to your staff? How do you make sure that it's presented in a positive light and bring everybody on so that you can implement that change in the most effective way possible? I'm new to leadership, not just supervising people, but being a leader. What does that mean in terms of training? And then the last big one is communication. Communication skills and public health are key, right? We're doing it right now. What do I put into a Power Point? What do I put into presentation when I want to talk to the public about something and I want to convey scientific information to them? We're actually partnering with the University at Albany, who is presenting a speaker series starting next month on this exact topic. These are just a few of the areas, but you can see some of the other ones here that come up. Project management, we've had trainings on de-escalation, talking about systems thinking. Lastly, one of the big partnerships that we've recently is within the department with the Center for Environmental Health, where they have helped us to take this even a step further and have been conducting a community of practice on a specific leadership and management training where an entire bureau has been dedicated to this for the last six months. That's thanks to Katie and her team. I'm going to leave you there. I'm going to turn it over to the next person.

Ms. Owens-Cody I apologize, we went a little out of order because Michelle has another presentation to get to.

Ms. Stefanik Sorry.

Ms. Owens-Cody In terms of recruitment, there's a lot of recruitment initiatives that are taking place within the department and within the grant. We have a strategic planning work group that myself, Kendall, the Director of Public Health Continuing Education and Dr. Jillian Bumpus, who you'll hear from shortly, we manage that strategic planning activity, but then also our engagement with Human Resources is imperative with this grant that we have. I just wanted to show you, like, because this is some of the internal work that now you'll see reflective through the next presentations of now how in terms of how this hiring process kind of diving into like our onboarding. I'm pretty sure many of us in the room have done similar activities of looking at how are we filling different positions, where are we posting different positions and recognizing that a lot of the hiring process is owned by program managers, hiring managers, not so much human resources. We've done a lot of work in terms of breaking down the recruitment cycle. We've increased different opportunities to post and engage with the public on ways to, just to raise awareness of careers in public health. I thought that this was important to show kind of the internal workings of like how we've really broken-down recruitment cycles, both for Health Research Inc, as well as HRMG. We hope to be able to share our story with local health departments. We do work, as I shared before with NYSACHO quite a bit, and we've been sharing this information with them as well. We've also attended their conference that they have for public health directors. We plan to continue that in the Fall. I'm going to pass this to Callie so she can share kind of how that recruitment cycle all that internal work has cascaded over into the community as well.

Ms. Messner Yes, thank you so much, Keshana.

Ms. Messner I'm really excited to share some of our strategies related to academic engagement. The first I'd like to discuss is increased presence at college career fairs in partnership with the New York State Department of Health's Human Resources team, Health Research Incorporated's Human resources team, civil service, and interested OPH units like the Center for Environmental Health, which you will hear from in just a moment. Collaboration has really been key. We've been able to collaborate with Human Resources on the New York State and HRI side to share their promotional materials and coordinate on events. The Department of Civil Service is another partner. They have regional staff who promote positions at all New York State agencies. They've been providing information about public health careers as well as making referrals by email. If they encounter a student who's interested in public health career, they usually introduce them to me, and I follow up. During all of our activities, we maintain a strong focus on our values when communicating our career opportunities in an effort to attract a mission-driven workforce. We've really been expanding the diversity of the institutions that we work with. For example, this Spring, we attended career fairs at SUNY Purchase, a public liberal arts college, Bryant and Stratton College, a small private college, and the Columbia Mailman School of Public Health, all within a couple weeks' time. We've seen a lot of success in that realm. With this diversity in mind, we have established the Pathways to Public Health Internship Program within the Office of Public Health and Regional Offices to expand opportunities for students from diverse educational backgrounds. This program is unique because it provides support to interns as they acclimate to the professional environment and provide support to intern supervisors as they become leaders in the public health field. Next, I'll talk a little bit about our expanded distribution list of college, workforce, and high school contacts, resulting in a higher number of applicants for our opportunities that are promoted by email. This was compiled from lists that existed within OPH units, and we've added to it through networking and research. It has grown to about 700 individuals. We continue to add to that. It includes college faculty, career centers, professional organizational contacts, CTE and BOCES program staffs, regional Department of Labor representatives and many others who are able to spread the word about our amazing career opportunities. Some of our Pathways to Public Health Internship Program opportunities from this Summer received about 200 applicants after being promoted through this listserv. It's been pretty successful. While increasing our efforts in the realm of academic engagement, we realized that we don't have one cohesive resource that really represents the depth and breadth of opportunities in the public health career field. We have decided to redesign the Public Health Works website to promote public health careers and grant related activities. We anticipate that being relaunched very soon. Please be on the lookout for that. We've also been providing public health career classroom presentations in person and virtually to college and high school students. We have an upcoming academic engagement webinar series. The kickoff event will be in August, which has been designed for professionals who work with students to educate those individuals about public health, career pathways, and partnership opportunities with the Department of Health. The subsequent webinar series will be for students and focus on educational paths that align with different disciplines and how they can join the public health field. Lastly, we've recently increased our efforts to connect with K-12 students. We have brought on an intern this Summer to help organize the resources available to educators and potentially create a lesson plan or a toolkit to promote amongst our partners.

Ms. Messner Now, I will turn it back to Keshana.

Ms. Messner Keshana, you're muted if you're talking.

Ms. Owens-Cody Sorry. I'm going to turn this to Katie to talk about, because I know that oftentimes we've talked about how maybe not easy, but it's like those positions that we did hire across the department. They may not have been as challenging, but we have had some positions that have had challenges. I wanted to give Katie an opportunity to talk a little bit more about some of the work that they've done in CEH.

Dr. Bumpus Great, thanks so much, Keshana.

Dr. Bumpus Before I get started, I just want to note that I joined the department about two years ago as Keshana was sort of building her team. While I sit in the Center for Environmental Health as part of the executive team there, I feel very much a part of this FIG team. Two of my staff, we've been able to build out our strategic operations unit here within CEH, leveraging the FIG resources. I very much feel part of his family and committed to this work, but within the Center For Environmental Health.

Dr. Bumpus You can go to the next slide and I'll just first kind of level set. Big picture first, kind of what is environmental health and our key functions. When I talk a little bit about the roles, you have that context. I'm sure everyone understands the role of environmental health within public health as a field focused on reducing exposure to environmental contaminants and eliminating hazards. We really work across the center to promote healthy places and healthy communities. At the heart of this work are our public health inspectors, sanitarians, and public specialists that work to enforce our environmental health regulations and the state sanitary code. These roles exist across the state at our local health departments as well as our district offices and support and oversight are provided here within CEH in our division of Environmental Health Protection. They're really the front line of environmental health in our communities. They're the ones conducting inspections at hotels, campgrounds, food service establishments, pools, beaches, children's camp, and also overseeing the safety of our public water supplies. They work diligently to reduce health risks and protect people really where they live, learn, work, and play in all of the places. Surprisingly, perhaps not surprisingly, these can be very difficult positions to recruit and retain. We've had sort of a targeted effort on recruiting for these positions and getting to work with people like Callie and Keshana's team on some focus targeted outreach efforts. Those have included attending a number of career fairs us to really talk about the work that we do and try to promote those positions, developing some targeted outreach materials and also engaging with academic partners.

Dr. Bumpus You can go to the next slide.

Dr. Bumpus CEH staff, in collaboration with some of our district offices, have attended nine career fairs over the last handful of months. We really were focused on promoting our Summer seasonal positions. There's a huge workload that CEH takes on across the state and our local health departments take on each Summer with the numbers of beaches and camps and temporary food establishments with all of the different fairs and everything happening over the Summer all across the states. There's a huge workload in the Summer. Our district offices and local health departments are hiring these roles in temporary positions each Summer. Each Summer it's a challenge to sort of re-recruit and refill those positions. We've really had a targeted effort to try to recruit for those. We were happy to see the number of people sort of making it through the interview recruitment process here. You can see in the table our public health inspectors, student associates and office assistance are all of these roles that we're filling each Summer. We're happy to see sort of the number of candidates being approved to interview, the number new hiring

packages moving through, and also rehires, because it is great to retain those staff year over year when we can.

Dr. Bumpus That's just a picture of one of our staff attending the Mohawk Valley Community College STEM Career Fair. We've been able to go to maybe some of the more STEM or science targeted events since these positions do require, I think, a core six scientific credits at least.

Dr. Bumpus Next slide, please.

Dr. Bumpus I think we all can appreciate sort of a tailored outreach materials and trying to really reach our target audience. We've spent some time to try to tailor our materials for these events to really speak to these Summer difficult to fill but so core and fundamental to environmental health those positions. We see a flyer we've created for our student assistant positions as well as our public health inspectors with quick easy access to the actual job postings that come out each February or March where we try to fill by May or June, and really trying to leverage, I think, just the experience as a real-world experience and maybe a steppingstone into a public health career.

Dr. Bumpus Next slide.

Dr. Bumpus A key part of this, which really aligns with the work that Callie was speaking to, is our building on relationships with different academic partners. We've been connecting with, again, partners across the state, but really focused at here in Albany, Binghamton, Syracuse, and CUNY for no particular reason, except these are people that we've sort of come into contact with who maybe have environmental health, occupational health programs. It's really sort of relevant partnership there. What we've been trying to do is align these seasonal position accountabilities with the requirements of their internships and practicum core competencies, really to reduce the barrier on both sides so that staff would be willing to take these students on who are competent and looking for work to do the work and do the jobs of these public health inspectors, but then also to meet the needs of the academic programs and the needs of students to sort of check the box for the academic programs. We're really trying to make it as easy as possible to take these students on as interns, but simultaneously fill the role of these public health inspectors. Things like creating templates, example project proposals, anything we can sort of do here to streamline the process for taking on these students, ensuring that the program requirements can be met, but also obviously fulfill the needs of those positions. We're doing a lot to build these partnerships now with the goal of really reducing barriers for next Summer season.

Dr. Bumpus You can go to the next slide.

Dr. Bumpus Sort of the crosswalk across our job accountabilities and some of those internship core competencies. I think doing this leg work ahead of time, having these templates ready to go will hopefully reduce barriers for our staff whose plates are already filled. Sometimes the idea of taking on students or taking on interns, you know, the cost benefit may not always be in their favor. We're hoping by making it as easy as possible for these students to step into this role that more staff will be willing to do that, and that we'll be able to continuously fill these high-need positions. That's all I have. Thank you.

Ms. Knoerl Next slide.

Ms. Knoerl The fellowship program kicked off its second cohort in August of 2024. It's currently supported through two federal grants or federal cooperative agreements from the Centers for Disease Control and Prevention. One of those funding streams was included in the list of grants that were terminated on March 24th by the U.S. Department of Health and Human Services, or HHS. Immediately following that letter of termination, the department took several days to review all options for any of the impacted programs, which included the fellowship program. Because the fellowship program is a Governor's initiative, the plan of how to proceed had to be approved by the Governor's Office. On April 2nd, all program participants and our partners were notified that the fellowship program would be ending for all fellows on May 30th and all programmatic staff on June 30th. This is in place of they were supposed to end on July 31st, 2026, so next year. Because we had a secondary funding stream, there was enough money to keep those fellows on for an extra month or two. As Joanne spoke about, New York and twenty-two other states filed a case against HHS in the US District Court for the District of Rhode Island. On May 16th, that preliminary injunction was granted. Because of that, we were able to send an updated letter to all fellows and partners on May 21st stating that the layoff of fellows has been postponed and that they could remain employed at least to the length of the preliminary injunction. So understandably, because of all of this, we've seen a drop in the number of fellows really over these last two months. What I can say is when we look at where they're now placed, they were looking for more stable funding stream or job opportunity, 71 percent of our fellows are now working in public health or health care sector post-fellowship, which is pretty encouraging. Then lastly, I will say, I think one of the big lessons we've learned about this is that we have to diversify our funding source. Because we are a Governor's initiative, we do think a state investment is needed and we do plan to be looking at alternative funding sources, including the state over these next few months.

Ms. Knoerl I'll turn it over to Jillian.

Dr. Bumpus Thanks, Erin.

Dr. Bumpus As you can tell, losing a whole program was with 180 fellows across the state was really hard. It was hard for the fellows. It was for the program staff. Ultimately, it was hard, for every staff member that interacted with each of those program staff and the fellows. Luckily, the PHI grant has baked in a ton of work on organizational wellness and employee wellness initiatives. It made sense that we were able to deploy in a very responsive way some of the initiatives that we are already working on to improve organizational employee wellness for OPH through the PHI grant. We were able respond to this federal transition for the fellowship program. Erin and I worked together. We offered pretty immediate, I want to say, the following week after we were alerted of the end date. We deployed a resume writing workshop with the fellows so that they could get their resume up and going and deployable for their job search. We also immediately put together, so I was able to facilitate and moderate an interviewing skills panel discussion with some really just amazing community partners that, again, responded in a short amount of time learning about the fellowship program and wanting to be a part of it. These community partners were from across the state, which was really critical because they were potential hiring managers, both in public health and in non-public health to get those fellows to their next job opportunity. I want to actually say, too, these community partners also responded with connecting with these fellows outside of this panel discussion and just offering services to help them with their job search, just as a community member. That was really inspiring. The other thing that we had done, and we had actually done this early on was we have a public health, specific public health employee mental health consultant. She specializes in working with public health employees on trauma-informed care as an

employee of public health and navigating the tough and sometimes critical world of working in public health. She was able to deploy some really critical role-playing initiatives with the fellows to help address some of the emotional rollercoaster that they were about to bark on during this transition. It couldn't have been timelier. We were very fortunate that we were able to be responsive to our fellowship program. I really want to emphasize that this work is really off the coattails of almost two years of organizational wellness work. I will kind of end Keshana with this for the team here. One of the huge initiatives that came out of this was that can come out of our work with the PHI grant and supporting our fellowship program, but supporting all the public health employees is a public health employee led organizational wellness magazine. It's really an elevated experience from what we already have at the state, from EAP to OER to all the resources that our HR departments offer. This is employee led. They're shared stories from public health employees, really based and founded in the U.S. Surgeon General's five essentials of worksite wellness and the holistic employee model. We're just taking a lot of the grounded evidence of what makes an organization healthy, what helps employees be healthy at work, and we're putting it in a magazine and employees are sharing their personal stories that really just help them stay in this space as healthy and as well as they possibly can. We have this idea in the FIG grant that we want to whatever we're putting out into our communities to help New Yorkers stay happy and healthy. We should also be reciprocating that back into our employees as well. We're hoping this magazine throughout the life of the grant will be able to have that conversation. We're looking at sustainability practices for all of this work past the grant as well.

Ms. Owens-Cody Thank you for the opportunity to be able to share updates on the Public Health Infrastructure Grant, I would say on the workforce side, and open to any questions that you may have. I know we're right at time.

Dr. Boufford Thanks very much. This is really great. I'm very impressed with your team and everybody's presentations and you're dealing with really Important issues.

Dr. Boufford Let's have a couple questions here. Ms. Soto, and I'm going to ask Dr. Watkins as our local health director here to comment.

Ms. Soto Yes, I really appreciate this presentation. My question is more directed to Dr. Bush. In your presentation and one of your slides is the recruitment spotlight, the academic partners. Have you been reaching out to the New York State Department of Education, in particular, the science technology entry program step and the collegiate science entry program which focus on STEM careers? They just completed their grant cycle. Between STEP and CSTEP, there are over 100 programs. I'm sure that, in particular, the students and the colleges, they would love this information about Summer internship programs. This is like collaborating within the state with the Department of Education rather than individual. Academic institutions that you listed in that slide. Have you worked with or reached out to the Department of Education?

Dr. Bush No, I haven't. Thank you for that. It's really been sort of an opportunistic sort of grassroots based on relationships that the center currently has. I would invite Callie to maybe speak to whether or not she's been engaging since she's sort of serving as a higher-level academic liaison, if those are people in programs that you're aware of, Callie.

Ms. Messner I think that it would be a great idea to connect with them. I haven't done that yet. I have made a note, and it will be on my list for this coming week.

Dr. Watkins I want to thank all of you for your presentation and outstanding job. I can't say enough about the Public Health Infrastructure Grant itself. I know that it took a while to get the program off the ground, but once it happened, I think, or I believe most, or overall, most local health departments were pretty impressed with the program itself. That is due to the partnership with NYSACHO, which was very instrumental for making that connection really happen. I do think, sitting in my shoes, though, as a Public Health Director, that approvals for some of the things that we're asking for, it was very daunting at first. It still takes a little while in order to get those approvals through. I think we could get just a little bit of improvement on that process. Overall, I think it's thumbs up for the program itself. I am very sorry to hear about the fellowship program. We were really devastated most local health departments about the Fellowship Program that you've talked about, although it has been a program through the first cohort that really worked very, very well. The second cohort was devastated when we learned that there were cuts from our federal funding source for that program. It really sorts of took a lot of punch out of the program altogether. As you indicated, fellows sought other employment. We're glad to see that a lot that employment occurred within the local health departments. Local health departments still have an infrastructure problem though. We still need to continue that recruitment process in order to build up these localities that we have. We know that. A lot of new things are beginning to happen with all these federal cuts. Until we get that infrastructure built up for public health programs, we are going to find ourselves in the same spot we did when the pandemic hit us. Overall, I think the infrastructure program has just been outstanding.

Dr. Boufford Mr. Perry?

Mr. Perry Thank you.

Mr. Perry Thank you for a great presentation as well. You mentioned your work with recruiting from and expanding your base of diverse outreach sources. Can you discuss your specific outreach to underrepresented communities and the percentage of employees from those communities that are a part of the workforce, including people of color, those with disabilities, and other underrepresented community as well?

Ms. Owens-Cody I want to pull up my slide in terms of diversity. What we did was we looked at where our current HR teams are placing their job postings. Through our strategic planning work group, we also presented that information to our strategic planning teams. We looked at where we're even posting our, like who are our community partners that we may be in subcontract with that are addressing health disparities and tried to identify, ask them, and request information from them on where to post positions. As Callie mentioned, she's been at different academic, different career fairs and things like that. We also were strategic in looking at reaching HVCUs. We actually went to the HVCU Career Fair last year. At APHA, we also attended American Public Health Association, their conference. We were very diverse. This even goes to the comment earlier from the local health departments, we did also our table included NYSACHO. It included our New York State Public Health Association as well as us in HRI and HRMG. We showed fully New York State opportunities to be able to come in to work into public health. The teams that are managing community engagement and subcontracting with community-based organizations we're also going through that avenue to build our recruitment infrastructure as well. I'm asking those organizations like where do you see postings? Where would you like to see postings? In some of our features with HR, we can actually direct and say, we would like our positions posted there. We're watching. A lot of us, when we get our applications in, and our pulls are much higher these days. Like Callie mentioned, she had 100 people apply for just one internship. We can see the data of where folks are applying

from. We're leveraging that too. That was a good place to post our positions or those were good events to attend. I can get back to you with our data, but I will say one of our posts for our targeted evaluation was to be more reflective of New York State. I know that we have hit that benchmark, but I can give you that data so that you can see that. It's definitely something we're monitoring.

Mr. Perry Thank you very much.

Dr. Boufford I think that would be good in a future presentation, because we'll have you back regularly.

Dr. Boufford Last question, Dr. Eisenstein.

Dr. Eisenstein Hi. Thank you for the presentation. Sometimes timing is everything. I just want to share with you, I have an 18-year-old daughter who was just looking for a Summer job and just finished her first year at Colgate University. She's a bright kid. Having been the Commissioner of Health in Nassau, I was aware of these seasonal jobs. I didn't want her to be at the department where I had been the Commissioner. I've got to be honest. We looked and looked and could not find the state health jobs. The kids have the websites that they go to, their standard job search websites that they look at, and we looked at all of them. Finally, I said to her, and I wanted her to do a lot of it herself. I said, call. When she called the department, she was told, oh, call civil service. Kids don't even know what civil service is. People graduate with MPHs don't know what civil services is. I'm just giving you the feedback that I know those jobs are there, but me with my twenty years of experience in public health couldn't help my own kid find them. We know on Long Island of every camp that's hiring, the town lifeguard jobs are posted on every streetlamp there is. But from the state for these kinds of jobs, which I would love, and I don't think my daughter's looking for a career in public health, but for the summer she would have been great for you guys. She's got a whole bunch of friends that are the same. I'm just saying that whatever. I get the fairs. I get that you're going to academic partners. I think that's great. There are a lot of really bright kids who don't even know these jobs exist and maybe finding them through the more common ways that kids look for Summer jobs would be helpful. That's just my own experience with this.

Ms. Messner I appreciate you sharing that, and I actually had a presentation for Colgate students in February this year. I'm glad that I had some representation at your daughter's institution. I would encourage students to always reach out to the Career Center. Please feel free to share my information. We have a list served. We love connecting with students and sharing opportunities, whether they're majoring in public health or business or education or anything, really. We know that we often can find a place for them here.

Dr. Eisenstein Callie, if I could just say, February in Colgate is very hard to be thinking about Summer on Long Island.

Dr. Boufford I was wondering about LinkedIn and handshake and some of the usual ones everybody uses.

Ms. Davis I just want to say thank you to our public health infrastructure team. You've done a great job today, and you continue to do a great with all of the activities that you have. I just wanted to also say that under my leadership, I mentioned health equity earlier, inclusivity is another goal of mine, and that has been stressed to all the leadership that I oversee in the health department.

Dr. Boufford I just want to take the right of the chair here to make two comments on the academic link, especially, I've been lobbying this. I'm going to raise it each time. I think the DRPH degree is neglected by the organized public health establishment. There are no financial supports for DRPH students across the country basically, unless the university manages to get some kind of a scholarship. I raised the question about there are fellowship and scholarship programs, workforce programs in state legislation that are kind of generic. In the past, business school students have been eligible for fellowships and scholarships when public health students were not, or public administrations were not. I wanted to ask your ledge affairs people maybe to take a look at that more generic language, not specific to programs supported, but just to the degree the state provides scholarships and fellowships for other people. I can talk to others about that again. The other really important issue, and I think it's a real challenge as well. Sitting in a School of Public Health at NYU, the entire environmental health activity within schools of public health is really undergoing major shift from traditional occupational health and safety and toxics to climate change, basically, and looking at broader environmental challenges. There's a lot of work going on there. People trying to figure out what is this? What does it need to look like? It's a huge shift. I think it may affect some of your thinking about people having to graduate with an MPH in Environmental Health to be eligible for some of these other more classic roles, sanitarian roles, inspection roles, and others are made to be another fix for that. Because I think the curricula are moving not away from it, but just putting it in a niche within a broader concern around environmental health training for at least the master's in public health students for sure. It's a really interesting area to pursue, may it reflect some of the difficulties. You were well represented at NYU. I blagged on you the last time we had our meeting. There was a long line looking for jobs, so I appreciate that.

Dr. Boufford Any other final comments for the good of the order here?

Ms. Soto What about the statement we received?

Dr. Boufford I mentioned it early on. I do want people to look at it. It was referred to a couple of times. This is the, starting with Part M, this is the budget language on community benefit that was approved by the legislature in the Governor's budget. This is a challenge for us, and I think for this committee, we identified community benefit as an area you wanted to attend to. Now, this opportunity has opened up to really think about what would that statutory language look like? As Dr. Yang said earlier, how might it help shape a more targeted investment in public health resources that this hospital's already spending or indicating their reporting spending into some of the more evidence-based areas or some of them more targeted areas that the prevention agenda has imagined. I'm glad you brought it up. It's always good to end with the important one as well.

Dr. Boufford Well, thank you very much. We'll be in touch around whether there may be another Public Health Committee meeting this Summer, depending on what we hear about the prevention agenda, but until then have a good Summer. We'll see you in September if we don't see you sooner. Thank you.