NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
PUBLIC HEALTH COMMITTEE
FEBRUARY 7, 2023 1:00 PM – 3:00PM
90 CHURCH STREET, 4TH FLOO7R, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Dr. Boufford I think I'll call the meeting to order just in the interest of time. We have a few people that are theoretically going to arrive down here. When they come, we'll go welcome them. I'm Jo Boufford, I'm the Chair of the Public Health Committee of the State Public Health and Health Planning Council. I'm delighted to welcome you all to this meeting. We do not have any members of the public here with us in New York City, but this session is being held under the Public Meetings Law. The webcasting is happening. People will be careful of their microphones and also talking over each other. Similarly, the recording will be available on the website after this meeting. If anyone should come in or anyone is there in Albany, we would encourage them to sign in and fill out the forms that are supposed to be filled out for this meeting.

Dr. Boufford Let me just make a few introductory remarks, and then I'll ask Commissioner Bauer to do the same just to kind of bring us up to date to today's meeting, really over the last few months starting in the summer. Again, thanks to Commissioner Bauer and her team for supporting this work. The Public Health Committee and the Ad Hoc Committee have convened several times to review the priorities, progress and metrics from the last cycle of the prevention agenda, which was 2019 to 2024. It ends this year. It has to be revised for next year. Looking at the implementation mechanisms as well. We've had really good updates from staff about the data that's been collected by local health departments and partners at the local level. We've also had panels and presentations from partner agencies. The NYSOFA, OMH, OASAS and Department of State on their smart growth and environmental justice initiatives. They have really been pretty core state partners from the beginning of the prevention agenda. I think we're glad to hear from them. We also had panels from NYSACHO and Greater New York and HANYS. We've kind of explored getting feedback from everyone. The last time we met we heard from Andrew Lebwohl on the Master Plan on Aging, which also has a committee, which I'm Co-Chairing with Linda Fried that is focused on health and wellness, which will have a prevention, we hope, emphasis, as it comes out of the report. We had a really nice presentation as well on community benefit, hospital community benefit, which is really part of the state Health Improvement Plan model. We can come back to that again. I think we haven't revisited it, but it's there and potentially an area that we might wish to address in the revision of the prevention agenda for the next five years. I think if I could summarize the general response, I think it's generally been positive from agencies, especially from the agencies and many of the state level agencies have developed prevention units, which they didn't have before. They're really pursuing it. Not always on the exact prevention agenda, but they're really put a much more greater emphasis on prevention in the work of their agencies. A number of them are actually working closely together to share data and develop initiatives. I think we saw very good ability at some of the local levels, the local health departments, in good partnership with the CEOs of their local hospitals or local health care systems with multiple stakeholders involved. Many of them had, in fact, connected locally to area offices on aging, regional or local sort of offices, if you will. I'm not sure that's the right term, but the Office of Mental Health OASAS. We're working quite closely together on the prevention agenda work. All of that the sense was that that could be strengthened, but that in some instances the local structure, even though it had been interrupted by COVID, had held together reasonably well and was something to look at as

part of an implementation strategy going forward for any changes that would be made. As I said, the other feedback we got was that... And to remind everybody that the priorities for the current prevention agenda, which ends this year, were developed because they were the major causes of avoidable mortality from the state health assessment. That obviously needs to be updated. There was a general sense that there were too many objectives in the earlier draft. The cycle should be lengthened so that it would be more of a six-year cycle, rather than a two- or three-year cycle. The objectives should be broadened and enriched to include attention to social determinants of health, which obviously when these were drafted now six/seven years ago that wasn't as strong a feature of our thinking as it needs to be going forward. That's kind of my thumbnail summary. At the same time that we were being supported in having this review by the Public Health Committee, the Ad Hoc Committee and the PHHPC, the leadership team within the health department was exploring other models for the prevention agenda revision. We're going to hear about that model today. It's sort of give us an update. The plan is that we would hear that work in progress. I think is still a work in progress, but it's reasonably well defined. We would hear that. Give feedback. There would be a revision. We have an Ad Hoc Committee of the Public Health Committee meeting on February 22nd, where the next iteration would be presented. I think the hope is either in that meeting or potentially in another pair of meetings we might have in April that we would decide how the prevention agenda is going to be structured and implemented for the next year because the guidance then has to be drafted and got out to local levels and other things. That's the plan for today is to hear Shane Roberts who's done a great job with his staff. I'll just finish what's going to be the agenda and answer any questions you have, Nilda. The other thing we did at the last meeting after some conversation. This committee has in the past identified a priority work area that we wanted to work on in addition to oversight of the prevention agenda. We picked Public Health Workforce. We will have a briefing on that. That group was really just getting started. I think Keshana Owens-Cody who's the leader of that group literally had been on staff for maybe three weeks or something like that at the time. We'll hear progress that she's made. I do want to mention the waiver, just so people are aware. My understanding is that Jeff Kraut is working with OHIP to try to get a briefing on the waiver for the full PHHPC, which is, tomorrow, right? Tomorrow. We won't talk about that here. It's not irrelevant. It's not directly related to what we're doing.

Dr. Boufford With that, let me stop and answer any questions.

Dr. Boufford Nilda Soto.

Ms. Soto Nilda Soto, a council member. What is the timeline for the prevention agenda to be finalized?

Dr. Boufford My understanding is that you would like to get the guidance out in the Fall of 2024. Shane Roberts can correct me. The departments or local health departments or whoever the actors and a structure would be in place so that whoever the actors are could make their own plans in response to it. We probably have a chance for another pair of meetings. This group can meet as a small group whenever we need to. This group plus the Ad Hoc Committee in April and we'll see where we are at that point.

Dr. Boufford Any other questions about my update?

Dr. Boufford Dr. Bauer, let me turn it over to you for opening remarks.

Dr. Bauer Thanks so much, Dr. Boufford.

Dr. Bauer Welcome, committee members and, and welcome to our Department of Health team. Thanks for that great summary and bringing us to where we are today. This is a bit of a milestone, as you alluded to Dr. Boufford. We are really at the point where we've done a tremendous amount of input gathering with our community members, with our key partners, through the Ad Hoc Committee and through other conversations and with our state agency partners. We've incorporated that feedback into our thinking about the prevention agenda what the framework for the 2025 to 2030 cycle should look like. Today we'll share with the Public Health Committee two choices, two frameworks and share with you also our thinking about the findings that we've had and the input that we've gathered. The point from the member about when would we like to have things finalized that we can actually implement the 2025 to 2030 cycle? You're absolutely right. We are at that milestone point where we'd like to make a decision. We do have the Ad Hoc Committee opportunity to review and kind of get last minute thinking on whatever framework the Public Health Committee endorses today and would like to move forward with. We can start within the department kind of fleshing out that framework so that we have the guidance documents, and we have the support that our main implementers in the community need for the launch in 2025. For the moment, I really thank you, Dr. Boufford and thank Shane Roberts and Zahra Alaali and Salman Khan for all of the amazing work that you have done and of course, the whole Office of Public Health team in developing these two frameworks and in pulling together the input and providing information to our partners. We can make a decision soon and move forward. I'm looking forward to the presentation and importantly, the discussion at today's meeting.

Dr. Bauer Back to you, Dr. Boufford.

Dr. Boufford Thanks, Dr. Bauer.

Dr. Boufford Just to say, I had mentioned there is still a window for another set of meetings if we can't come to a conclusion today. I just want to not put too much pressure on the group since this is the first-time folks have seen it. As Ursula said, we want to get the questions out, reactions out, suggestions for additional information that you need.

Dr. Boufford Dr. Watkins is leaning forward, but I think he doesn't have a question.

Dr. Boufford Over to you, Shane Roberts again and Zahra.

Dr. Boufford Thank you.

Mr. Roberts Thanks, Dr. Boufford. Thank the council for the opportunity to present. Thank you, Dr. Bauer, for the introduction. Zahra is going to share our presentation slides. As talked about or mentioned we have a few objectives here with the presentation today. The first objective is going to be just a brief review of what the state health improvement planning process is. We're going to do a review of the current framework that we're using for the current cycle of the prevention agenda. From there, Zahra will take over. She is going to review the revised framework that we're currently proposing and working on. We're going to talk about the separate process, which is the prioritization of the health priorities or the focus areas in this case of what the significant health issues are for the State of New York in this next six-year cycle. We'll have some next steps on where we're at in the process and sort of discuss what the Ad Hoc meeting might look like on the 22nd.

Mr. Roberts Zahra, if you don't mind next slide.

Mr. Roberts Just a real quick recap on what the State Health Improvement Plan or the SHIP is. The State Health Improvement planning process is a framework that was developed by ASTHO, the Association of State and Health Officials that is what majority of the fifty states, DC and the territories use for developing their strategic plans for health for whatever cycle they use during their process. Ours is a six-year cycle currently. We are looking at another six-year cycle for this upcoming version. The SHIP is informed by what we refer to as the SHA, which is the State Health Assessment. As Dr. Boufford had mentioned that that is an assessment of the major health issues that the state is facing. It also it looks to identify resources and strengths that we have as a state. It also looks to identify collaborative partners that can be utilized when implementing the SHIP. It also identifies an evidence base for interventions that could be used to tackle these issues. The SHA informs the SHIP. The SHA, you received a preliminary version of the SHA back on December 12th last year, but we are going to have the final version presented on the Ad Hoc Committee meeting on February 22nd. If you think about the SHA and the SHIP as sort of two pieces of the same process. There is a third process that goes on, which is a health department's organizational strategic plan, which is not part of the SHA ship process, but it is the third pillar in the prerequisites for PHAB accreditation, the Public Health Accreditation Board. The SHA, the SHIP and the strategic plan are all required in order to maintain accreditation. As I mentioned earlier, ASTHO does maintain this guidance. That is the process that we use for our planning the cycle.

Mr. Roberts Next slide please.

Mr. Roberts There are three what I would call phases to the SHIP planning process. I'm referring to them as phases, but they don't happen sort of in a succession. They all sort of happen together. The three phases or maybe the three major activities I should say are stakeholder engagement. In our case, that would be the engagement with the Ad Hoc Committee, which is the organization that is a subcommittee of this committee, which I think we're up to fifty-eight organizations at this point, over one-hundred members. It's a diverse group of professionals from many sectors across society. The other major activity is the State Health Assessment, which I just described. The third and final major activity is the health issue prioritization. That's using the stakeholder engagement and the SHA to identify with the major health priorities are for the state and then developing an action plan surrounding those.

Mr. Roberts Next slide please.

Mr. Roberts If you were to think of New York State's SHIP organizational structure, you know, we have the Public Health and Health Planning Council, which is obviously the Public Health Committee is a subcommittee of. The Public Health Committee oversees the Ad Hoc Committee to support the prevention agenda. That Ad Hoc Committee is our stakeholder engagement body. What we have here in the department is that we have the Office of Public Health Practice and the Office of Science, which are both within the Office of Public Health under Dr. Bauer. They are the two sort of coordinating bodies for the SHIP and the SHA. The Office of Public Health Practice really is focused on the health issue prioritization. The Office of Sciences is focused on conducting the State Health Assessment. We both utilize the Ad Hoc Committee and stakeholder engagement to inform both these processes.

Mr. Roberts Next slide please.

Mr. Roberts As I mentioned earlier, there's been three cycles of the prevention agenda so far. The first cycle was the 2008 to 2012. We had ten priorities at that point. There was the sort of a revision of the prevention agenda for the framework for the 2013 to the 2018 cycle. That's where we have the five priorities that we are using today in the prevention agenda for the 2019 to 2024 cycle. Obviously, we're in the final year Dr. Boufford mentioned for this 2019 to 2024 cycle. We are currently looking at two alternatives for the framework for the next cycle, which starts in 2025.

Mr. Roberts Next slide, please.

Mr. Roberts One more.

Mr. Roberts Thank you.

Mr. Roberts Just a little background first on the current cycle. We have here the 2019 to 2024 prevention agenda priorities. We refer to these as priority areas. Maybe another way we can refer to them as the major domains under which our health priorities are organized. As you can see here, we have chronic diseases. We have healthy and safe environment, healthy women, infants and children, promoting well-being and preventing mental and substance use disorders and then communicable disease.

Mr. Roberts Next slide please.

Mr. Roberts Underneath each one of these priority areas there's multiple focus areas. The focus areas in this case are really what we're calling priorities. They're the health issues that we're looking to move the needle on with the prevention agenda to make progress on and indicators that we're looking to improve. Under each focus area it's made up of goals which are measurable objectives. We have evidence-based interventions which are provided. Each focus area contains resources for implementation. We identify populations and age groups that are affected. We also identify organizations that play a leading role or supporting role in these focus areas. Again, the priority areas as sort of the domains and then the prioritization process I was talking about earlier is really these focus areas that we're working on. That is a separate process from the two frameworks that we're discussing now.

Mr. Roberts Next slide, please.

Mr. Roberts To discuss the implementation of how the prevention agenda works. There are a few terms that we should probably talk about. The first is the CHA, and that is similar to the state health assessment. It is the community health assessment. In New York State, local health departments and hospitals both conduct a community health assessment. In the case of the hospitals, a community health needs assessment. It's very similar to the SHA. It's looking to identify key health needs and issues through data collection and analysis. The CHA informs what we refer to as a CHIP or a Community Health Improvement Plan similar to the SHIP, which is a State Health Improvement Plan. Also, the hospitals have another version which is referred to as a CSP Community Service Plan. The way that it works is that the prevention agenda is a six-year cycle. At the beginning of that cycle hospitals and local health departments will write their community plans and conduct their assessments. They will work with their local stakeholders. Much the same way that we develop an Ad Hoc Committee they will develop a Community Based Committee, which they will then use to inform their development and their CHA development. For the next three years they will work on implementing that plan. Midway

through that six-year cycle, we have an update for that plan, another comprehensive plan. They do an update on that plan and then carry forward for the final three years of that cycle. When they're not doing a comprehensive plan they provide an annual update on their implementation plan as well. One of the changes that we are discussing and we're looking for feedback on is that we think that maybe the three-year sort of midpoint is something that we might consider removing going forward. The feedback that we see from stakeholders, local health departments, hospitals is that after that first year is spent developing a plan, a comprehensive plan. Two years really isn't enough to implement that plan and then have to go right into developing a plan on the third or the fourth year. That is one area where we are looking to potentially make a change.

Mr. Roberts Next slide.

Dr. Boufford Shane, before you go on, I just want to add two things to your really helpful description. One of them is that the request to local health departments and hospital partners. We've been hoping to get them to collaborate using the same community health needs assessment and also bringing together the same stakeholders. That's been working at about a 45 or 50% level, as we've looked at the data over the last several years. We did not make them. We were asking them. Wouldn't it be nice if, I think is the language. The idea is that each local group or stakeholder group, alliance, whatever you want to call them, would pick two of the five areas that they wish to work on, two of the five that are the statewide goals, and then, in addition, address a health disparity. That's kind of what they would be organizing around and reporting on, ss Shane identified. It's not doing everything. It's doing the ones that are the most relevant locally. Thank you, Shane. I just wanted to clarify that part.

Mr. Roberts Thank you, Dr. Boufford. Actually, I was just about to get to that point. Again, the local health departments and hospitals are asked to select two priority areas and a focus area under each or two focus areas under a single priority area. That is currently how it works. We would probably seek to maintain that guidance in whatever version of the framework we use going forward. I guess what I'll do now is I'll talk about what our, two sort of goals are for today. We're presenting two frameworks as Dr. Boufford and Dr. Bauer Both mentioned. I don't want to steal Zahra's thunder. I'm going to just describe them very broadly and then I'll let her talk about it in more detail. One framework is what we're referring to as an integrated framework. That is keeping the existing headers, the five priority area headers that I mentioned a few slides back maintaining those and then looking to refocus our health priorities underneath those headers and then adding in a greater focus on the social determinants of health underneath those headers. An alternative proposal that we're also proposing is looking at Healthy People 2030s domains under the social determinants of health as the headers. The reason we are looking at that is we did receive some feedback during the stakeholder process, particularly from local health departments that had discussed that those headers were a mechanism that they were looking at. We also believe that they sort of describe the social determinants of health activities that we're looking to implement in a slightly better way. That being said, regardless of which framework we choose ultimately the prioritization process that we're looking at is to streamline the current number of focus areas down to a smaller number and to increase the number of local health departments and hospitals that are working on the same focus areas and seeing if we can have better success in moving the needle on some of those indicators this cycle. I will, switch it over to Zahra now, and she will discuss the revised framework.

Ms. Alaali Thank you, Shane.

Ms. Alaali This is Zahra Alaali, the Prevention Agenda Coordinator. Before we go to the next slide, I will revise or review first the process for identifying the priorities and then I will talk about the two frameworks. The process of identifying the priorities for the next cycle involves a thorough analysis and dialogue with key stakeholders over an extended period. This process includes a careful review of the state health assessment data. We also conducted numerous meetings with vital health partners over eleven months. These partners consist of members of the Public Health and Health Council Planning Council, the PHHPC, the Ad Hoc Committee members, the state government agencies such as the Office of Mental Health, the New York State Office of Addiction Services and Support, the Department of State and the New York State Office for the Aging. We also have the local health departments and hospitals at the table. Additionally, we held several meetings with internal stakeholders from various programs and offices across the Department of Health. We ensure that the priorities are aligned with the topic outlined in Healthy People 2030. Finally, we reviewed the progress of the current cycle of the prevention agenda to identify successes and areas that require more focus. The identified public health priorities have been structured into two distinct frameworks, as mentioned by Dr.Boufford and Shane. The first one is the integrated framework. The second one is the revised framework. For the integrated framework the 2019 and 2024, or the current prevention agenda framework serve as the framework or the center. The five main public health priorities have been maintained without changes. Within this framework, existing focus areas are included, and new ones have been added along with new goals. In other words, the new identified health issues and the social determinants of health has been incorporated into the existing 2019-2024 framework. For the revised framework, which is the second proposed framework, the Healthy People 2030 served as the framework. This framework, the priority areas are oriented toward the five social determinants of health domains. I will talk about the domains in the next slide. The revised framework includes a new focus areas, new labels and new goals basically. Here are the five social determinants of health domains from Healthy People 2030. The first one is economic stability. Second one is social and community context. Third one is neighborhood and built environment. Fourth one health care access and quality. The last one is education access and quality. The revised framework will have these five domains. When comparing the integrated versus the revised framework the priorities or domains in both framework overlap. Although the labels are different both frameworks share the same identified health issues. The integrated framework expands the 2019-2024 prevention agenda to include social determinants of health factors. However, the revised framework priorities are more concrete and places a stronger emphasis on social determinants of health and highlights the importance of addressing social determinants of health factors to reduce health disparity and improve health and overall well-being. After COVID-19 pandemic, we all understand the importance of social determinants of health. Basically, the pandemic highlighted health factors such as housing stability, job security and social network influence, and individuals or communities' ability to cope with the health crisis and their wider effect on society. Just promoting healthy choices won't eliminate health disparity. Instead, public health organizations and their partners need to take action to improve the conditions in people's environment. That's why the next cycle of the prevention agenda has an increased and overarching focus on social determinants of health. Each domain in the revised framework will have a focus area, targets, indicators to track progress, evidence-based interventions for hospitals, health departments and other organization. This is something new. We are aiming to have evidence-based intervention at different levels or a different organizational level. We will also have resources for resources for implementation. Identification of population or age groups affected and partners or organization that play a leading or supporting role. Moving to each domain of the revised framework. Domain number one is economic stability. The

overarching goal is to ensure all people in New York are financially stable and supported in pursuing economic prosperity. Under this domain we have four identified health issues. Number one is poverty. Number two is unemployment. Number three is housing stability and affordability. Number four is the nutrition security. Domain number two is social and community context. The overarching goal is to ensure all people in New York live in communities that foster and support a continuum of services that address all residents unique physical, social, and behavioral health needs. We identified eleven health issues, including healthy eating, depression, suicide and anxiety and stress, drug overdose, death, alcohol consumption, cannabis use, tobacco and e-cigarette use, compulsive gambling, adverse childhood experiences, and social cohesion and connectivity. Domain number three neighborhood and built environment. The overarching goal is to ensure all people in New York have equitable access to safe and healthy communities and fair, stable and healthy housing. We have ten identified health issues. This includes safe community, access to exercise opportunities, injuries and violence, lead poisoning, indoor radon, outdoor air quality, healthy schools, environment, water quality, climate change and built and indoor environment and proximity to contamination. Domain number four is health care access and equality. The overarching goal is to ensure all people in New York have access to comprehensive, high quality and affordable health care across their lifespan. We identified sixteen health issues. This includes health insurance access, physical access and proximity to health services, prenatal care and maternal mortality, infant mortality, receiving appropriate screening services for children. This includes immunization, growth and development screening and others. Oral health. The list continues in the next slide. We have healthy aging ecosystem, which refer to the preventive services for chronic diseases and associated risk factors. Sexually transmitted infections, HPV vaccine for adolescents, teen pregnancy, HIV, Hepatitis C, foodborne illnesses, health care associated infections, tick borne diseases, and end of life care and planning. Under the last domain education, access and quality. We have the overarching goal is that all people in New York have equitable opportunity and access to quality education. We have three identified issues. This includes access to high quality education opportunities for all ages, early intervention education. The last one is increased language access to person with limited English proficiency. In the next few slides, I will use poverty as an example for social determinants of health, and I will provide more details about the goal indicator and interventions and resources. The target here is to reduce the number of people living below 200% of the federal poverty line. The potential indicator we could use for this health issue is the percentage of individuals with income at or below 200% of the federal poverty level. Again, this indicator is a potential indicator. For the interventions and strategies to address poverty and other identified public health issues in this revised framework will be categorized into three organizational levels. We will have evidence-based interventions for hospitals and for health departments and other governmental agencies. Last, for other organization such as community-based organization if they wish to use this framework to implement or to adopt this framework for their work. We provide three examples of evidence-based interventions for hospitals. This include forming partnership with local nonprofits to incorporate economic services such as financial coaching, tax preparation and other services into primary care settings and clinics. Other evidence-based intervention at the hospital level is implementing strategies to screen patients for economic hardship and social needs with the aim of connecting them to community resources. Taking a closer look at intervention number two, which involves screening patient for resources, insecurities and social needs. We have identified several evidence-based resources for implementation. You see a list there. Additionally, we have compiled a list of potential partners that could play a leading or supporting role in this intervention. For instance, here we have on our list, we have Department of Social Services, the Government Benefits Project and the Street Cred. Also, here we provided three examples

of evidence-based intervention for health departments and governmental agencies they could implement to address poverty. This includes increasing low-income families, access to financial aid, creating partnerships with community organizations, and expanding income support policies. The last example here is intervention levels. Evidence based interventions for other organizations, such as community-based organization. One strategy is the enhancing the skills of community-based organization staff to implement evidence-based programs in community facing health disparities. This includes providing a workshop, supporting tools such as tailored web portal resources, networking opportunities, and mini grants. Each of those organizational level intervention will have a list of evidence-based resources and implementation resources, as well as the partners. We have identified the health issues. The next step is prioritization. To objectively ranking the forty-four identified public health issues and making a decision about what to include or exclude. We will follow the following steps. First awaited voting method will be employed to rank the forty-four public health issues. I will get more details about this method in the upcoming slides. The second step will be a feedback session with stakeholders. We will conduct this session to discuss the top scored public health issues. This will help to ensure that the most critical issues and of the pressing issues are identified comprehensively for the agenda. The second step, which is the feedback session, we are trying just to make sure that any pressing public health issues is addressed in the next cycle, and it's not missed. The third step is once there is consensus on the selected priorities, the specific focus areas and indicators. Then, we will we basically start or begin identification of strategies and intervention. The prioritization process is designed basically to streamline and focus the prevention agenda. The existing 2019-2024 prevention agenda contains five priorities, and fifty goals, 210 objectives and 99 indicators. As you can see, it is a holistic, comprehensive framework. Our goal from the prioritization is to refine the framework and reduce the number of the selected priority topics to no more than fifteen public health priorities overall. The pyramid you see on the left is the 2019-2024, the current prevention agenda. Our vision is to have less priority topic and more focus and streamlined framework. Each of these priorities in the 2025-2030, will have one goal, one target and one indicator. The reason behind this is because the current prevention agenda framework has multiple focus areas and indicators. Aligning the priorities of hospitals and local health environments has been difficult. This challenge was prominent in large counties with multiple major systems, hospital systems. By adopting a more streamlined and focused framework, we anticipate a higher level of collaboration between the local health departments and hospitals. The first step of this prioritization process is the weighted voting method. We will use an online survey that is based on seven criteria. The main purpose of this survey is to rank the forty-four public health issues. Priorities in the next cycle of the prevention agenda will include the highest scored public health issues within each domain. I'm going to talk about the criteria in this survey. Criteria number one is severity of the problem, which refers to whether the identified issue can reduce life quality, limited opportunities, or cause serious health outcomes such as disability or death. The survey question is, does this issue have a significant impact on health? The rating scale is from 1 to 5, with 1 is less severe to 5 extreme it has severe, extreme severe impact. Criterion number two is the size of the problem, which refers to whether the identified issue affects a large number of individuals and has the potential for significant impact on the health of the community. The survey question will be does this issue affect a large number of individuals? Again, the rating scale is from 1 to 5 with the relatively few individuals affected and 5, large number of individuals affected across the entire population. Number three, this proportionate effect amongst other groups refers to worse health outcomes caused by the issue in specific subgroups defined by age, race, ethnicity, income, gender, or geography compared to other groups. The survey question is, does this issue impact specific population groups or not? The rating scale is 0 or 5. If the answer is no two 0

points. If the answer is yes, then it is 5 points. Criteria number four is economic and social costs. Refer to the consequences of not addressing the issue, which include increasing monetary costs such as health care and social services expenses and social costs such as loss of productivity or use quality of life. The survey question does this issue result in significant economic or social cost? And again, the rating scale is from 1 to 5 with 1 minimal economic societal cost or 5, extremely high economic or societal cost.

Dr. Boufford I wonder if you could just move a little more quickly through the presentation, because I want to have some time for discussion and questions. We can go over to for the group, but just...thanks.

Ms. Alaali Sure.

Ms. Alaali I'm almost done. I was just going over the criteria five, six and seven. Criteria number five is the impact on lifespan. Whether the health issue arising on life stage impact the rest of their life or not. Number six, the feasibility refers to the practicality and adequacy of logistics including the cost, resources and interventions needed for the state to address this issue. Number seven, the availability of evidence-based intervention and whether it is easy to implement them or not. We are almost done. The survey will be electronically distributed to the following entities: New York State Department of Health Programs, Centers and Offices, including regional offices, local health departments, all nonprofit hospitals, New York State Association of County Health Officials, Greater New York Hospital Association, HANYS, the Health Care Association of New York State, other governmental offices and agencies, and the Ad Hoc Committee members. For our next step, we will present the results to stakeholders, internally and externally and the Ad Hoc Committee. We will also conduct the feedback session after that. We have consensus on the priority areas, we will finalize the focus area and indicators. The last step will be identifying strategies and interventions. This is the end. I made a great job finishing really quickly.

Dr. Boufford Very good. Thank you.

Dr. Boufford I would like to ask colleagues for questions, observations, etc. I'll hold off on mine until the end.

Dr. Boufford Dr. Watkins.

Dr. Watkins Sure.

Dr. Watkins I want to commend the department and all that have worked on this prevention agenda. I want to say hats off. Great job. I want to get back to Dr. Boufford's question about whether or not we're going to... Either incentivize hospitals and local health departments to work together on the future, CHA and CHIP, I think, if there's not going to be an incentive or a strong mandate that we do something to incorporate data that must come from either local health departments or hospitals. If they can work together, I think it's really important that the two entities work together. I see you're driving this new prevention agenda with a survey. I want to make sure that we align our prevention agenda and our new CHA/CHIP to be aligned with the accreditation, Public Health Accreditation Board. They often ask about questions for local health departments and their CHIP. There's a lot of things that I don't think are included as part of the state's requirement when we're choosing different areas within our CHIP. I think you looked at the focus area, your objectives, your strategies, interventions, your measurements and things of that nature.

When you look at the Public Health Accreditation Board guidance and their requirements, I am hoping that we can align some of those requirements with what we are going to ask our hospitals and our local health departments to do as well. Because we found a lot of things as we were going through accreditation that we probably could have done or chosen. For instance, evidence-based programs and making sure that policies are included in some of your interventions and strategies. I don't know that we chose those things. I can go down a whole list of things that are we probably didn't do, but I think could be put into this new prevention agenda, this new CHA/CHIP requirement for local health departments.

Dr. Boufford Thank you.

Dr. Boufford Other comments? Questions?

Dr. Boufford Dr. Lim.

Dr. Lim I'm going to look this way.

Dr. Lim Echo Dr. Watkins. Congratulations. I just have a couple of questions and comments. Part of what we're asked to weigh in on is whether which framework we should adopt, right? I think my initial impression is, is that the second framework, where it's basically the social determinants of health using the Healthy People 2030 is that would actually align very well with the overall structure of the waiver. It would meld that very nicely. We've talked about how we make sure that that's connected. I think one of the sorts of caution areas in using that is really more in the details, in the sense that I think hospitals and other health care organizations, but hospitals in particular, I think the idea of how do we get into the meat of addressing the social determinants of health? I think there is agreement, certainly, that we need to do that. Exactly how the health care sector does that in a substantive way... We're still learning about that. I think we probably just want to be cautious about what the measurable objectives or the goals or the targets would be because if one of the goals is to reduce the number of people under the federal poverty line, right? I think just to make sure that whatever roles health care organizations and how they contribute to it, that the actual target can be met by the health care sector contributing to that. Because just want to make sure that we succeed. When we're still sort of really early on in the process of getting our industry to think about what does this concretely look like if we engage in these kinds of efforts in a more meaningful way? That's all.

Dr. Boufford Thank you.

Dr. Boufford Ms. Soto.

Ms. Soto I want to reflect backwards a little bit. Maybe this is more directed to Mr. Roberts. Now that we're concluding the 2019-2024 agenda is there going to be a report? Is there going to be feedback as to what was accomplish? Not accomplished? What objectives were met? What certain communities sort of a best practices that we can look at the success of this? I know we're focusing right now on the next phase. What about the one that's concluding this year?

Mr. Roberts Thank you for that question. I would want to defer that to Dr. Rosenberg, but that we have a presentation that we gave earlier in 2023, which was up to date to 2023. I think that we could probably and again, deferring to Eli that we could probably update that with the final years data and make that available.

Mr. Rosenberg The dashboard is, is a living is a living is assessment of that. We actually just updated jeez a week or two ago the dashboard to be the latest year's data as well. We're always happy to summarize as needed. And then of course, the introductory matter that the state health assessment that Dr. Davis presented and any other matter that will feed into the next cycles documents also will summarize where we've been and how we got here.

Dr. Bauer Maybe you weren't intending to raise this, but I just wanted to ask I think you mentioned the notion of best practices. It's come up a number of times. It may be useful also to think about that is which local health departments were able to develop strong partnerships with their hospitals and with other stakeholders in their communities. I think we've heard some were super successful and others really had difficulty. I think the qualitative angle of that, it would be great to just get some examples from that as well in addition to the dashboard and the metrics that Ms. Soto was mentioning. Just for future implementation, it'd be great.

Dr. Boufford Dr. Soffel.

Dr. Boufford Dr. Bauer, you wanted to comment on that question.

Dr. Bauer It's a great question. Kudos to the team for the really stellar dashboard that we have in place where counties and hospitals can really look at their data over years over the prevention agenda cycle. The finer points are kind of beyond the trends that we're achieving, I think are really important. One question that we asked at the outside of this planning period was county health departments and hospitals are engaging in their communities and doing public health and prevention work. What difference does the prevention agenda make, right? Does having the state health improvement plan actually accelerate or expand or extend that work? That's a question we put out there. We'd love to figure out how to evaluate that over the next cycle. And then to your point, Dr. Boufford, I'm intrigued by the idea of a set of case studies really looking kind of in-depth in particular communities how partnerships work, what makes them function, how they're able to develop synergies, what they deliver to the communities I think I understand this correctly, that most local health departments do work with a hospital for their prevention agenda work. Most hospitals do not work with local health departments. That's because we have many, many more hospitals than we have local health departments. Figuring out how we can bring in hospitals that may not be engaged fully with their local community is a question we should ponder. Thanks.

Dr. Boufford Dr. Soffel.

Dr. Soffel I'm going to pick up on what Dr. Bauer just said and what Doctor Lim said. I think that the five goals under Healthy People 2030, the economic stability, the neighborhood and built environment and education, access and quality really don't touch hospitals in what they do at all. I was looking at the sort of the subcategories within each of those three particularly. I don't see how hospitals have a significant role in achieving economic stability, reducing people below the poverty level. There was one example that you gave about poverty where hospitals could be used to screen for resources. That's really not what hospitals do. It's not what hospitals are good at. There are people out there who do that and who are really good at it. They somehow aren't part of this plan explicitly, at least not yet. My concern is relying on hospitals to achieve social determinants of health is not likely to be a winning strategy in any sort of timely framework. My second concern is

what infrastructure the department has in place, or local health departments have in place to support those folks who actually do affect social determinants of health, whether it's the local health department, their connections to the community-based organizations that serve those communities that in fact do social screening and referral and provide services that try to tilt the seesaw on social determinants issues. I am concerned that the current way we think about the problem, which is hospitals work with health departments is not the framework and the infrastructure that we're going to need. I think Dr. Lim is absolutely right that the waiver tries to move us in a different direction. I would love to see more thinking about how this process could sort of piggyback on waiver efforts much more explicitly and deliberately and think about ways to include community and ways to partner with CBOs to try to develop a more robust strategy. My last comment being, as I am a consumer representative to the council, the distribution plan doesn't include consumers. I think that that's a problem. I know we like to think that the health departments speak for consumers, but consumers also speak for consumers. I think that they are missing from this in a fairly large way.

Dr. Boufford I guess one question is, might just to take that last point, might this be posted on the department's website for members of the public to respond? Is that technically feasible?

Mr. Roberts I'll have to get back to you on that and look into what's possible. I mean, I think that it's a good point. We'll have to look at that and see if there's a way that that could be made available to consumers.

Dr. Boufford There are some ads what I would call advocacy group members on the Ad Hoc Committee. We have to look at that also Shane, just to be sure we get answers from people that are sort of representing an advocacy position for certain populations that may or may not have access.

Dr. Boufford Dr. Yang.

Dr. Yang Hi. This might be a little sacrilegious as a public health person at heart and in training and in work. We've been struggling. I consider myself still. It's a bit of an identity crisis. It's not health in all policies, but it's health in all things. Public health is everything if you go far enough upstream. We are basically about poverty. We are about all those other things. When you describe social determinants and that that continues to be sorted out. It may be very local. It might be very variable with a wide spectrum of what public health looks like at a local level and a state level what we take on. For the Public Health Committee of the PHHPC though, I guess the question is...What are we tackling? I mean, the waiver, the question about the partnership between local health departments and hospitals is absolutely key. That is, let's be frank about it's still about really health. We can make recommendations about housing. We can make recommendations about public assistance. We make recommendations about hourly minimum wages and environmental stuff. The things that local and state health actually has authority over like environmental, which is a regulatory thing or communicable disease, which is really EPI and looking at patterns of emerging and diminishing are good partners with the health care delivery side, which we are primarily partnering with at a public health and health side. It's still health, though. I don't know that our priorities should focus on that while noting those other things that are absolutely critical. We don't have those other partners at the table. We don't have that electoral authority, which is broader than even number of people that we can put around the table. I don't want to lose the aspiration of it because that is building the village, going upstream, fixing the social determinants, all those things that lead to it. To be,

measurable or at least feel like we're accomplishing that we're not the lowest state, we're not the highest state, but we are improving regardless of how... I don't know that our progress is steadily improving. I don't know when we drop down to the ranking everybody else floated up or we actually improved. I don't know that anymore. To be achievable, maybe we focus more on what we actually... We, as public health facilitating, supporting, informing, advising, monitoring, observing what the health care delivery system does and what the funding sources to that service are is a way to prioritize. Otherwise, we end up, I feel highly aspirational, which we don't want to lose but then I don't know what we're doing, right?

Dr. Boufford Dr. Ortiz.

Dr. Ortiz I'm just curious if there's a way on the dashboard because I'm thinking from a workability side if we are looking at these partnerships and then having the dashboards show what partnerships are working well. It'd be nice to know what the top five states are doing really well and how they link to partnerships that are working well in our state. Because I think if people can replicate that and see how it's done, then why would we waste time to create all these for the partnerships that may be sort of low hanging fruit for us to sort of move up in the rankings? I'm not sure what the top five states are. You're probably right. They're probably moving all the time. There has to be states that are doing things extremely well and so explicitly that we'd be foolish not to just follow lead.

Dr. Boufford I think staff had looked at we had a brief presentation, but Shane, I think you and Zahra had looked at what other states were doing. I don't know how granular you got into that. Maybe you want to respond to that because that would be good. Do we already know what worked? I mean, some of the states that were listed, I would say much simpler than New York State, but not irrelevant in terms of looking at the model. Maybe you want to respond to that piece and then we can come back to the partnership leverage question.

Mr. Roberts Absolutely.

Mr. Roberts If you remember off the top of your head the rankings. I don't remember which states were in the top five. I do remember that what we were looking at was what the priorities were, the health priorities focus of all the states across the country and which states were focusing on social determinants of health and how their plans had evolved to their cycles. We do have that. We can get that. I agree that, you know, looking we did do some discussions with other states. North Carolina was a state that we met with one on one. I think we talked with New Jersey. There may have been others as well. Just to speak a little bit, again, to the last topic is one of the things we did take away from North Carolina was that they have a community council, which is a sort of a statewide entity that looks to focus on these larger social determinants of health at a policy level, but also drills down into more and more community and regional level. That is something that we are exploring internally here for our implementation. We don't have the details on it, but we do have goals. Part of that would be, again to be able to facilitate those relationships at the community level. Also here obviously, as our committee does at the state level. We can certainly look back at the SHIP analysis. I think I actually have the presentation still.

Ms. Alaali The top five is in New Hampshire, Massachusetts, Vermont, Connecticut and Hawaii. As you can see, none of them have similar governance and or even population level as a New York State, except Massachusetts, I would say like they are more similar to us. The others no. The top five all of them they have at least one social determinants of

health factor in their plan, except one. I don't have more details about the collaboration and who is at the table in each state, basically.

Mr. Roberts One thing that we can add to that it's the state health rankings that we were looking at. The areas where we scored, lower was after there was a shift in the criteria that was being evaluated and it was residential segregation. It was housing. It was poverty, economic issues. COVID also factored into that. That is how we ended up going from if it was 11 to 23 or whatever that drop was. This was previous cycle. We can find that. I think we have that in another presentation.

Dr. Boufford I think it would probably be important to remember COVID and opioid epidemic as well. It may have had some influence in the drop. I want to come back to Dr. Yang's point, and I think Dr. Lim's. You've laid out very nicely the how one would approach the broader social determinants, how hospitals would, how local health departments would. I think that to me, the real question mark is in the other organizations bucket. Because obviously, as we indicated, you know, many hospitals as anchor institutions are taking on issues of local economic development and others. It's kind of each one has their own strategy within the framework of what they can do. I think similarly, it's pretty hard for local health departments and hospitals, even with local partnerships to leverage this really large issues that you have in mind. I wondered how you were thinking about the leverage getting that going at the state level. I appreciate it's not in the slides. It's probably something that's still a work in progress. How you're thinking about moving, leveraging the ability to partner that might trickle down, in terms of what might give people more leverage at the local level. If, in fact, the goal is still to address local health concerns or health, meaning largely local health. Just one editorial comment. I think the waiver is great, but it's still social care services. It's not changing conditions in community. I think the alignment is a really important cautionary tale. People are beginning to think about it more and certainly hospital behavior, what you'd want to align with what they're being asked to do on the waiver. It might not give the leverage that would be necessary for this broader engagement. I don't know, just how were you imagining. You mentioned North Carolina. How would you imagine getting other sectors involved, I guess, other state agencies, other categories of organization?

Dr. Boufford Dr. Bauer, do you want to take that one or Shane?

Dr. Bauer Sure. I'll start out.

Dr. Bauer I do agree with you. It's somewhat daunting. When we look over the last fifteen years of the prevention agenda in many areas we've made steady progress. Hopefully, over the next six, ten, fifteen years, we'll make steady progress here if we can really focus in on some of these conditions that really help communities thrive. I do agree. We'll learn more about the 1115 Waiver at the PHHPC meeting tomorrow. I do agree there's some potential opportunity there to kind of get hospitals thinking about health-related social needs and how they can plug patients into resources. In terms of the health department, we have been exploring kind of new ways of working with community members. I'll call out our COVID Disparities Grant, where we have put out over 20 grants to community organizations, most of whom are organizations we have never worked with before. We're expanding to a whole host of partners who are embedded in the community and who work on a range of issues in the community and distilling those partnerships and building their capacity to have an even greater impact in their community. With the Public Health Infrastructure Grant, we will expand that kind of community engagement. You'll hear more about that over time. While I don't want to put her on the spot because this is her third day

on the job, I will call out Natasha, who just joined us as the lead for our Health, Wealth and Wellbeing Unit. Welcome, Natasha. This unit is also funded under the Public Health Infrastructure Grant. Its purpose is explicitly to go out beyond public health, go out beyond the health department to pull in data from other sectors, to pull in ideas from other sectors, how we can lift up communities, how we can build wealth in communities, how we can help communities thrive because we know that doing that has a huge public health payoff. Natasha is not going to solve that problem in the next six months to a year. We are investing in developing and discovering, these solutions. We can bring those to bear in the prevention agenda.

Dr. Boufford I would just have two questions and then we will sort of have to wrap up and move on, so we have time. I mean, one of the issues is I think Dr. Yang was alluding to it. If we are going to have metrics to measure effectiveness, how do we do that if it's a question of... And I think the other thing that was mentioned, Shane mentioned the idea of trying to sort of focus more activity in certain areas so you could begin to see results across the state rather than leaving so much to local option. How does that happen if, in fact, we go beyond the public health and hospital partnerships that have been created? I think that's really one question. Secondarily, I wanted to remind us of all that we do have a standing Executive Order on Health in All Partnerships Across All State Agencies, which was actively meeting and collaborating before COVID, unfortunately, and has not met since COVID, but that issue of bringing the agencies together and having conversations with them about how they're looking at their policies in transportation, in Parks and Ag and Markets, etc. I mean, that is a potential vehicle at state level for beginning to leverage broader political support. It's not the council that you talked about in North Carolina, which obviously requires gubernatorial support. I'm just interested in the metrics with health departments and hospitals if they're the key actors with whoever they can bring to the table at local level. Similarly, is there any thinking about this sort of across state agency beyond OMH, OASAS, NYSOFA and DOH who've been with us pretty regularly from the beginning. Maybe those two questions.

Dr. Bauer Just to clarify, I think the group that Shane spoke about in North Carolina, if I remember correctly, Shane, that was like a citizen's advisory committee to the state health improvement plan. It wouldn't involve the Governor. We'd have to think about how we might pull that together. It would be a way, as one of the members mentioned to bring in that community voice. Certainly, that is something to think about. I agree, the metrics are to be worked out. Once we have a framework to move forward with we can get to work with what those metrics would look like. I've been impressed, frankly, with the evidence-based interventions that the team has pulled together for hospitals, for local health departments, for other organizations and working with those looking at what might be some focus areas within the 1115 Waiver. I think will help the wheels turn and identify those metrics.

Dr. Boufford What about at the state level in terms of the department's engagement with other, shall we say, non-directly health related agencies? Are they part of this conversation? Will they be? How are you seeing that develop?

Dr. Bauer I think absolutely we can have that conversation and figure out what the state health department's role is and how we want to advance that.

Dr. Boufford Any other questions? Observations?

Dr. Boufford I mean, this is a lot to take in. Again, congratulations on all the work and thought that's gone into it. I will perhaps invite the committee to send questions if they have comments, questions on the slides, things they'd like more information about would be super helpful in terms of the prep for the Ad Hoc Committee and or for perhaps one other set of meetings that we might have on this topic. That would be great.

Dr. Yang You'd mentioned that we'd get an update or a briefing on sort of how the waiver impacts. A few meetings ago we had heard from OHIs. They had made a presentation. We were in Albany. They talked about how they were aligning with the prevention agenda. I don't know if they followed up. We were curious about how the state's reimbursements thinking structure strategically might be aligning or trying to align and support the prevention agenda. I don't know if those same people.

Dr. Boufford I sat in on an hour and a half briefing on the waiver the other day. Obviously, the term prevention agenda is being used by a number of state agencies and the Master Plan on Aging and others. I've cautioned the Master Plan on Aging folks a little bit. I mean, we don't want to deemphasize prevention, but we have to be really careful about the prevention agenda issue, because you're right. It has a historical structure and a set of issues associated with it. We can pursue that again. I haven't been involved with them that closely.

Dr. Yang A broader question about how the money side, the reimbursement.

Dr. Boufford Well, and then the other issue, this has been a pretty much an unfunded initiative from the department. I'm delighted that Dr. Bauer's investing some of the Public Health Infrastructure Grant in that area. Obviously, as we know grants end. This is a really important set of challenges you've raised. I think we'll want to pursue these some more. I really encourage people to take this seriously and really appreciate again, all the work that you've done to get us to this place.

Dr. Boufford Keshana Owens-Cody is Workforce Director of the Office of Public Health. She's new to us. I'll give you her whole entire title. I think she has a Power Point as well to give us an update on the work, the activities in the workforce area. Again, I think we're still kind of circling around this topic to sort of see how, as is our practice, how we can be helpful as a Public Health Committee and obviously with our PHHPC colleagues on shining a light on an area that was important. One of our, I think our happiest precedence is the issue of maternal mortality some years ago. We'll be getting an update on that at our next meeting that we're not ready to this time. We haven't dropped it in terms of ongoing. So, had a nice talk with Keshana when she first came on and told her we would continue to work with her. We're looking for her to tell us an area where we can really help her.

Ms. Owens-Cody Thank you for inviting me back. I think you were right. When I first came on, I think I was a couple weeks into my role or maybe a couple months. We are actually in year two of the grant. I thought I would at least give you an update on what we did in year one and what we're hoping to accomplish in year two. Just to level set with everyone, the grant that we have is the... We were awarded the CDC Public Health Infrastructure Grant. We have five years, to strengthen and increase the diversity of our public health workforce, increase the size of the public health workforce, invest in training and development, as well as improved organizational systems and processes, as well as, we have a big data modernization project that's also attached to this grant. The purpose and hope are that we will be ready and responsive to our next public health emergency. I would say we spent a lot of time getting to know and strengthen partnerships and relationships that would touch

this grant. So, me presenting in this group initially but also working with our local health departments who, as a reminder, 40% of our grant also went to our local health departments to be able to utilize the funding in the ways that are identified on the first slide. We did in the midst of this year strengthen our relationship with NYSACHO. We've held quite a few town halls with the local health departments to answer questions. We've really been focused on speeding up the process for them to get their budget modifications approved. I know that was a part of our discussion last time as well. Maximizing our relationship with NYSACHO to really host conversations, answer questions. Actually, we just scheduled another one today. We'll have another one next week with local health departments. We've also taken advantage of CDC technical assistance. We have the opportunity to ask them to support us with any questions or issues that we see arise within the grant. That gives us the opportunity to collaborate with other states. My team and I'll share a little bit more. It feels good to see my team. Some of my team members have reached out to other states to ask them how they're specifically working with local health departments and their distribution of funding. That's been also fruitful to this. Definitely working internally with our HR departments because we know in order for this to be successful and effective, we have to understand our human resource departments, how we can work collaboratively together, but then also identify some of the pain points they have and see how this grant can be used to support their efforts too. Also working with community-based partners. Again, internally, also collaborating with the Office of Health Equity and Human Rights. Being that this grant is also focused on advancing health equity and reducing health disparities. Definitely some collaboration there as well. I would say that was like the crux of the beginning of the year. Just to give updates on local health department contracts. We are moving the needle on these contracts being the budget modifications being approved for year one. We're also in the process of giving out guidance for year two for those counties that chose to receive their funding annually versus receiving it in one lump sum. This has been our process of doing that. This process continues to evolve making sure that we're collaborating with the CDC and also getting information to our local health departments so that we can move these budget modifications forward. Another big piece of this grant is I thought it would be good to share with you how we're being measured in terms of our performance by the CDC. This grant does look at our hiring and retention practices. We are working with human resources to understand how long it does take. What are the median days to fill a position? We're looking specifically at the new hires for this grant. How long does it take for us to post the positions? Create the positions? Interview? We're really looking at that process. We're also looking at the retention rates both on permanent staff as well as temporary contract staff. Analyzing that. I would say the first year was kind of getting our baseline data so that now we can analyze it during our steering committee meetings that we have. We were also asked to add procurements in. We are looking at how the number of federally funded procurements and the days, the number of days it takes for us to execute contracts. The other two that you see here, one is related to accreditation. This Department of Health is accredited. We do answer questions to that, but also the quality of the data that we are receiving. It does take quite a few, partnerships to be able to share this information. We also are analyzing it and working together and workgroups to see how we can use this grant to improve in different areas. The other area that we were able to focus on with their performance measures with the CDC is we were able to develop a targeted evaluation plan. I know that we are going to discover together ways that this group could help, but I thought showing you this. This might be an area at some point that we can work together through. What we're going to do initially is evaluate our workforce recruitment processes and the timeliness and also looking at increasing diversity. We are going to be working with our human resource department as mentioned before on the previous slide looking at hosting some hiring manager interviews, staff surveys, reviewing existing staff

engagement surveys. Also, reviewing existing hiring guidance, efforts to increase diversity. Where are we posting positions? Making sure that the community knows about different positions that are available. We'll be looking at job awareness, job creation, job posting, interviews and job offers that entire process. We're hoping that our outcomes are increasing the size and diversity of workforce, increasing pipelines and pathways, as well as increasing flexibility and job creation as we recognize our grants, some of the services that we're delivering may call for new job creation or new job titles. We're also looking at that as well and improving our hiring timeliness. This is what we've decided in the Office of Public Health that we would gear our targeted evaluation plan towards for this year. It could go across the five years of the grant. We also have the flexibility to also add other areas too. Over the course of the couple of months we have built our team. The Public Health Continuing Education Unit. There is a director that is now in that seat. Dr. Bauer just mentioned our Health, Wealth and Wellbeing. We will be making an offer on the Community Engagement Director position. They're already hired, already working with a variety of our regional offices, academic institutions and starting to engage with local health departments, which is helping us to move those contracts forward. Our program leadership team has also been hired. I know last time that I shared, I think there were maybe three of us around staff, but there are seven of us now. We are all stationed across the state or will be through the roles that we have. We will have staff that are in our regional offices as well as here in the Capital Region. My team that has been hired. These are the other eighty plus positions. I know I shared this with you all last time that we met. We will be supporting each one of these different centers with some of their hiring challenges and needs that they may have. We did have a day where my team got to meet all of OPH centers and be introduced to all the work that they do and to learn about training and development needs, but also learn about different positions that are hard to fill. We are going to work with each one of the centers, kind of unpacking that, understanding where jobs are being posted, what skills they're looking for with degrees, what academic institutions do they already have partnerships with, and seeing how they can leverage the team to support them with getting more candidates, and increasing our public health workforce. These are the positions that are in the regional offices that are to be hired as well. We do have a Regional Office Liaison that is working with the regional office commissioners to hire a variety of these different positions. Also collaborating with one another and bringing resources from the Capital Region into these offices as well. I know that was a quick update, but I wanted to at least share what we've been working on for the past. Seems like it's the past year in the CDC Grant language, but the last few months.

Ms. Owens-Cody Dr. Bauer's is there anything that you would like to add to Public Health Infrastructure?

Dr. Bauer Thanks so much for that presentation. Definitely a work in progress. I'm just thrilled with the progress we've made to date. We literally started from nothing, if you will. We have a lot of money from the CDC. We were delighted to bring Keshana on board. As she builds out her team that just increases by orders of magnitude our ability to do this work. The first year was really building up. Hopefully, it's full speed ahead for the coming years. The one thing I'll maybe elaborate on a little bit, and Dr. Boufford, you had asked the question, how can the Public Health Committee and PHHPC help? We are laser focused on the hiring that we need to do, the support that we need to give to local health departments for hiring and then these metrics that sound very bureaucratic; number of days from when you're at the procurement to when you sign the contract. Number of days from when you develop a job posting to when you actually fill the position and so forth. That kind of work takes an amazing amount of time from our day-to-day public health

work. Streamlining that, making it more efficient, building in efficiencies, cutting down those timelines will be absolutely critical. We don't want to lose sight of that. However, we're not doing all of that work for the sake of doing that work. We're doing all of that work in the service of creating a strong public health workforce that can actually tackle our public health problems, right? Can actually reduce health disparities and improve health equity. It can be easy to lose sight of that. We want to make sure that we attend to the hiring and the strengthening that we need to do day to day. We're recognizing that this is for our purpose that we need to attend to as well. In terms of how the Public Health Committee and PHHPC can help us with that. It's maybe not the sexiest work the committee does. Recognizing the role that these bureaucratic processes play in kind of taking the time of the public health workforce and how important it is to have efficient and streamlined systems for us to do our work so that we can pay attention to the public health programs that we're implementing and the public health goals that we're trying to achieve, I think is maybe a message that that could be amplified a bit out there. Dr. Boufford, you also mentioned, grants come, and grants go. That's absolutely true. I am confident that this grant is not going to be taken down now four years from now. The centers for Disease Control and Prevention have invested $3 billion in building up and strengthening the public health workforce. They are absolutely not doing that so that they can take it down in four years. I don't know what the plan is. I'm sure we will be having those discussions over the next four years. How do we build sustainability into that work? There will, I have no doubt be continued federal funding to support the strengthening of our public health infrastructure. Thank you.

Dr. Boufford Thank you.

Dr. Boufford I think one of the questions is whether... I know the last Governor's budget had a significant amount of money in for the health care workforce. Is there a way not only getting a grant renewed but getting the thinking of our legislators and others into public health financing.

Dr. Boufford I've got Ms. Soto, Dr. Yang and Dr. Watkins and the order in which I saw them.

Ms. Soto Thank you for the update. I was looking at your workforce team. Two areas that I don't necessarily see here. One is the New York State Department of Education, which is involved with some of the licensure of some of these professions. And in addition, the New York Education Department has launched and has maintained pipeline programs in the STEM careers with a focus of diversifying the workforce in New York State. The other piece, which can be a little tricky is the committees on health with the New York State Legislature. Recently, I heard on the news that New York State is considering increasing the expansion of the responsibility and ability of physician assistants. There's some of which had stepped up during the pandemic and as a way to address both physician shortage and costs. I realize that part of this could be political. Some of the things that we may be wanting to advocate and or and funding may come out of those committees.

Dr. Watkins I want to thank Ms. Cody for a great presentation. Of course, Dr. Boufford for, backing that up. I just have a couple of questions. This is through multiple meetings we've had with your Public Health Infrastructure team as local health departments are still trying to get through this waiver. I mean, this process for approval of their budgets. Year one seems to have been really difficult for local health departments to get their budget modifications approved. Where there are still a few local health departments, I know at our last meeting who are still in that waiting period of getting those budgets approved. We're

hoping, maybe there could be a liaison person assigned to these local health departments who are still waiting to get that first-year budget modification approved to move them along because we are concerned about this grant going to end in four years. With different administrations, I know that we have this positive outlook. We are going to be positive about the objectives in the future that this funding will continue. There is that possibility that it will end soon. We just want to make sure that local health departments are going to be able to participate in this great program that you have initiated here with CDC. With that being said, we are concerned about the sustainability. I know Dr. Boufford has talked about the sustainability, and she's very optimistic about CDC will continue this program beyond the four years.

Dr. Boufford Dr. Bauer, I think.

Dr. Watkins Was its Dr. Bauer?

Dr. Watkins Yes, it was Dr. Bauer. I'm sorry.

Dr. Boufford I hope I could join her, but...

Dr. Watkins I'm sorry.

Dr. Watkins Dr. Bauer, you were very optimistic about CDC will continue this program beyond the four years. Again, there may be a change of administration. Things might happen with CDC that is unbeknownst to us. What would happen to all of these new positions that the department is bringing on? These positions that you're bringing on. Are they any positions that going to deal with the social determinants of health? As we try to incorporate sort of determining the health and our prevention agenda and ways to improve localities who have not seen any kind of improvement. Some of the things that you have on the dashboards. How will these new positions help those localities as well?

Dr. Boufford Thanks.

Dr. Boufford Ms. Cody or Dr. Bauer, you want to take that on?

Ms. Owens-Cody Sure.

Ms. Owens-Cody the first question was related to having a liaison for the local health departments that are needing to move forward. I am happy to share that we do have a local health department liaison that's actually working on that as we speak. We'll be introducing Meredith Paterson to. Local health departments through NYSACHO, a meeting that will be announced, I believe, for next week. I'm excited to share that. In terms of sustainability, and I'll go to the question of are any of these roles focused on addressing social determinants of health? I would say all of the staff that are coming on will be addressing social determinants of health or have it embedded as a part of their foundation and all of their work. I would say we have a Director of Training and Development that will be supporting local health departments and will be offering or will be available to provide training and use our subcontracted awards that we will have with the School of Public Health and Cornell University to bring training and development to all of OPH, but local health departments. We also have a Community Outreach and Engagement Unit that will be formed. Social determinants of health will be embedded in their activities as well. Academic liaison is working with education institutions. That is a social determinant of health. I would say foundationally, even the training and development that we've been

providing in terms of onboarding, everyone will have that as a focus as well as reducing health disparities. In terms of sustainability, Dr. Bauer, did you want to add more to what you shared about sustainability?

Dr. Bauer We did address sustainability in our grant application. CDC did not ask us to do that. We committed to after year one and after we started bringing staff on board, putting forward some budget proposals to see if we could demonstrate the value of the work that this grant is doing and make the case for supporting that through state dollars. That work is to come in the subsequent budget seasons. We'll see how we fare there. That's another place that PHHPC can be a strong advocate for us.

Dr. Boufford Dr. Yang.

Dr. Boufford You got your question answered?

Dr. Boufford Thank you.

Dr. Boufford Thank you, Dr. Watkins, for answering Dr. Yang's question.

Dr. Watkins No problem.

Dr. Boufford I want to go back to, just briefly, Dr. Soto's point about the Department of Education, because I think Commissioner McDonald spoke at hospital fund breakfast last Thursday morning and indicated that the broader workforce area is one that he's very interested in personally. A lot of the conversation obviously was around the health care workforce and practitioners and others relative to the scope of practice, which is controlled by the Department of Education. It's a really interesting question as to whether we might be more creative inserting some public health roles in the current job descriptions, if you will of health care delivery system staff. I mean, I know some of the folks that are in other places have looked at the role of community health workers who very often they may be doing home assessments, but they might be looking at some of the broader environment, some of the economic issues. Others is a training question. Obviously, whoever's sponsoring them and scope of practice and training. I think a lot of environment people are looking at those groups as an opportunity to increase the understanding of indoor and outdoor environments in terms of community conditions. It would be interesting. You might think about that before next time and see if there's any wiggle room there. Because I think that's an area that the committee and the council might have some interesting thoughts about. If we were kind of trying to piggyback on what is considerable investment in the health care delivery workforce. I know they need it. I'm not saying that, but just figuring out where could we get more of a public health lens, a population health lens, into some of the some of that investment? Since it's clear we're... I think we're never going to have that level of investment in the public health workforce no matter how successful everybody is. It's just the real world. Just something to think about.

Dr. Bauer I'll add, just along those lines, Dr. Boufford, you know, we're the New York State Department of Health. We do a lot of public health. Yet there's no civil service title for epidemiologist. We can't hire an epidemiologist through the civil service. We have to hire a research scientist or hire a data analyst or hire a program specialist. We can put epidemiology in the job description. That's another opportunity in terms of workforce development that we can strengthen.

Dr. Boufford Dr. Watkins.

Dr. Watkins We were still talking about sustainability. You indicated that beyond the four years the state Department of Health has indicated to CDC that they will find... Oh, I don't know, funding or resources in order to make that happen. I know that this infrastructure grant, 40% of that went to local health departments. Will some of that sustainability beyond the four years, if it has to be picked up by state/DOH still continue to trickle down to local health departments as well?

Dr. Bauer I have no way of reading the tea leaves there. I will say, just to clarify. We committed to try to get state funding, right? There's no way that we can actually commit to getting that. We can absolutely with NYSACHO's help and with the local health departments help kind of put in for the whole shebang, as it were and make the case and see where we end up. Can we continue any part of the staff that we've hired? Can we continue any part of the grants that we've awarded to local health departments, to community organizations, to our academic partners and so on? Absolutely all possible. What actually becomes reality we don't know.

Dr. Boufford Thank you.

Dr. Boufford We have no members of the public here with us in New York City, which I think the place they would be if there were those.

Dr. Boufford I think, Shane, you mentioned the issue of the agenda for the Ad Hoc Committee coming up and then I'll just kind of close up the meeting.

Dr. Boufford Do you want to say anything? Any of your thoughts about that? Maybe members of the committee have thoughts as well.

Mr. Roberts Thanks, Dr. Boufford.

Mr. Roberts February 22nd, we will have a presentation that is evolved from the one that you received today regarding the framework. Ideally, we'll have a direction to go and then we will also try to address some of the issues that were brought up here today in that presentation. Dr. Davis, Dr. Chris Davis, who I believe is on the call now will be presenting the final state health assessment presentation as well for Ad Hoc Committee. We'd like to be able to have an opportunity to have a robust discussion with that committee as well as just like we did today regarding both the SHA and the SHIP. That is our agenda. We're also open to additional, ideas as well.

Dr. Boufford I guess one question is, will you have results from the survey that you're going to be putting out by any chance... Or preliminary results relative to the... Because I think one of the issues that it'll be really interesting to see of all the objectives which ones really do rise to meet some of the criteria you've identified and where they might fit in terms of actionability.

Mr. Roberts We do need to look into the... You'll be able to get a consumer input into that survey. That may delay the results. We can certainly start with the partners that we have and hope to have results on those back.

Dr. Boufford We could focus on the members of the Ad Hoc Committee so that they could provide specific input to the questions that you're asking at least at that meeting if we're waiting for other results. That's one possibility. I guess the other question that comes up

would be whether there would be any examples. I think, Shane, you and I have talked about this a little bit offline. I think there might be an example of a county local health director that's really kind of sort of barrel, you know, working on all cylinders relative to broader partnership development, local determinants of health, working with their hospitals. Maybe you could identify somebody. Because I think we've gotten a lot out of local health departments presenting their agendas in the past and how they're working on issues. Maybe that's another possibility.

Mr. Roberts I'll work with Sarah in our hospital association to see if we can identify some successful partnerships that we would like to highlight at the next Ad Hoc.

Dr. Boufford That's going to be important regardless of what the priority areas are to work on.

Dr. Boufford Any other thoughts from colleagues?

Dr. Boufford Dr. Ortiz.

Dr. Ortiz I'm curious about the connections between the utilization of the social determinants of health and then accomplishing the tasks for hiring diverse persons into roles. In my thinking from an academic side is that just in my college alone, I have 1,500 students who must complete practicum hours on projects to learn and graduate. You can couple those with the needs of health departments that have projects, social determinants of health and persons and populations that have health care needs and gaps. I'm wondering is, is if I have built in HR...

(Laughing)

Dr. Ortiz You have built in needs that are going to accomplish local and then also state outcomes and indicators. Is there a way to align those so that as those students are working on the projects they also sort of get a direct entry into the job that you're trying to fill for the project that they're already working on?

Dr. Boufford Interesting.

Dr. Ortiz So that everything is sort of working... I mean, at first it'll be clunky, but once you get it working you'll have an easy, streamlined thread of students moving in and out of not only the projects, but then you can almost do sort of like a hiring process as they're going to graduate. They're already learning the role. Their startup is going to be pretty quick as they move into that line.

Dr. Boufford Yeah, I know you have an academic liaison. I mean one of the issues certainly from schools are public health there's a need for field experiences. People would love to work. Again, this gets into the HR issue. If you call them an intern does that have different meaning? How do you arrange that? I also like the idea of other disciplines being considered seriously because part of Public Health 3.0 is bridging to other disciplines to get the changes in community that we need. I think that's a really interesting idea to add to the soup.

Ms. Owens-Cody Our Academic Liaison actually has ten student assistantships that will be posted through HRI each semester. That sounds like a great opportunity for that connection between the academic liaison in schools, not just School of Public Health, but

any school were students, even if they're coming home for summer break there's opportunities there too.

Dr. Boufford That's great.

Dr. Boufford Any other comments? Thoughts?

Dr. Boufford Dr. Yang.

Dr. Yang That's a great idea by the way.

(Dr. Boufford laughs)

Dr. Yang I think one of the greatest benefits of talking to a class is suddenly you get students who are interested and want to come work for you. You're looking for projects? I was wondering, going back a couple of years from the PPS DSRIP days. There were a few local experiments that were significant. I don't know what's happened to them. If they're still alive and if they serve any good models. Those were very local. Everything's local. There were a few, not very many, but there were a few things that came out of that. I don't know if there are any of those that would be interesting.

Dr. Soffel Is there anything that we learned from DSRIP that could be applied here in terms of community partnerships with hospitals? I really did. She said, not really. I agree with you, Dr. Yang. I think that we should at least go back and look and see of those PPSs that were most successful at connecting to community-based organizations and local initiatives and efforts? Certainly, there should be lessons there.

Dr. Boufford It was certainly goal of the DSRIP agenda.

Dr. Boufford It could provide an indication of how likely we are to move in.

Dr. Soffel I think a lot of what we did learn in DSRIP was that hospitals speak a different language from community organizations. One of the challenges of DSRIP was trying to find a common language. I think that's an ongoing challenge in these social determinant's conversation.

Dr. Boufford The waiver is geared to try to correct some of that.

Dr. Lim I think the community partnerships in DSRIP there were some that were successful, but they were heavily focused on health care projects and not necessarily social. To your point, I think it's certainly worth looking at.

Mr. Roberts I could follow up. I know both Keeshan and I did work in that space back when we were both in the community together. We can follow up.

Dr. Boufford That's great.

Dr. Boufford Any other comments?

Dr. Boufford Really helpful discussion. Thank you all very much for coming and being involved. We'll welcome comments between now and the Ad Hoc Committee and the next will discuss whether the need for another Public Health Committee cycle on the options.

Thank you very much, everybody, for your help. Dr. Bauer, as always, thank you and your team.

Dr. Boufford I think we'll sign off now. I'll give you back five minutes of your day.

Dr. Boufford Thanks.

Dr. Lim Thanks.