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PUBLIC HEALTH COMMITTEE
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TRANSCRIPT

Dr. Boufford I'll call this meeting of the Public Health Committee to order. I'm Jo Boufford, Chair of the Public Health Committee. I'm very happy to convene us and welcome all our members and participants and observers. I want to go through the webcasting protocol, just reminding everyone that this meeting is subject to the Open Meeting Law and is being broadcast over the internet, can be accessed at the Department of Health's website. On-Demand webcast will be available no later than seven days after the meeting for up to thirty days and then a copy will be retained for four months. We'd like to remind everyone because there is synchronized captioning it's important that people not talk over each other. The first time you speak, if you could give us your name and your relationship to this meeting, whether you're a council member or a guest or otherwise. They are hot mics. Side conversations are discouraged. I think we are the only open site here in New York City, I'm advised by Colleen. We have no one in our audience. I will make a call for public comment. We don't have anybody here. I don't have to give them the caveat of signing up.

Dr. Boufford Let me just make a few opening remarks and then an overview of today's meeting of the Public Health Committee. We've been having meetings really during the Summer and the early Fall. Our last meeting of the Public Health Committee was the end of August. We also met previously in June. We've had a couple of meetings of the Ad Hoc Committee to advise on the prevention agenda. The goal of those meetings has really been to review obviously interrupted by COVID, but to review the leaders using their prevention agenda. In July, we had a panel with Commissioner from Office of Mental Health, representatives from Oasis and also Greg Olsen from NYSOFA, talking about their experience with the prevention agenda, their own activities in their respective departments, promoting prevention in their particular areas. We also talked a bit about the collaborations among those departments, both at the state level and then at the community level in terms of their various area offices on aging and local offices that are funded through each of those agencies. We then had an analysis Shane Roberts and Zahra Alaali gave us an overview of some work they've been doing to look at what the other states are doing in terms of their state health improvement plans. I think it was useful to hear some of the categories, some of the ways they're thinking about it. It was pretty consistent with, I think, the goal of the department as we look at the next version of or phase of the prevention agenda. A lot of agreement on wanting to bring in broader determinants of health. The need to look at that and what that means relative to inter-agency collaboration, since a lot of other agencies are the ones that lead on those other determinants. In September, we had a presentation by Isaac Michaels on Community Benefit, followed by a panel of the local; Sarah Ravenhall is Executive Director of NYSACHO, Lloyd Bishop from Greater New York and Kristen Phillips from HANYS and Teresa Green, also from HANYS, also talking about their experience with the prevention agenda over the last cycle and their recommendations for improvements going forward and then Paul Beyer from the New York State Department of State, who's been really very important, I think, in supporting in past years, at least technical assistance to some of the local health directors on Age Friendly, as well as the Health in All Policies work. I think the takeaways were that people have certainly found the current model of the prevention agenda really helpful as a heuristic device, if you will, sort of like Healthy People 2010, 2020, 2030. People kind of

know about it. They're familiar with it. It can be a kind of organizing conversation. We also realized that it's going to be important that obviously the objective, the data on the dashboard and other things have really not been updated since before COVID. We're also expecting the state health status plan fairly soon and hoping Dr. Bauer can give us a sense of that. Because that was kind of the basis on which the current prevention agenda was designed. Is really knowing what the major causes of preventable morbidity and mortality in the state are and how might we begin to address those. All of that background is sort of in response to the Public Health Committee's role on behalf of the PHHPC, of, if you will, overseeing the prevention agenda, the development of the prevention agenda. The other thing we've done as a committee for the last several years is picked a particular issue of importance that we wanted to focus on. Just sort of thing that we could do a deeper dive in working with staff in that area. Today we will get an update from our colleagues at the maternal mortality at the Family Health Division talking, giving us a second update. We had one in our earlier meeting over the Summer on progress on maternal mortality in the state of New York and other related issues. In our last meeting of the Public Health Committee, we decided that the issue we wanted to focus on going forward this year is the public health workforce. We have a presentation today by Keshana Owens-Cody, who's the new Workforce Director for the Office of Public Health Practice. We look forward to hearing from her. She and I had a really good talk a few days ago for this meeting. We told her that when we engage on an issue it's not a one off presentation. It's an ongoing collaboration. She was very keen. We want to figure out how we can use our sort of public bully pulpit to address issues in public health workforce, which we know is a huge issue, obviously, along with the health care workforce, which is also getting attention. The final discussion today, Salman Khan is going to be giving us an update on his on the prevention agenda, sort of the data that they've begun. We had a sort of preliminary update. What data has been coming in and what it looks like at this point in time before we end. Anyway, I think that gives you a good reason for the overview. Dr. Rugge, we were expecting. He has not arrived. If he arrives, we'll let him say hello, because this is a joint meeting of Public Health and Planning.

Dr. Boufford I'll pass it over to you, Dr. Bauer, for your opening remarks and welcome.

Dr. Bauer Thanks so much, Dr. Boufford.

Dr. Bauer Thanks to the Public Health Committee members for joining us today and our DOH colleagues. I'm very excited in today's meeting to showcase our Office of Public Health Staff. Dr. Boufford, you ran through our agenda of speakers. I'm particularly pleased to launch the discussion of the public health workforce. I'm very appreciative of the Public Health Committee and PHHPC for choosing this as an important area of focus for the committee and an area that will benefit from the committee's attention as we strive to highlight the issue and really grow our public health workforce. Dr. Boufford, as you noted, Keshana Owens-Cody is our Workforce Director for the Office of Public Health. She is also in that role overseeing the entire CDC Public Health Infrastructure Grant. As this committee knows well and we've described before, we received last year, just at the end of the year, $137,000,000 roughly grant from CDC to focus on the public health workforce, our public health foundational capabilities and our data modernization efforts. Keshana will really relay how workforce is critical across all of those areas. It's really the workforce that allows us to do our work and to make progress in advancing each of those areas. We're looking forward to that conversation. I'm similarly grateful to have Salman Khan with us today. Thank you for providing the prevention agenda update. We are proceeding apace with our State Health Assessment, and we do look forward to presenting that to the Public Health Committee in advance of I think we have a presentation scheduled with the Ad Hoc

Committee in February of next year. We will absolutely be presenting to the Public Health Committee in advance of that. We'll hear more about our prevention agenda progress from Salman. And then, of course, the committee is very familiar with Kirsten Siegenthaler and Dr. Marilyn Kacica, who are joining us to provide an update on maternal mortality and another area of great interest to the committee. Welcome everyone. Glad to be here this afternoon and looking forward to the presentations and discussion.

Dr. Boufford Thanks very much.

Dr. Boufford Again, we'll come back sort of at the end of this meeting to kind of get a time frame relative to the needs assessment report, the convening of this committee versus the Ad Hoc Committee, and then the sort of timetable for the development of the successor of the next version of the prevention agenda.

Dr. Boufford Without further ado, Keshana Owens-Cody, you're on. You have the mic.

Ms. Owens-Cody Great. Thank you for inviting me to this committee meeting today. I'm to tell you a little bit more about the Public Health Infrastructure Grant.

Ms. Owens-Cody I'll share my slides.

Ms. Owens-Cody Can everybody see my slides okay?

Ms. Owens-Cody Great.

Ms. Owens-Cody What I plan to do is provide at least an overview of the grant just to level set us back to on the PHI grant, talk a little bit about the implementation team that will be driving the grant forward, provide you all with updates as to where we are as well as our program evaluation. A little bit about me, I'm new to this role. I started this role in April. I'm not completely new to the department. Before coming into this position, I also worked on the COVID Health Disparities Grant with Kirsten, who will be presenting a little bit later and help to roll out COVID health literacy funding opportunities in rest of state. Prior to coming to the department, I teach Community and Public Health at a local community college. I've been there for the past six years. I've also worked with community-based organizations that were working with our district initiatives in terms of value-based payment, as well as just understanding their connection to a lot of the district initiatives that happened previously. I also have experience working with our local county health departments as it relates to the prevention agenda. I was on the ground at one point in my career where we helped two local health departments that I was assigned to, to work on a priority setting with the community health improvement plans and helping to evaluate and document all of the different interventions and things that were taking place as related to the community health improvement period. I'm excited to be in this role and be able to really help to reinvest and re-empower and demonstrate value of the public health workforce. As Dr. Bauer already hinted that we have received, and as the CDC calls it, a groundbreaking grant as it relates to investing in our public health infrastructure. There are three pillars of the grant. This is also how kind of our funding also has come in as release of the grant as well. A1 really focuses on our workforce in terms of recruitment and retaining our workforce and also providing different training and development opportunities. A2 focuses on public health foundational capabilities. That can be looked at as looking at how we are processes are in place as it relates to... It could be related to recruitment. It can be related to the way that our organizational competencies, workforce development. We also have data modernization. We have a big data modernization project

connected to this grant as well. Ultimately, all of our activities that will be driven through this grant are really centered on preparing us for our next public health threat, but also advancing health equity in reducing health disparities.

Ms. Owens-Cody This picture that I shared with you is what the CDC has put out in terms of the grant. I at least wanted to give to a deeper dive into what it looks like here in New York State. For A1 activities we're looking to hire eighty plus staff across the Office of Public Health. One of the key components of the grant was to hire the Workforce Director, as well as Data Modernization Director, which is underway. We're going to be establishing three new units through the Office of Public Health that will help with strengthening our community engagement efforts, our training and development, our public health of subject matter training and development, as well as looking for innovative approaches to holistically meet New Yorkers where they are. I'll talk a little bit more about this in my presentation shortly, but we also a part of this grant, also 40% of the funding did go to our local health departments. We're also going to be providing technical assistance to our local health departments as well. As it relates to A2, this is what it looks like as well is really focused on strengthening our recruitment to attract and retain qualified diverse talent. We're going to be offering different training and development opportunities for both OPH staff as well as local health departments, looking at our data reporting systems, continuing to strengthen our community partnerships and also leverage some of the lessons learned during the pandemic in terms of engagement with community-based organizations and seeing how we can transition some of those activities or scale those activities across OPH. I'm glad that you did mention coming to you all and sharing our updates on the grant. That it's going to take a team to really get this grant off the ground and really, really hit our outcomes.

Ms. Owens-Cody I always like to show this picture in any of my presentations is all the different teams that are working together. I'll add this committee to it as well.

Ms. Owens-Cody We are working and partnering with NYSACHO to work with our local health departments. We've done quite a few activities with them in terms of offering office hours with our local health departments to help them with their budget modifications and activities. We have our grants administration, the department as a whole. We're working with Health Research Inc. Community based organizations will also be essential. The CDC has offered us a lot of technical assistance and support that's available. Again, our local health departments and just all the new units that are going to be coming on. I always like to show the web of different supportive opportunities to really bring this grant to life.

Ms. Owens-Cody Our anticipated outcomes are to strengthen our capacity, improve organizational processes, progress toward a more modern, efficient data infrastructure, engage communities across New York State and public health program development. We're really hoping that there's a lot of long-term public health solutions that are embedded and through, as I mentioned earlier, through all of our activities is to really drive our activities to focus on reducing health disparities and inequities affecting our communities in New York State. Our local health department investments. 40% of our funding to go to the local health departments. They are able to use their funding in very similar ways that we're going to be using our funding through OPH. Some of the short-term outcomes that they may be using their funding for may be related to hiring or filling vacant positions. Some of the long-term investments may be working with community based organizations and to really affect or to impact socially and economically marginalized communities. Right now, all the counties have been working on submitting their budget modifications so that they can receive the funding and invest in the areas that they see fit

and in their respective local health departments. As I mentioned, we're going to be introducing quite a few new teams or new units. Hiring is actually currently underway. There will be a Public Health Continuing Education Unit that I mentioned that will be providing different training and development opportunities throughout OPH. We'll have liaisons that will support connections with colleges and universities, as well as strengthen internships so that we can strengthen our career pipelines into OPH and local health departments. We also will have liaisons that will be working with local health departments to help with their programs or their budget modifications and then regional offices to help the different positions that are coming their way to support them as well. We also have a Community Engagement Unit that will be helping with community-based engagement. Our new unit, Health Wealth and Wellbeing Unit will also be added where this team will be researching different ways and different interventions and identifying different opportunities to increase wealth as it relates to improving the health and wellbeing of New Yorkers as well.

Ms. Owens-Cody This is just a snapshot of the team that is coming on, as I mentioned. I actually put in an order of recruitment. I would say we're kind of at a baseline right now. We're working on these recruitments as we speak and then moving over into our Public Health Continuing Education Unit and Community Engagement Unit. I thought I would at least share with you what this looks like. I thought it's important to note where everyone will be working. Some positions are here in the Capital Region, but we also wanted to make sure is we're talking about a diverse workforce that's representative New York State. Some of our positions actually will be in our regional offices across the state as well. The big pushpins are in our regional office areas.

Ms. Owens-Cody These are the positions that will be recruited. Some are underway. Some are already hired. These are some of the positions that will be inside of our regional offices. A part of our grant funding, it did go into our regional offices as well. We are supporting the Capital District Office coming live as well. There's quite a few more positions than some of our other regional offices. Central, Metropolitan and Western New York also did receive staff as well. The Regional office liaison will be helping with recruitment activities as well. Across OPH these are the other positions or other areas that will be receiving staff. The Centre for Environmental Health will have quite a few staff that will be brought on. Wadsworth, Grants Administration. As I mentioned, the Health Wealth and Wellbeing Unit. You can see the new positions that are coming in this space. Emergency Preparedness, Center for Community Health, Bureau of Vital Records, as well as the Office of Science will receive positions as well.

Ms. Owens-Cody In terms of timeline, as Dr. Bauer mentioned, we did receive this grant December. One of the critical roles to get the grant off the ground was to hire the Workforce Director, which is myself. I started in April. Local health departments were notified of the awards. There was some work that started to notify them, as well as educating them on how they can use the grant funds. I would say, behind the scenes, we've also been working with the CDC on our evaluation plan. A lot of groundwork has been happening. We did hire our Program Evaluator to lead with those evaluation efforts. We're hiring. We had a mini pause because we changed recruitment systems. There's been some transitions there because all of our staff are going to be hired through HRI. Our evaluation plan is actually going to be submitted shortly. That's due today. Just continuing, I would say, on recruitment across all of the different positions and making sure that our implementation team is hired so that we can provide more support to the Office of Public Health and the local health departments.

Ms. Owens-Cody From an evaluation standpoint, I thought it would be nice to share with you what the CDC is actually looking for us to submit in terms of our performance measures. There are a big component on hiring. We are to look at how many new hires we're hiring for this grant, where those positions are actually going in terms of classification and areas of the Office of Public Health. We're also looking at how long it takes to fill a position, what's the median to fill positions. This is not restricted to just the grant staff. This is actually the entire Office of Public Health. We do work collaboratively with HRI HR as well as HRNG, which is DOH's HR. We're also looking at what are the max days to fill a position? We hope over time, that is we're looking at these numbers that we develop interventions to reduce how long it takes for new hires to come on. We also are looking at retention. How many staff are we retaining? We also look at temporary contract staff and our retention rates there. We do have some components around accreditation and our data quality to make sure that we're able to capture what's needed for each of the deliverables described. We also had the opportunity to also create an evaluation plan that's kind of outside of the CDC. What we've decided to focus on is our recruitment infrastructure. We have already started those efforts really looking at job creation. There's a lot of teams right now that are developing positions that we haven't had before. Evaluating that process. Where are we posting positions? Are we getting the candidates that we need? Are there different ways that we could be recruiting? Also looking at our interviewing, our panels, our questions, things like that. Getting to like how long does it take for someone to go through this process and the person is actually here at OPH or potentially our local health departments as well. This is what we're looking at focusing our evaluation on initially. We have the opportunity to build over time. This is the person, Eric, who's been slated to do all this work. His contact information is there. I think this would be a great group to share reporting or to receive insight on different things that we can do around performance improvement. That concludes my update.

Ms. Owens-Cody Dr. Bauer, did you want to add anything or share anything?

Dr. Bauer Keshana, thanks so much for that terrific overview. I think as the committee can appreciate it's a huge job to bring on eighty plus staff to build out this infrastructure, not just in the Office of Public Health, but across the state, including our regional offices and then working in close collaboration with our local health department partners. Really appreciate the vision and the can do that Keshana brings to the position. We're really excited to be building out our public health infrastructure rebuilding, in fact, because of course, we took such a powerful hit during the pandemic. I will maybe try to short circuit a question that someone's bound to ask and we ask ourselves every day, which is this is grant funding. It's a five-year funding. What happens at the end of the five years?

Dr. Boufford Please go ahead.

Dr. Bauer I mean, the fact is we have no idea. However, I think it's been clear from CDC and across public health that we are not building public health infrastructure for the purpose of taking it down in five years. We don't know what the sustainability plan is at this point. We do know that the CDC is already aggressively working on that plan in partnership with our national public health partners. We do anticipate that in one form or another, this funding and this work will continue. As a hedge, however, we have committed for the New York State Department of Health as we go through the five years of the grant to make an effort every year to fill new state positions and to look for additional resources from state government. This year, we have been very fortunate to receive scores of positions from the Department of Health State items to fill. We're off to a good start with that effort. We'll appreciate the Public Health Committees support on that.

Dr. Boufford Absolutely.

Dr. Boufford Thank you.

Dr. Boufford I'm going to invite Dr. Watkins to lead off our discussion, being a local health director and on the council.

Dr. Watkins Absolutely.

Dr. Watkins Kevin Watkins, member of the council. Dr. Bauer, it's a pleasure to see you again and to talk about the infrastructure grant as you presented this grant. Its delightful perspective of being able to increase the workforce for local health departments. At our last meeting, a number of the members really were concerned about the gridlock that seems to be imposed upon the... I think you have a budget modification that we all submitted as local health departments. We're waiting to get those budget modifications approved. We were just unable to build that into our 2024 budget because we were really concerned that because there was such a stale... It was just such a delay in getting those approvals done prior to our budget. We're just hoping to hear that those modifications approvals will be released real soon for local health departments.

Dr. Bauer Thanks so much for that question, Dr. Watkins. Of course, we have fifty-seven contracts in process with our local health departments. They are all at varying stages. We certainly have a bureaucratic process on our end. We know that local health departments have bureaucratic processes on their end. The startup has been much slower going than we would have liked. We absolutely are working I'll say full speed ahead. That's relative to how the Department of Health moves in terms of its bureaucratic contracting wheels. We are making good progress and working with to, I will say, entrenched bureaucracies on the local side and on the state side. Looking forward to hitting the ground running perhaps in a year or two.

Dr. Boufford I think that is an important question and one obviously to the degree that a lot of the evaluation plan has to do with hiring, retention of sort of building up the workforce. We'll have to try and track that. I think the committee will be interested in working with Keshana to keep an eye on that part of it seeing if there's anything we can do there.

Dr. Boufford I wanted to ask another question relative to the local health departments. I think the NYSACHO colleagues in one of the panel discussions we had on the Ad Hoc Committee mentioned the concern. I just don't know what the rules of the road are that in some counties the county execs were having perhaps not necessarily passing through the funds to the local health department. I just wanted to raise that. I don't know of that kind of earmarking coming from CDC protects local health departments in getting their funding or if it's more flexible. I know if you can answer that question, Ursula.

Dr. Bauer Absolutely.

Dr. Bauer We're very clear in terms of our guidance to the local health departments. They can then take that guidance to their County Executive or their county legislature. In terms of the dollars are for public health. The dollars may not supplant other activities. So, for example, if a county has money dedicated to public health, they can't replace those funds with the grant funds in order to free those funds up for another nonpublic health use. We

heard loudly and clearly exactly that point that you have raised from the local health departments. They requested that language. It's completely consistent with CDC's expectations for the use of these dollars. We were able to provide those requirements to the local health departments.

Dr. Boufford Good.

Dr. Boufford Thank you.

Dr. Boufford Other questions?

Dr. Boufford Mr. Lawrence.

Mr. Lawrence Thank you.

Mr. Lawrence I think it's great that we are building out our public health infrastructure. I think I heard that there's a focus on health equity. Recently everything is being done in the name of health equity. I would like to know what some of the measures of success in terms of equity and outcome with this funding are.

Dr. Bauer That's a really great question. Thank you for asking that. It's one that Keshana and I posed when we met with all of the local health departments in October. We put forward that we are well underway in terms of our efforts to build the public health infrastructure, build out the public health workforce. Why are we doing that? We're not doing that just for the sake of having a stronger public health workforce. It's so that that stronger public health workforce can implement effective interventions and serve their communities. Per the CDC grant, the focus really is on, as Keshana mentioned, addressing the adverse health outcomes that often we find in socially and economically marginalized populations. We will be working in years two through five of the grant with our local health departments in identifying those neighborhoods, those communities, those communities within the Health Department jurisdiction to really zero in on the interventions that we can put in place to address health equity. Keshana mentioned the Health Wealth and Wellbeing Unit. This is probably the aspect of the grant that I find most exciting because it is innovative. It is intended to identify interventions that we don't typically think of as public health interventions but that will have a profound effect on the health of our community. That unit it's small to start with. It's a seven-person unit. I just had an interview this morning with a candidate for the director of that unit. It's just getting underway. We're hoping to bring on economic development staff, community development staff, people with expertise in community development, financial institutions or Community Redevelopment Act activities, people who understand economics and community economic development, understand what community wealth building is. Because these are some of the issues when you look at the acquisition of generational wealth, right? That profoundly impact health outcomes. If we can take data from economic development, from labor, from the New York Federal Reserve, who's an important partner with us and look at how we build community wealth, even though that's not what we think of as a public health intervention it will have profound public health outcomes. Entrepreneurship is another component of that. How do we with a broader public health view support entrepreneurs in their communities who are enriching their communities, building wealth, securing opportunity for future generations? Those are some of the things we're thinking about.

Mr. Lawrence I think those are great things. Generational wealth and building out the economic infrastructure. As we know, probably 80% of the social drivers of health are

outside of what we do in health care. I guess my question is more focused on what are the metrics for success? Because often times we talk through the process and how we're going to engage. At some point can there be certain metrics? Are we going to look to reduce diabetes in the neighborhood or in the state or chronic disease in the state or the level of mortality from some chronic disease? Is there something that is tangible that we're looking to achieve that can be quantified that this existed at the outset, three years later, four years later, we've moved the needle on these indicators.

Dr. Boufford I just want to connect my question to yours about that. One of the areas that had been identified in the prevention agenda as a weakness in the last round was this question of addressing disparities in health equity. I think, again, the answer to that question bespeaks the question we're all sort of trying to figure out. It had a dashboard. Being able to answer the questions you're asking is that traditional structure or the alternative that the department is considering relative to the feedback we've been getting about it. Is there the notion of a superstructure that could begin to answer those questions around the priority areas of preventable morbidity mortality in the state, which presuming will come out of the state health plan. Because I think if we're going to be micro at evaluating X, Y, Z, in my view, I think we're not going to have a good sense of how this is affecting, especially given the equity unit at the department how this is affecting the state in terms of improving health.

Mr. Lawrence So often the discussion is about the process.

Dr. Boufford I'm trying to get away from the process and sort of answer the question about how we are going to measure. Is there a framework for measuring?

Mr. Lawrence In the neighborhoods if we're going to involve CBOs. What does that look like? What are some of the outcomes that we're hoping to see for that population? Because we can talk about process but at the end of the day if the dollars are spent and we're looking at pretty much not really major, major improvement in outcomes for those communities, then that's not to say that some good didn't come out of it. What was the bottom line?

Dr. Boufford I completely agree.

Dr. Boufford Let me ask Dr. Bauer to reply then. I just try to connect it to the agendas of the committee but you don't have to.

Dr. Bauer Totally. Dr. Boufford. I was thinking the same thing. We'll have a presentation on the prevention agenda that gets at some of those critical public health outcomes that that you mentioned. In terms of the grant, I want to make sure that we get you an answer. It's not going to be this year. Keshana went through some of the outcome measures that CDC is making sure we are laser focused on in terms of hiring our workforce, building out our workforce, making sure that we are improving our processes for hiring. We hope to get that done in fairly short order, although we are almost a year into the grant at this point. As we get into more of our routine with hiring, we have built out our staff more than five or so of our eighty-two plus staff. We really have the wherewithal to start digging deeply into your health equity question. That's really the activity for what I'll call the second half of the grant. We will be able to bring back to you what we are expecting to achieve in terms of concrete outcomes related to health equity and population health.

Dr. Boufford Denise, please.

Dr. Soffel Hi. Denise Soffel, council member. I was interested. You talked about creating a unit within OPH on community engagement. You also talked about under the public health infrastructure engaging community-based partners. I am interested in how you define community-based partners beyond community-based health care providers. Because it seems so much of what we know about health as Mr. Lawrence was just talking about has to do with addressing social determinants of health. How does this concept of defining community-based partners and working on community engagement embrace social determinants of health in a broader way of thinking about the challenges?

Dr. Bauer Great question.

Dr. Bauer I'm going to ask Keshana to jump in here.

Dr. Bauer Thank you.

Ms. Owens-Cody I would say community-based organizations definitely goes broader than we'd be looking at community based organizations that are addressing social determinants of health as well in terms of that engagement. One of the nice things about this grant is it does charge us to look at our lessons learned from the COVID, from the pandemic and looking at other grants that we received and kind of scaling some of those activities. We did have a grant that went after that put out funding opportunities that reached community-based organizations that may have not been a partner with the state in the past but were addressing social determinants of health. The definition, I would say it's much broader. We would be looking for the community engagement team to engage with community-based organizations that are addressing social determinants of health. I believe like in the previous grant food pantries were funded to provide COVID health literacy. Housing providers. It would be more expanded than just our community-based health organizations.

Dr. Soffel I'm sort of thinking about the last Ad Hoc Committee meeting where we had several representatives from the hospital community saying that they really struggled to find and engage with CBOs. I know from the community side there are lots of CBOs that would love to engage with entities, especially entities that have money. I think that we all need to be a little more creative than the hospital has been to date in terms of thinking about how you find those community partners and engage them in ways that acknowledge their value that recognized what they bring to the table, and that in fact, value perhaps financially what they bring to the table as well.

Dr. Boufford Well, I was going to ask how you... I mean, you mentioned that you're going to be putting staff in regional offices. Because I think historically community engagements really occurred at the local health department level with partners from the other agencies that have infrastructure in communities and local communities. I mean, that's one question. The other point Denise is making, I think and we keep raising this. I think we have to get credentials to understand what's going on with the waiver. The idea of the social determinants networks is really... This is fundamental to that. I'm just curious about where putting staff in the state health that the state level or the regional level... Sort of asking Denise's question. Given what's happening with health care reform, we think and similarly, the sort of consortia at least that many counties have developed over the last several years with local partners. We could maybe address what you're thinking is at this point. I realize it's very early in your hiring but just to get a sense of it.

Dr. Bauer One of the things that we're trying to do and the grant gives us an opportunity to do this, although we would be doing it even independently of the grant is really building out our regional offices. I think, as Keshana mentioned, we're trying to learn lessons from the pandemic. One of those lessons is that we really need our regional office capacity. First, it builds the diversity of our staff when we can locate people in very different areas of the state. They don't all have to be in Albany, for example. If we have a cadre of staff they have close relationships with the local health departments in their regions. If they have staff who can be at the side of the local health departments, who can support the local health departments, who can kind of amplify the work of the local health departments in terms of reaching deeply into the community and reaching deeply and widely across the region that strengthens everybody.

Dr. Boufford Dr. Torres.

Dr. Torres Good afternoon. I have an image in my mind here. It's the challenges of going to a concert and you have like more than a thousand people. You have that diehard fan that somewhere out there. How do you spot that gem? How do you spot that CBO that is doing that phenomenal work and is truly engaged but is not amplifying in a traditional business development visibility type of initiative? Most of the efforts go unnoticed, which is what's happening in many of our neighborhoods. It's like unsung soldiers.

Mr. Lawrence I think that's a great analogy, but I think also so often maybe the hospitals are playing classical music and the CBOs are doing hip hop. That's part of the problem, I think. Often times is that there are different currents that are at play.

Dr. Boufford I think it's important for us to remember that this particular grant is really a capacity building within the Department of Health. It's not going to solve the problems we're talking about now. That's where the big money comes in. The strategic thinking, I think that the issues that have been raised here is really important because we know what didn't happen under disruption, what is being expressed relative to the idea of CBOs being crucial really to solving broader determinants of health.

Mr. Lawrence With the department and the local Department of Health they provide that opportunity potentially to bridge and also translation.

Dr. Boufford Absolutely.

Dr. Bauer I do want to call attention to Keshana's comment. Before we had the Public Health Infrastructure Grant through the enormous COVIS dollars that flowed to the state, we had the COVID Disparities Grant, which was a $33,000,000 grant to specifically address disparities within the COVID-19 pandemic. What our fantastic staff and Family Health did with those resources is put out a small grant so under $50,000 to community organizations. As Keshana noted, most of those awardees had never worked with the State Health Department before. The way we were able to reach out and engage communities, we clearly hit a number who have never thought to apply for department funding. Once we had those, I think there were what? Two-hundred grantees at this point?

Ms. Owens-Cody Yes.

Dr. Bauer Two hundred community organizations across the state. One of the supports that they're getting from the department is how to write a grant, where to find grant resources, how to kind of grow your portfolio so that they're able to apply for foundation

funding or other government funding. How do you pitch yourself? How do you showcase the good work that you're doing in the community? How do you collect evaluation information so that you can tell your story in a compelling way? We think that's a really wonderful model for some of the work that we can do with the Public Health Infrastructure Grant.

Dr. Boufford I wanted to ask a question, I think, Keshana, we had talked about this very briefly. Obviously, you have a plan for this first year that you've got to execute. One of the questions I had was the possibility of using the essential public health functions self-assessment process. New York was one of the leaders that did that a few years ago, which helps you kind of in a more granular level allows local health departments to sort of diagnose their needs. Is it surveillance? Is it workforce? Is it data? Is it outreach? That sort of stuff? I think you mentioned it was something you might be looking at. Obviously, there is an acute need for additional workforce numbers in all of these health departments, I'm sure. They'll make the best judgment about what they need in the short term. In terms of really understanding what some of the key infrastructure capacities ought to be, I think pillar number two, the foundational areas. Could you share your thinking about how that might play out going forward?

Ms. Owens-Cody Our relationship with NYSACHO is definitely going to help us with this too. We're already starting to dive into some of the assessments that they do with the local health department. We're hopeful that we'll be able to understand like what different positions are challenging for them to fill as well as what other infrastructure needs, they may have and be able to provide either technical resources but also help them direct the funding that they receive in that way as well. I would say our partnership one, I mean, we'll have the local health department liaison too. I'm excited for that role to come out as well. To be able to engage and probably dive deeper into the assessments that you mentioned. I would also say that our relationship with NYSACHO who does a lot of assessments and engagement with the local health departments will help us with that as well. They're also working with our program evaluator already to share what data they have collected already too.

Dr. Boufford That's great.

Dr. Boufford I also wanted to ask about this had come up in the panels we had with the Office of Mental Health, Oasis, State Department of Health. Is there a structure now, Ursula, where some of the interagency work could be done? Because I see you're sort of hiring economists and other people what some of the agencies obviously have. You need a liaison, obviously, who understands the language they're speaking. Is there a thinking about really these broader determinants, as Harvey said, are not in the Department of Health but they are elsewhere. I wondered what the current thinking is around engaging withr other departments, other agencies of government around these determinants of health.

Dr. Bauer A really important question, I would say for all of public health all the time. Compared to what education can do to improve health, housing can do to improve health, transportation can do to improve health. I mean, in some sense, the tools that public health has or that the Department of Health has are minuscule compared to the impact of high school graduation or safe and secure housing or outdoor spaces. Absolutely. You know, I think in public health we tend to invite people to our table. One of the things we need to do is start going to other people's tables. Because if we can help them achieve their goals, we're going to achieve our goals.

Dr. Boufford Is one of the units in one of the new groups going to be managed? I'm interested in the how as well. I mean, I know you've spoken eloquently before. We all agree that these other sectors are really important. Sort of the person power to do that. Is that part of the new design? Is that something that'll happens in another way?

Dr. Bauer I mean, it's certainly something that we try to do with the prevention agenda. That's probably the stronger vehicle to do that because it's not just within public health infrastructure. It's not just even within public health but across the entire department.

Dr. Boufford We're going to finish up so you can present. Sorry about the. Do you have a timeframe?

Ms. Phillips Apologies. I'm muting.

Dr. Boufford Thanks.

Dr. Boufford Just a last question. I want to know how the new structure relates to the Office of Public Health Practice that as we have known it. Does that continue? Is that being subsumed? Is it now the responsibility being taken over by one of the new units?

Dr. Bauer To be determined. We are looking at that now.

Dr. Boufford Okay.

Dr. Boufford I think for in the interest of time, we probably ought to keep moving. Our next presentation is on the sort of updates on the prevention agenda Salman Khan. You want to introduce yourself? I think you're a sort of new face to most people. Let us know a little bit about you and then present.

Mr. Khan Hi, everybody. I am Salman. I am working as a Program Coordinator with the Office of Public Health Practice. I joined through the Fellowship Program. Today I'll be presenting on the 2022/2024 Community Health Assessment and Community Health Improvement and Services. Before getting into the analysis, just a brief background on the prevention agenda. The prevention agenda is New York State Health Improvement Plan and is a blueprint for state and local action to improve the health and well-being of all New Yorkers and to promote health equity across populations who experience disparities. The goal of the agenda is to make New York State and to improve the health standards of New Yorkers and reduce health disparities through an increased emphasis on prevention. The prevention is in there consists of five priority areas, which includes prevent chronic diseases, promote a healthy and safe environment, promote healthy women, infants, and children, promote well-being and prevent mental and substance use disorders and prevent communicable diseases. Some common definitions associated with the prevention agenda are the community health assessment. The health assessment is conducted to identify key health needs and issues through systematic, comprehensive data collection and analysis. It's also known as the Community Health Needs Assessment. Next, we have the Community Health Improvement Plan, which is a long-term systematic effort to address public health problems based on the results. It creates a framework for measuring the impact of collective action towards community health. It's updated every three years to meet the current needs of the community and allows the community partners to address health concerns. Lastly, we have the Community Service Plan, which is similar to the CHIP and helps us personally from data to action to address the priorities identified in the CHHA.

The DOH asks hospitals to work together with their community partners, including cities, to address public health priorities identified in the prevention agenda. It is updated every two years by hospitals in New York State. Here we the timeline for this type of prevention agenda. This presentation will focus on the analysis of the 2020 to 2024 assessment. Under the terms of the prevention agenda required local health departments and hospitals to select one of the following options: two prevent areas and a minimum of one focus area within each priority or one prevention area and at least two focus areas within priority. At least one of the selected priority areas was required to address the disparity and promote health equity. Hospitals with their counties were encouraged to submit combined needs of the population they serve. In total, we had 111 submissions. Hospitals could submit one plan per county or organization or combined. Collaboration was also permitted, allowing for combined areas, cities and hospitals. As a result, we had sixteen that submitted individual plans, thirty-seven combined plans that incorporated seventy-four hospitals and forty-two and fifty-eight plans in hospitals and hospital systems, which translated to 72% of those surveyed and combined plans of hospitals and 40% of hospitals combined plans. For the 2022 and 2024 submissions, overall well-being and preventing children substance use disorders and prevent chronic diseases were the biggest priority areas for both hospitals and clinics. Promote well-being and prevent mental and substance use disorders facilitated by 90% and 83% hospitals. Prevent chronic diseases was selected by 81% and 91% hospitals. Hospitals are most effective priority east prevent chronic diseases. The biggest priority was preventing mental illness and substance use disorder. Prevent communicable diseases and promote healthy and safe environments with at least three priority areas. The trend was similar across both with only 14% and 18% hospitals. 16% and 16% hospitals choosing to prevent communicable diseases. We take a closer look at preventative diseases first. Prevent chronic diseases was one of the highest priority areas amongst both. It was selected by 47 and 167 hospitals, which translates to about 81% areas and 91% of hospitals.

Mr. Khan Next slide, please.

Mr. Khan Within the priority areas 4.1, which was to increase cancer screening rates remained the highest selected for both. Was selected in 81 hospitals, which translates to 53% and 44% in hospitals. 3.3, which was to eliminate the exposure to secondhand smoke was the least selected. Next, we look at promote well-being and prevent substance use disorders. Promote well-being and preventing substance use disorders were selected by 52 and 153 hospitals, translating to 90% of cases and 83% of hospitals making it one of the higher selected priority areas. Within the criteria selections followed similar trends across both. Which is to prevent opioid and other substance misuse and death was the most critical within this priority and was selected by 66% and 61% hospitals. Rule 2.6, which goes to reduce the mortality gap between those living with serious mental illness and the general population was the least picked being selected by 5 and 16% respectively.

Mr. Khan Next, we have promoted healthy women, infants and children. Promote healthy women, infants and children were selected by 17 and 94 hospitals, which translates to 29% and 50% hospitals. 4.1, which was to reduce racial, ethnic, economic and geographic disparities and promote health equity for conservative populations was the most selected goal for hospitals. Overall, the priority remained more cooperative in hospitals. An exception to this was 3, which was to reduce dental caries among children, which was the least selected by hospitals and one of the highest by LHDs.

Mr. Khan Promote healthy and safe environment. Promote healthy and safe environment was one of the lesser priority areas only selected by eight LHDs and thirty-four hospitals.

Similar trends for both with goal 1.1, which was introduced for vulnerable populations being the most selected by both, selected by 7% and 13% hospitals. It's also worth noting that a number of goals in this very area remain unselected by both. These goals include 4.1, which is to protect water sources and ensure quality drinking water. 4.2, which is to protect vulnerable water bodies to reduce potential public health risks associated with exposure to recreational water. 5.1, which is to raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure. Rule 5.2, which was to improve food safety management.

Mr. Khan Next, we need to prevent communicable diseases. It was only selected by 16% and 16% hospitals within the priority group 1.1, which was to improve vaccination rates was the most effective one by both. There were also some goals that remained selected for both in this priority area, which include 4.2, which was to reduce the number of new cases among people who inject drugs and 5.2, which was to reduce infections caused by multi-drug resistant organisms and goal 5.3, which is to reduce inappropriate antibiotic use. To include those identified as serious health concerns within the community. These are included as other goals. In this case, these goals were inspired in response to COVID-19 and was elected by one LHD and three hospitals.

Mr. Khan All plans are required to address health disparities and promote health equity for at least one priority area. Most times reporting, we tend to address disparities. Some common equity issue was identified across 311 plans: where socioeconomic status, race and ethnicity, health care access, disabilities and age and gender. Urban counties were more likely to identify race and ethnicity as a leading disparity, health equity issue. Rural and suburban were more likely to identify socioeconomic status as the leading disparity. Those plans were not clear how to measure the impact on equity. In summary, the top selected priority areas included preventing diseases and promote well-being and prevent mental and substance use disorders. The least selected per reason to promote health and safety environment and prevent communicable diseases. There were multiple goals that were not selected by any plan which included 4.2, which was to reduce the number of cases in people who inject drugs. 5.2, which was to reduce infections further than multi-drug resistant organisms. 5.3, which was rated using inappropriate antibiotic use. More of those that were not selected were 4.1, which were protecting water sources that ensure quality drinking water. 4.2, protect vulnerable water bodies to reduce potential public health risks associated with exposure to recreational water,. 5.1, which was to raise awareness of the potential variations of the contaminants in promote strategies to reduce exposure. Lastly, 5.2, which was improved food safety Management. That's it.

Dr. Boufford Thank you very much. I wanted to just make a couple of observations having been in this data for a while. I think one of the really important areas, the areas where there was really low preference or low uptake of activities, I think have been explained in the past in a couple of ways. One was that there were already sort of federal passthrough funds designated for that activity. If it wasn't put on the prevention agenda for that work, it was because it was already being done as part of the DNA of the health department or the partnership. I think that's one area to think, especially in the MCH area and the infectious disease area and those kinds of areas. The other issue, obviously, if you're dealing with water quality and reservoirs and toxic substances. It's not necessarily the audience here that we're talking about. It's perhaps a different level, maybe who is regulating those? It might be EPA. This is the other agency question that might have got left out. The other area, an environment that I think is really a great example of really the opportunity to look at. As Ursula, you've been saying get assistance from the other departments is we had preventing falls, I think was an area. Now, that from before prevention agenda social

determinants point of view, preventing falls could be promoting physical activity which could lead to issues of zoning, greenspace, urban planning, etc., all of which happen elsewhere. I think, you know, the sort of preventing falls is something that's kind of been a classic Department of Health area because it's incredibly expensive and the health care delivery system, which is totally understandable. If you convert that then to looking at the more upstream determinants of health that might be reframed in a revision and working with other agencies around sort of built environment, housing development, transportation agencies around, bike lanes, sidewalks, greenspace, zoning, other things. It sort of points out the sort of somewhat limitations of the historical goals in these areas that could be expanded.

Dr. Boufford Dr. Torres.

Dr. Torres Dr. Boufford, you mentioned some interesting points. I just had a discussion with a couple of other folks on the community level where there is a predominance or a higher risk of falls because of the way the neighborhood is with the unsteady streets and pavement, trees and so forth and obstacles. Some folks are thinking maybe there would be a nice discussion with community planners or community people that would have funds that would do that whole environmental assessment and also conversations with developers that are coming into our neighborhoods to look at restructuring, rehousing, repurposing space. I think that they should be part of the discussion as well. Something just that has come up, especially with redevelopments.

Dr. Boufford Dr. Watkins.

Dr. Watkins Sure.

Dr. Watkins Thank you very much for this report. It's quite interesting. this is about our third or fourth cycle for this prevention agenda with these priority areas anyway. What I've noticed is that we continue to see that there is a priority selection for both local health departments and hospitals for preventing chronic disease and of course promoting well-being and prevent mental health and substance use disorder. Just wondering if we've seen any metrics where things have started to improve. Oftentimes we'll get these red, green, red, yellow, and green indicators to show us in our community whether or not they've seen improvements in these areas. I was wondering if you were noticing any kind of indicators that show that although these priority areas are number one for both hospitals and local health departments, we are starting to see an improvement statewide for these indicators that we have here.

Dr. Bauer Dr. Watkins, thanks for that question. Thanks so much for the presentation. I feel like I learn something new every time I see and hear about the prevention agenda. Thanks so much. We did present. We have, as you know, such a robust dashboard for prevention agenda indicators. We did present to the Public Health Committee some of our well, the outcomes across a selection of the 99 indicators and indicators within each of those categories. If I remember, we did not make actual progress in many of the chronic disease indicators. We can refresh that and take a closer look over the fifteen years of the prevention agenda. That could absolutely be interesting. I did want to address an earlier point and Dr. Watkins; you can probably speak to this as well. What I have heard from local health departments is that they tend to choose the priority areas, the focus areas, the indicators that they're already working on. Because they know that they'll at least be able to put some effort toward those. I they choose something that they don't have funding for, they don't have staff. Because there's no funding with the prevention agenda they don't

feel like they'll be able to make progress. That's one of the concerns that we have going forward. It's like how do we kind of energize the prevention agenda? What are our options in terms of trying to figure out how we can put some funding, some something behind it so that our local health departments and the hospitals maybe have some resources? I know that's a huge interest of yours, Dr. Boufford, as you think about community benefit.

Dr. Boufford Thanks.

Dr. Boufford Other questions about this item?

Dr. Boufford Mr. Lawrence.

Mr. Lawrence Thank you.

Mr. Lawrence I think it was a great presentation. I was sitting here thinking about all of the different ways you could cross tab the information. To your point, Dr. Bauer, one of the things I was thinking is that at some point if people are in fact for lack of a better word, sort of gaming the system with complacency. This is something that we have to do so we'll just on a knee jerk basis because we've been doing it for the last five years and we are short of staff and all of these things. We'll just continue to report out and select these priorities as opposed to, well, how does that line up with the, in fact, the priorities that should exist in that neighborhood? We have no way of calibrating whether the priorities should be the priorities for that hospital or for that community based on whatever you're seeing in terms of chronic disease or other health challenges that are confronting the neighborhood. It would be great to be able to do that type of side-by-side comparison. If this particular local health department selected... I don't know. Some measure or some priority which is completely out of line with what's going on in the neighborhood. It might be helpful for them to see that and to know that. That might be an incentive for someone to say, well, this doesn't calculate compute the selection. The other thing that would be helpful, I would also be some sort of a trend line to see whether in fact over time that is happening that people are continuing to select the same priorities, even though there are changes within the health status of those particular neighborhoods. That's another indication. To show the variance between the hospital's selection and the local health departments where there's complete alignment and where there's complete diversions. That type of information would be useful as well.

Dr. Boufford I think what Salman showed is that in the aggregate, but county by county would be a different issue.

Dr. Boufford Thank you so much. Really appreciate it.

Dr. Boufford We may have some question, Salman, afterwards, and then maybe you can crunch the numbers. As somebody said, look in the cross tabs, cross the numbers in a different way and present at a later date. Thank you very much.

Dr. Boufford The next segment of our agenda is on one of our historical areas of great interest, which is maternal mortality, which we had a long series of hearings. We've developed a white paper about four years ago, which I think we like to take credit for the fact that we raised the issue, which led to the Governor's Commission and several other things happening. I'm delighted that Kirsten Siegenthaler and Marilyn Kacica, both of whom were involved in different ways in that early work are now continuing to follow this

important issue. We wanted to bring it back to the committee on a regular basis just to get an update on progress and see if there's any way we could be helpful.

Dr. Boufford Kirsten or Marilyn, shall I turn it over to you, Kirsten?

Ms. Siegenthaler Hi. My apologies for talking earlier. I was actually saying hello to somebody else. I apologize. I didn't realize I entered unmuted. Thank you. Dr. Kacica is here as well. We appreciate your support and interest in this topic. We're happy to share more information.

Ms. Siegenthaler If you want to go to the next slide, I'll kick us off and then Marilyn's actually going to walk us through the slides. Since we last talked with you, we're very excited to share with you two new grants that we received from the Federal Government, the Health Resources and Services Administration, that will directly support the Department and the state's ability to further address maternal health and maternal health outcomes. Both grants are innovation grants. What you will see is some really great ideas that we have been putting forward based on recommendations from our task force, our Maternal Mortality Review Board and our Maternal Mortality and Morbidity Advisory Committee. We just wanted to take a moment to highlight these and let you know what we plan to do. Each of these are over the next multiple years. We were just awarded these grants within the last basically two months.

Ms. Siegenthaler If you want to go to the next slide.

Ms. Siegenthaler Do you want to present this, Marilyn?

Dr. Kacica Sure.

Dr. Kacica Thanks, Kirsten.

Dr. Kacica We're very excited, as Kirsten said, in obtaining these two grants to really help us forward the work that we want to concentrate on. The first one we want to talk about is our Maternal Health Innovation Grant. This is a $10,000,000 grant. It's $2,000,000 a year for five years. It's from HRSA. It concentrates on decreasing maternal and infant morbidity and mortality and improving outcomes for birthing people and infants in New York State.

Dr. Kacica Next time.

Dr. Kacica The funding had three different components that we needed to focus on. One was to establish a maternal health task force. The second was to really concentrate more on state level maternal health data and surveillance, sort of supplement and expand what we're doing. The third was really to think innovatively about initiatives as to how to reach the community to improve outcomes. With this, we selected two different projects, which is the perinatal project ECHO, which ECHO stands for Extension for Community Health Care Outcomes. The second was a universal postpartum virtual home visiting initiative.

Dr. Kacica Next slide.

Dr. Kacica With the Maternal Health Task Force, what we need to do is look at all of our data around different measures and how maternal health is in New York State. This information is to be provided to this task force to identify any kind of gaps that impact maternal health outcomes to have a discussion in a development of a strategic plan for the

state, which aligns with our maternal grant needs assessment. This will help us improve our outcomes as measured by HRSA also.

Dr. Kacica Next slide.

Dr. Kacica The second is to improve state level maternal health data and surveillance. What we're going to focus on is severe maternal morbidity and associated disparities. We know that there are many more morbidities than mortalities. If we can assess those, understand those and focus on those in the upstream, then we'll prevent the downstream morbidities and mortalities in the future. We're also going to look closely at our low-risk caesarean births to see as far as decreasing our caesarean rate in the state. We also want to make use of all the data that comes into the state. We want to improve linking our data from the pregnancy risk assessment monitoring system and the other maternal data sources that we have to have a broad picture of maternal health.

Dr. Kacica Next slide.

Dr. Kacica to give you a little idea of the two innovative initiatives that we have as far as the perinatal project ECHO. This is a telling mentoring model of clinical provider education. It's really to enhance capacity across the state with both hospital and community-based providers. We want to reach especially those medically underserved or maternity care deserts in the state. We have two existing project ECHO hubs in this state that we sort of invited to work with us. One is in the Finger Lakes, which is the University of Rochester, and then in the Lower Hudson Valley, which is Westchester Medical Center. We'll work with them to design the curriculum. What each of these will do then is reach out, especially in rural areas and areas that are underserved to provide educational opportunities and a forum to discuss clinical care and management to improve outcomes. They're not limited to the area that they're located in. We hope that they expand outside of those areas to reach across the state. Because it's virtual, I think that's possible. The second is the Universal Postpartum Virtual Home Visiting Initiative. Here we're pairing birthing hospitals and established perinatal home visiting programs in New York State counties. We're working with two is sort of a pilot, sort of a demonstration project. We're working with two rural areas. North Country Prenatal Perinatal Council for Saint Lawrence County. They will be pairing with a level one facility. Mothers and Babies Perinatal Network in Cortland County. What they will do is there will be staff within the hospital that coordinates with the birthing people to talk with them about home visiting, recruit them for home visiting and then work with the home visiting agency then to deliver. It can be at least three visits during the first thirty days. We're hoping that that connection serves as a model that we can write a best practice and then disseminate across the state. We're also hoping that this serves as a model to work with our Medicaid partners to get this benefit more widely paid for across the state so that we could implement this type of service for all birthing people.

Dr. Kacica Next slide.

Dr. Kacica The second grant that we received was from the Alliance for Innovation on Maternal Health. It's a capacity grant. This is a $800,000 grant. It's $200,000 a year for four years. We really are going to be expanding our work with the Perinatal Quality Collaborative to work on primary cesarean birth reduction. Associated with preventing caesarean section. This really also works with the analysis that we're going to be doing on primary C-section. I think it really complements each other.

Dr. Kacica Next time.

Dr. Kacica We're going to expand the reach and depth and quality of identifying and disseminating best practices to other hospitals across the state. We want to improve maternal and infant health and reduce preventable maternal mortality and morbidity. We're going to reach out to more facilities with this to implement the bundles. We'll be able to support the consistency of bundle delivery and implementation. Also measure this to see if we're successful.

Dr. Kacica Next site.

Dr. Kacica I just wanted to also just give you an update within the legislation that established the Maternal Mortality Review Board. It also established the Maternal Mortality Morbidity Advisory Council. We've been working with this council for a couple of years now, but very intensely over the last year to develop their own record. This council is more of the community arm of maternal mortality. It's a very diverse group. It has insurance providers, social workers, midwives, doulas, etc. How the council worked was they looked at the 2018 board report and then examined the recommendations made by the board and then made recommendations that really supplemented those recommendations where something might be clinical. They would then find the community aspect or where else hospitals could work. In their report they really address disparities in maternal health. Their focus was to look at that in the state. They emphasized the data that we saw in analyzing as far as the board report. Black people who give birth in New York State died at over four times the rate of white people who gave birth. The board determined that 78% of pregnancy related deaths were preventable. We saw discrimination as a circumstance surrounding pregnancy related deaths in almost half of the deaths. These recommendations were developed using health equity principles. The council really calls on individuals, institutions, organizations, and government bodies to take action to improve maternal health outcomes in New York State. Currently, that report is going through the approval process. It should be released soon. That is our summary.

Dr. Boufford Thank you.

Dr. Boufford Let me invite questions. I have a couple.

Dr. Boufford Dr. Soffel.

Dr. Soffel I think maybe the answer to my question came in your last statement but maybe not. I'm interested in the idea that doing provider education is a strategy for improving birth outcomes. What evidence you have that that is an effective strategy. Because I would assume, I would hope that every provider in the state of New York is already very well-educated on how to improve birth outcomes and prevent poor outcomes. I'm sort of curious about what that strategy is sort of focused on what the problem is that it's addressing. I'm wondering then whether it's, in fact, the fact that so many pregnancies related deaths were preventable. There's something else going on there that we're not capturing. Maybe I'm answering myself. That's my question. Am I answering my own question or is it something else?

Dr. Kacica I think we would hope that everyone practices the standard of care. I think through our reviews we're seeing that there are certainly some deficits, whether it's in communication, inviting the right subspecialists to the table or perhaps not having the subspecialists in the area. I think we also want to as far as education, sort of raise the

education level of all providers. It's just not physicians. With us, especially like with Project ECHO, we're going to have nurse practitioners and midwives and other providers at the table also. I think we're seeing that there's room for improvement.

Dr. Watkins Well, I sit on the Maternal Mortality and Morbidity Advisory Council, and they did a very extensive report that I'm hoping that the Public Health Council could eventually hear from this advisory council as well. I think it was a very, very good report. During all of the meetings that we've had, we really talked about the standardization of how women of New York State just do not have when they have a C section. We were hoping that with some of this new funding that we could implement some form of a standardization of how a woman should be treated after a C section occurred at any of our local hospitals. We think that if we could do that, we can start to see a reduction in the number of mortalities that are seen, especially amongst African-American women in New York State.

Dr. Boufford That would be that project. Would that be connected, Kirsten, or is that something different?

Dr. Kacica No, the project is focusing on caesarean section, standardization, etc.

Dr. Boufford Great.

Dr. Boufford Mr. Lawrence.

Dr. Boufford I wanted to ask about, I guess, that report that Dr. Watkins mentioned, which would be great for us to hear, would explain the 78% preventable maternal deaths. For your next visit, I think it's 78% of pregnancy related deaths are preventable. That was, I believe, what you all said from the report.

Dr. Kacica That's in the board report. That's in the board report. We can send you that link.

Dr. Boufford That would be great. It might be interesting to have you come back and talk about it. I think that would be great for the next round.

Dr. Boufford The other two points I want to mention, because you mentioned them again that I think that the Public Health Committee and PHHPC had identified one was exactly what you said, which was early identification of high-risk women in high-risk pregnancies. One of the dilemmas that had come up at the time was just the degree to which how we get them in the system. They get access to subspecialty OBGYN care in a timely fashion. I think that had been an issue. I wondered if you could address that because, again, it looks like one of the priorities is to really have that early identification. The question of the availability of subspecialty obstetrical care or just early identification and support, which may hopefully prevent complexity or preventing complications. Is that still an issue? Is the health system's ability to respond still an issue?

Dr. Kacica The one project is working with postpartum individuals to make sure that they have all the services they need when they're leaving and to take care of themselves and their newborn. We find that's critical in so far as you woman care, etc. I think early identification. We have our home visiting programs also that are working with individuals who are pregnant to also identify any issues and connect them to services. I think that in Upstate New York, the subspecialists are are not everywhere. I think sometimes linking

people to subspecialists needs to be creative. I know that there are telehealth models and different facilities handle it different ways.

Ms. Siegenthaler These two projects do not specifically address early identification. That doesn't mean we're not working on it. I'll highlight, I think we've mentioned before, but just in case not. We do work very closely with the Office of Health Insurance Programs and Medicaid, which cover about 60% of birth. They have passed a budget initiative and expanded so that not only is telehealth covered, but that individuals can receive the equipment that they need to monitor. Things like taking blood pressure in the home so that someone say, who is in a remote situation can receive additional care through this telehealth model. We are doing several initiatives to support prenatal care and early identification and working with obstetricians on ways to connect with it. We're not immune to workforce issues. I think we're probably right in the trenches with everyone who does have workforce issues. The training and availability of obstetricians, midwives, doulas is not great right now. We are working on different ways to try to address that. These two specific grants were more geared at reducing outcomes for people who were pregnant and giving birth and their newborns. Based on the maternal Mortality Review Board data a lot of the deaths happen very soon. It's often because things were missed. The State Maternal Health Innovation one was being responsive to that data because we know that people are maybe not aware of or not seeking or not being heard for sequelae that they need to have attention for medically as well as social determinants of health. I mean, even if a people on private insurance we don't know all the extenuating circumstances in their lives. We want to use this opportunity to ask screeners about safety, security, access to supports and services, as well as screening for maternal depression and supporting breastfeeding. If an individual requires more than three virtual visits, we're working with an established home visiting program that could then provide additional follow up to them. It's not like we're doing three and then saying good luck. We're going to say if someone needs more additional support, we're going to connect them to one of our established home visiting programs. We're very adamant about this being universal because there's such a stigma against home visiting. That I think is an excellent aspect of it.

Dr. Boufford It's interesting that there's a stigma. It used to be the choice, sort of action of choice. Can you describe the stigma question?

Ms. Siegenthaler Sure.

Ms. Siegenthaler It's geared towards providing people who are poor and have a lot of risk factors. We've received feedback from families that they equate it to Child Protective Services visiting their house. In the city it's ACS. I think this younger generation does interface more through virtual means than in person. There's not always a desire in the other end aspect of virtual to have someone come into a home. They're much more comfortable through telehealth interaction. Absolutely. We receive that feedback that people feel like they're being targeted, that they're being cross-examined, and that they have to be worried if someone comes into their home because of the way that it's offered now is really an income-based effort.

Dr. Boufford Not universal if it were then. The stigma might disappear. The other area that the department had identified in one of the initial areas relevant to maternal mortality was prevention of unplanned pregnancy. I wondered where New York was in that space. I know that's something you all have been very assiduous about over time. Maybe just a comment or two in that regard.

Ms. Siegenthaler Sure.

Ms. Siegenthaler We have expanded our family planning program. The state had left the Title 10 federal program under the prior administration. The state had provided emergency funding to ensure that services weren't in any way impacted by that loss of federal funding. We were able to return to Title 10 funding and the state maintained its level of funding. Plus, we added the Title 10 funding. That ultimately resulted in a higher level of funding than we've had historically. We expanded with three additional organizations. We're in five more clinics with that additional funding. We also were able to increase the base funding for our programs and had a bit of a rural differential because rural areas were particularly struggling with recruitment of staff. Our family planning program is an extensive network of clinics across the state providing service to I think over 100,000 people. It's more than just contraception. But it, of course, is one of the cornerstones is contraception as well as planning and discussing choices about when a pregnancy may be of interest. The other area that we've mentioned, I think, is that the state has received its first ever state investment of $25,000,000. First ever investment. We received $25,000,000 for abortion services. Being able to ensure that people have access to information, that they can make informed consent form decisions and that they have access then to the services that they need. This $25,000,000 went directly to expand services into fifty-one organizations and over 120 clinics that we've sponsored that are now able to provide additional abortions in a few cases to begin providing abortions. We do a lot of work related to family planning. The last thing I'll highlight is we have several adolescents facing programs that are about sexual health and relationships. We have three major programs that all primarily work in different age groups from middle school through the high school and slightly beyond high school. They really focus on ensuring youth understand, that they know about their choices, that they have access to the contraception they want. A large part of each of them is about healthy relationships and how to form those and what a healthy relationship looks like. We have initiatives across the state. The number of unintended pregnancies has not necessarily declined. I think I provided that in the last meeting. It's gone down some. Our teen pregnancy is very low. That's been a huge public health success that we've continue to maintain, and we keep an eye on. We do work very hard on pregnancy intention and birth spacing with our primary care providers.

Dr. Boufford Thank you.

Dr. Boufford Any other questions on this area?

Dr. Boufford I don't see any down here. I think we're ready to sort of wrap up.

Dr. Boufford Thank you very much for the presentation. We appreciate getting the report. It would be really helpful. We might want to invite you back to talk us through it a little bit.

Ms. Siegenthaler Just to be clear, just to clarify, we'll send you a link to the Maternal Mortality Review Board report, which does have the information about the preventable death. The report we're talking about is a follow up to it, which the advisory committee has produced a series of recommendations to address the preventable deaths that were identified by the review board.

Dr. Boufford That's great. It'd be great to get both at the point the second one is cleared. That would be terrific. I think people would be very interested in it. Thank you very much. Appreciate it.

Dr. Boufford I think we're ready to wrap up. Just keeping on time.

Dr. Boufford I wanted to ask you. You mentioned earlier part of this has to do with the planning of the subsequent meetings of this committee and or the Ad Hoc Committee. I think we've sort of done a lot of the review. We've sort of talked a bit about how the prevention agenda is linked to the Master Plan on Aging, one of the subcommittees there is focusing on health and wellbeing. I think probably we've kind of reviewed the ground about the feedback that we might get from anyone. I don't know. There may be other folks we should do that with. I think at this point we were sort of the new cycle is as I recall is 2025 to 2030. Presumably, whatever guidance is going to be developed would need to get out at least by the second quarter of 2024, maybe the third quarter. I don't know what the cycle is so that the local health departments would have a chance to prepare responses, etc. As I said before, the whole prevention agenda had been informed by the state health needs assessment. That will not be available until February so the cycle would pick up at that point? Is there a way from the Public Health Committee point of view? I'm trying to figure out. We have a tentative meeting scheduled December, but it doesn't sound like that material would be available for presentation at that point. Kind of laying out what you're envisioning as a timetable for a revised guidance on whatever the prevention agenda option is going to be going forward.

Mr. Roberts I'm happy to answer that, if that's okay.

Dr. Bauer Jump in, Shane.

Mr. Roberts Sure.

Mr. Roberts Dr. Boufford, we did have an Ad Hoc Committee meeting scheduled for December. I think the plan was that you and I had discussed it that it probably makes more sense for us to try to schedule a Public Health Committee for December and be working with Dr. Rosenberg and Dr. Wynn, who have been overseeing the state health assessment a process that's ending. Where we're at really now with that is polishing the presentation. We are working with internally with our own PAG to get it into a very aesthetically appealing sort of brand. That is feedback that we've received consistently from our partners at HHS and other state is that we're making that presentation and that having a physical copy that is appealing and user-friendly helps get more engagement from our community partners in terms of being able to use it. We are anticipating that we would be able to preview to the to the council in December.

Dr. Boufford That was kind of my question. I wasn't sure if we were going to be ready. When Ursula said February, I got a little unclear.

Mr. Roberts February is Ad Hoc meeting scheduled that we're going to present it to the Ad Hoc Committee. Definitely the council would have it before then. We would hope to also have our state health improvement plan proposals to the council obviously before then as well. We are working currently on it and updating them based off the information.

Dr. Boufford Great. That's fantastic. Thank you. That answers my question.

Dr. Boufford We will have a Public Health Committee meeting. The date is December 5th. Colleen's telling me it's in the morning. We'll have a three-hour block. We'll have a lot to talk about and digest from you folks. I really appreciate all the work. I know with all the good news going on about all the money that's coming in and having to get ready to spend

it effectively. This is really an important undertaking as well to keep this going. I appreciate that.

Dr. Bauer I will not be available at that meeting. I'll be at a meeting in Atlanta at that time. The team will be here.

Dr. Boufford Knowing how hard it's been to get a day at a time I'm not going to... Normally I'd say that's fine. We'll change it. I'm not going to say that because I think it's been an ongoing struggle. That's great. We'll keep that and reshift that to be Public Health Committee and not Ad Hoc, which is great. That's all there is for me. I would sort of thank everybody for the effort put into the presentations, the great work that you're doing. It really makes our job interesting and important. We will certainly be wanting to follow up with because that will become sort of a regular part, maybe not in December, but after the first of the year we'll want to begin identifying as a joint agenda of work with her on the workforce stuff.

Dr. Boufford Ursula, over to you for final comments.

Dr. Boufford We have no public here. I don't know if there's any public there. I sense everybody's virtual. I think we're the only site.

Dr. Boufford Go ahead.

Dr. Bauer Thank you, Dr. Boufford.

Dr. Bauer Thank you to the Public Health Committee members and thank you to my stellar staff. Really appreciate your presentations. Appreciate you being at this meeting today and all the work that you're doing. Looking forward to wrapping up the planning for the next cycle of the prevention agenda and looking forward to charging ahead with our workforce and infrastructure strengthening. A lot of opportunity ahead of us and look forward to the partnership.

Dr. Boufford Great.

Dr. Bauer Thanks.

Dr. Boufford Thank you very much.

Dr. Boufford Thanks, everybody again.

Dr. Boufford We stand adjourned.