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TRANSCRIPT

Jo Boufford Welcome. Good morning, everyone. Let me welcome you to the second meeting of the Ad Hoc Committee to on the Prevention Agenda. I'm Jo Boufford. I'm the Vice Chair of PHHPC and Chair of the Public Health Committee of the Council. I'm here with Dr. Bauer, who she and I will be going back and forth most of the day. She'll have some remarks after I speak. I wanted to just orient us to this particular meeting. This is the second of what we're planning to have at least three or four, three or four other additional meetings. We're looking at something in September, November and January. We're going to get those dates nailed down thanks to Colleen's hard work and work with Dr. Bauer's office. We'll be able to announce those shortly. Just to be sure, this committee is fully engaged at each stage of the revision of the 2025 to 2030 prevention agenda. You're going to hear the term State's Health Improvement Plan. The prevention agenda is, in fact the state's health improvement plan just to avoid any confusion. When I first saw it, I thought, wait a minute, yeah, that's exactly what it is officially. I want to welcome members of the Public Health Committee and other members of the public. I think we have Mr. Holt, Dr. Soffel, Mr. Lewin, and Dr. Rugge, Dr. Watkins and Dr. Ortiz are here virtually at least. I want to acknowledge them. Thanks very much for waiving. This is the council. The overall PHHPC has been super involved and interested in the prevention agenda. Obviously, the Public Health Committee are the core members of this group and also the other members of the Ad Hoc Committee are organizations working across the state, nonprofits, professional associations, advocacy groups, associations with a broad involvement in and influence on health in the broadest sense of the term. The focus of the prevention agenda is obviously on prevention at a personal level, but also at a community level. How can we, especially in this next revision, change conditions in communities that affect people's ability to be as healthy as they can be? The so-called social determinants of health, whether it's social services around the individual or conditions in communities that can be changed. I just want to remind us there are sort of four really important things going on in the state now that are kind of context for our discussions, and we're trying to maintain connections in our interagency nature here. It makes it a little bit easier to do that. First is the 2018 Executive Order that really promoted health in all policies and healthy aging policies across all the agencies of New York State government in their programs, their policies, in their purchasing. Obviously, that initiative was somewhat interrupted, certainly interrupted by COVID. Again, it sits as a structural opportunity for us to take advantage of the 2022 Executive Order by Governor Hochul creating the Master Plan on Aging, which is developing really over the same time period, the same sort of twelve to eighteen months of the revision of the prevention agenda. There is a subcommittee on health and wellness in the master plan, which we hope will become a direct link to the sort of the objectives and priorities for older people in the revised Prevention agenda. I Co-Chair that subcommittee with Linda Freed. I think it's interesting that the interim report to the Governor, which is in the final draft stages of the master plan, is really emphasizing the public health and preventive theme in its work, which is unusual, it would seem, across master plans, across states in the United States, that very few, if any, have a public health approach or a prevention approach. It's really become exciting to emphasize the links. We have the new Department of Health, Office of Health Equity and Human Rights. Commissioner Morne has been involved in several of our meetings with the Public Health Committee. We'll be

having her back to speak to us at hopefully the next meeting, a future meeting. We're very excited about that office and her staff in order to address really the health disparities goal of the prevention agenda, which everybody agrees has not been as effective as we would like it to be. We'll shift it into the term of dealing with the additional challenge of health equity with a lot going on. Finally, I don't want to leave out the Medicaid waiver. I don't think anybody is 100% sure what it is going to be. There have been elements of social determinants, networks and other areas which will undoubtedly be relevant to our work going forward. Just quickly, at our April meeting, we had a nice review of the prevention agenda to date with an orientation for new members of this group having revitalized the membership activity. We heard a progress report on the 2019 to 2024 five priority areas. I just want to mention them because they explain a lot in our program today; prevent chronic disease, promote healthy and safe environments, promote health of women, infants and children, promote well-being and prevent mental health and substance use disorders and prevent communicable diseases. We also heard early thinking from the Department of Health on its internal review of the prevention agenda and also some consultations that have been taking place. We want to take that process further in our discussions with you. Our first panel are our core partners in the prevention agenda. These are the folks that sort of own priority area four in terms of well-being and substance use and mental health, as well as the integration of objectives to address the needs of older persons. They've been with us really from the beginning, and we're eager to hear from them. We're going to get a review of commissioned by Dr. Bauer and her team, looking at other states state health improvement plans and what we can learn from them will be presented to you. Finally, we'll have a sort of open, if you will, open mic discussion, we hope, in the last panel. We have some questions to ask if there aren't enough sort of questions to start, but I've never seen that as a problem with this group, so I'm not worried about it. Anyway, let's get underway.

Jo Boufford Let me ask Dr. Bauer to make any comments she wants to make and then we'll start the panel.

Dr. Bauer Good morning, everyone. Good morning to the Ad Hoc Committee. Good morning to PHHPC members. Thanks, everyone for being here today. Thanks to our sister agencies and all of our partners who have joined us. We really depend on you to shape the prevention agenda and to execute on the prevention agenda. It's really all of us working together that can improve the health, promote the health, prevent disease. The prevention agenda is indeed about disease prevention. It's also about health promotion. As the state's health improvement plan, it is certainly a driver in the Department of Health's mission to promote the health, productivity and well-being of New Yorkers. We're thrilled to have all of you here today. We are looking forward to our panel discussion and then to a robust discussion in our last hour together where we hear from you about the priorities for the next six-year cycle of the prevention agenda.

Dr. Bauer We'll turn it over to our panel, which Dr. Boufford, you'll be moderating.

Dr. Bauer Thank you.

Jo Boufford Thanks very much.

Jo Boufford Let me start by introducing our panelists. Dr. Anne Sullivan, Commissioner of Office of Mental Health, is on Zoom looking at us. Maybe we can make her picture a little bit bigger for this section so people can see her. Greg Olsen is Acting Director of NYSOFA is on the panel and two colleagues from Oasis, Patricia Zuber Wilson, who's Associate

Commissioner for the Decision of Prevention and Problem Gambling Services, and Barbara Bennett, who is Director and Associate Director, I gather of Prevention. They use the word prevention. We didn't add the gambling services here, but it's not irrelevant. We're happy to have you with us. I think we've set some questions to our colleagues here to start with, and we'll hopefully get through them. If not, we want it to be a dynamic session, but the first thing we ask them to do and a little bit longer response from each one was to really reflecting on their involvement in the prevention agenda, just to give us some feedback about what they see as some of the successes and positives of it in general and also specifically for their area on mental health or aging and or substance use, and then some specific recommendations for how to make it stronger.

Jo Boufford Let me start with Ann Sullivan, if I may, Commissioner Sullivan.

Jo Boufford Please put your microphone on mute if you are on the call.

Jo Boufford Could everybody please check that they're on mute.

Jo Boufford Very good.

Jo Boufford Thanks, Ann.

Jo Boufford You're in the middle now at least. You're not any bigger, but you're right in the middle.

Dr. Sullivan Well, that's okay. I don't need to be any bigger.

Dr. Sullivan Thank you very much for having us. Thank you so much, Dr. Boufford and Dr. Bauer. Thank you for having us here today. I just wanted to say that, first of all, how important the work has been over these years on the prevention agenda and how seriously we've taken it and to let you know that one of the things which we did was probably about a little over two years ago now is really establish within the Office of Mental Health and Office of Prevention and Health Initiatives with an Associate Commissioner, which means that its way up there in terms of our organization and our priorities. I just wanted to take a second. They are in the room. To introduce the Director of the program, which is Dr. Audrey Trevino, who has joined us as the Director for the Office of Prevention and Health Initiatives. Dr. Merrill Rotter, who I think some of you probably had contact with already, who is the Medical Director for the office. They will be the two individuals who will really be interfacing very closely with you on all the initiatives as we push them out and all the work that's going to be done on the prevention agenda. I'm glad they're there. They're in Albany. I'm sorry I couldn't join you guys. I wish I could have been there. I'm in the city today. Sorry about that. One of the questions was where we're at relative to the plan. One of the things I'd like to emphasize first is that I think probably most of you have heard about the billion dollars for mental health that came from the Governor's budget. An important piece of that is prevention. We've never kind of put that upfront this way before. There are three buckets of dollars. There are dollars for prevention, dollars for care and access to care, and then there's dollars for programs for the seriously mentally ill. Just to say that those dollars of there. They are enhancing our ability to do some of the work we've already started and some of the work we look forward to. The other big point is that when we look at the agenda and the major goals that are there, we're certainly aligned with all of them, including working on health disparities, working on making sure that we work with the social determinants of health, that we consider things way across the lifespan. The things that we put in place are really aligned and they really fit closely, very closely with

everything that's happening with the prevention agenda. We want to continue that close interlocking relationship. Because to make these things work you've really got to work interagency across the state, all our agencies together and then all our communities together. I think you said that Dr. Boufford, the emphasis on communities is so critical. Just to get in a little specific about the plan itself. If you look at the mental health part of the promoting well-being and preventing substance, use disorders. Those first two goals, I think speak to what we're trying to emphasize more and more, which is the upstream work of really primary prevention. The way we've been seeing some of it, but we want to expand on this is populations. A big one is schools. Post this pandemic if we've learned anything it's the impact on our youth from the pandemic, from the isolation, all the things that happened in schools. How do we intervene there at that age to help individuals not have the long term of what could happen post something like a pandemic or other things that are happening all the time? Work in schools becomes primary and important. The work in schools, I think has to be widespread. There's a number of things we're doing. I won't go into all of them. The work in schools currently includes expansion of our clinics in schools, but it also includes a whole approach to social emotional well-being and mental health education in schools. It's linking those treatment services which are getting out there because they're important to the more basics of helping students from even the earliest ages in curricula. We're working very closely with the Department of Ed on this. They've done a wonderful job of social emotional well-being. What does that really mean? It means different things at different ages. It means different things to kids and different things for families. That's a major initiative. The Governor said she wants social workers in every school, but they're not just social workers to do social work. We're there to be assisting and helping with the development of that kind of social emotional well-being. Particularly in high schools, what we've done is a whole listening tour across all of New York State, where we talk to high school students about what they need. What comes out very clearly is what I think the whole agenda is that we're all going to be talking about. Is, yes, they want to have access to a counselor if they have a problem. Yes, they want to have mental health first training, but they also want to have a social set in their schools and in their communities that is positive. There's reinforcing of health and kindness and caring about each other. We met with Boys and Girls Clubs across the state. Their involvement with an agenda is critical. What they kept telling us is, yes, we need mental health, but we also need relationships with our teachers. We need our social relationships reconnected. The ability to have the positive interactions. Wellbeing for youth is critical to have this multi factorial approach. When you look at some of the data that you had in the first, for example. One of the dangers I noticed was one of the improvement points was that actual suicides were down, and that's probably true. I think that may even hold through the next year's data. What's up is still suicide attempts among adolescents and a sense of sadness and hopelessness when these surveys are done. During the pandemic, we saw a significant increase in depression and anxiety. Tackling that from a mental health perspective is having services available is having things in schools, but also getting the environment, the social environment, the interacting environment one. That's where we're doing work with things like Youth Mental Health First Aid. What's Youth Mental Health First Aid? It's actually having peers work with peers. Talking about what is social emotional wellness? How can a high school student talk to another high school student about the things that maybe are important? It's that kind of expansion of the idea of prevention in schools, which I think is so, so critical. We're going to be doing a lot of work on that going forward. The second group where we're emphasizing is in pediatricians' offices. Why that? Because that's where Moms go with the kids and that's where Moms go with their issues and their problems and what's working and what isn't. Pediatric best practice of healthy steps and this is something we've been growing across the state, want to continue to grow. Puts a mental health professional in a practice of 1,500 or more families. That mental

health professional does primary work. They're not just dealing with individuals who have mental illness. Families under stress they work with their family about the stress issues. If a child is having trouble in school, they talk about what are the problems? What are they? Far different, not necessarily linked to mental health diagnosis, but to how to work with that family and with the pediatrician connecting them too when it's needed to all the social services that are needed in communities, all the things that families might need, those social determinant things that become so important for families raising kids. Healthy Steps as now we will spend within two years to cover over 300,000 families and youth across New York State. We hope someday we'll get it embedded into the Medicaid benefit. We're working on it. We're working on it. I think it's that kind of primary prevention. Those first two goals, I think, and then for adults. This is still at more of a beginning stage. One thing we learned with Project Hope during the pandemic was the value of having individuals available in communities in reach, not outreach, but in reach into communities to understand what their issues are and having people there who can be helpful to the extent that those begin to move both into social determinants but also into mental health. We touched over a million New Yorkers in doing this. We did great working with communities. We engaged our underserved communities in ways that we had never engaged before. We've kept some of that workforce going with the community support programs, especially in the areas that are most affected post-pandemic. These are truly community in reach workers who worked with the leaders of communities, what are you needs? Are there to work with schools. Are there to work with churches. Are there to work with organizations. Helping connect things and make things happen at the same time are also available for screenings for mental health interventions if that's needed. It's a workforce of paraprofessionals under the supervision of professionals. This is something we would love to make even bigger. We started in sections of the state because we kept some of those Project Hope teams going. We have three in New York, a couple on Long Island, we have some in Westchester. We have a slightly different lean on it up in Buffalo post the awful shooting in Buffalo a couple of years ago. That's the other based community work where you try to have communities be healthy and be a partner with them. They have to decide what they want and what they need. We're just there to support them with what they need. That's one thing I'd just like to emphasize. As we think about the prevention agenda is getting the grassroots communities involved with us. What do you need? What do you need? How can we be there to help you with that? I think is such an important message. That's what we're trying to do with the schools and with our offices and with the outreach in the community. That's those first two goals. Now, when you go to the other ones, the ones where we improved things, where we didn't improve things. There's a couple of spots where... I mentioned already in schools, we're going to be working a lot, I think, with ACES to see the impact of ACES takes a while, but I think everything I've been talking about should help. The other areas, though, that are particularly thorny for us and that we haven't been successful in in terms of things put forward. One of them was to decrease smoking among serious mentally ill because of the disparity, the huge disparity in health for individuals to mental illness and lifespan, etc. We've been working on this for a long time, guys. We really don't have the answer. There are evidence-based practices. We've pushed those out. Other states have pushed those out. We know that the individual is... Just taking one example of this particular health problem. We know that individuals, probably with the combination of some of the medications connected to their illnesses make it even more susceptible to the use. The reality is we haven't gotten there. I think what we're trying to think of is, again, on the line what I've been talking about a wellness approach with this group where we don't go at just stop smoking. We say, what's a really, really healthy lifestyle? What about harm reduction for your smoking? What about pulling it back a little bit? Not just going after the smoking. Haven't been successful. It hasn't worked. A real wellness kind of approach. That was for that one in particular. There's

massive suicide prevention, which we've been doing for years, and we continue to do. I actually think it's been helpful. I think that the suicide prevention that we do in our schools and throughout communities, across communities with our church with everybody. New York now is probably the second lowest rate. We bounce between the lowest and the second lowest. We certainly still have a huge issue. Still, many, many too many people die by suicide that is unacceptable. I think we're doing great. Again, here community approach. I have a wonderful county. They did this pretty much on their own with some support of us that every year has a suicide walk. Every year that suicide walk spreads out into other activities that they have. Chemung has one of the lowest suicide rates in the state. It's because the community has gotten together and said we need to pull everybody in to deal with this. That's the kind of work that, again, whether it's the mental health community, the hospital communities, etc. That's where we are. I think we're aligned with lots of what's happening. I don't want to take up too much time, but just to say that that's kind of where we are and where we go into the future. Just one more point is one of the things that we've done recently is develop a data dashboard. We've taken the Medicaid data, Medicaid data that looks at the core indicators, indicators look at things like a follow up after hospitalization, but they also look at whether you're schizophrenic, hemoglobin A1C is being treated well. We've taken that data, broken it down by race and ethnicity and provide it to our provider community. Clinic X gets for their clinic how many of their individuals were Black are getting appropriate primary care? How many of the individuals who are Hispanic are getting into hospitals? How many other individuals are staying engaged in treatment? Getting that data out under real time basis, relatively real. I mean, we don't have it daily, but we have it within a couple of months to people to look at how they're performing and be able to follow it, I think is critical if we're going to move this agenda. I think getting data way out isn't as helpful. We feel, especially the mental health people that we, the state has don't provide that data because it's not something that they can easily get their hands on or have the time to do. I think that's one of the things that we can provide.

Dr.Sullivan I'll stop there.

Jo Boufford Commissioner, you've touched on almost every question we had for you, but we're going to come back a little bit later and drill down a little bit more on some of the things that you touched on. Thanks for that getting started. Well, you talked a lot about youth, let me go over to our colleague from NYSOFA, Greg Olsen, maybe let you go next and sort of present again the idea of sort of what's worked, what hasn't worked, both in general and also specifically for your population of concern and then we'll hear from our colleagues from Oasis.

Greg Olsen You got it.

Greg Olsen Thanks.

Greg Olsen Thanks for having me.

Greg Olsen Good to see a Commissioner Sullivan. A tough act to follow. First, I just want to let folks know what we do, because most people don't know that you have an Office for Aging or what it is that we do. We oversee a network of fifty-nine county-based offices for the aging that work with another 1,200 community based organizations contractually to provide about twenty-five core services with the goal of helping healthy older adults stay that way and trying to prevent individuals from spending down and winding up in the hospital, nursing homes and so on so that they can live as independently for as long as

possible. In addition to that, it's the partnerships not only with OMH and Oasis and the Health Department and many other agencies, older people and families do not touch one agency. They don't just live at the state Office for Aging. They touch every single agency. So, for example, in New York State, 70% of all the veterans are over the age of 60. Obviously, we have to work very closely with the veterans. We have 24,000 individuals on our caseload that are veterans, 12,500 that have a diagnosed mental health condition, 8,500 with alcohol or substance abuse. We're starting to work more closely with Oasis on the problem gambling, because all you got to do is walk into a casino and you know who's there. That's kind of a little bit about what we do. We cover four pieces of four of the five priorities. I think that if the question is, how is this working for us? I view prevention in multiple ways. There's trying to stay healthy, preventing disease, but there's also managing disease, there's preventing hospitalizations, preventing nursing home placements. That's kind of the lens and view that we look at this from. Dr. Boufford mentioned a couple of key things that are happening in New York State. Talked about health across all policies, E190, the Master Plan for Aging. There was also Executive Order 190, which I know Paul Byers here as well, to build healthy aging and other types of principles into state planning and procurement. We also have our four-year plan as well. Our four-year plan is really organized around the prevention agenda and health across all policies. We know what we know. We're not experts in everything. We need to leverage other resources, state agencies, county agencies, local agencies. Looking at some of the priority areas, how's it works for us? I think great. I think that there's a real recognition for the population that we serve about how they can manage their own health, stay active, combat isolation, be engaged, exercise more. We have a lot of data that backs up that. Some of the things we were able to innovate and implement over COVID-19 with technology platforms, etc., and the reduction in depression, isolation, loneliness, improvement in health, improvement in engagement, which is really one of the hardest parts. Getting people engaged and following up on advice/guidance that folks may give them, whether they be clinical or social in nature. Affordable food access. We look at the whole nutrition realm. We oversee the largest nutrition program in the country, do about $30 Million a month for 300,000 individuals, and that's also working with Food Bank Network, etc, but that's primarily meals delivered to the home comes obviously all the meals meet the highest federal standards are reviewed and menus developed by registered dietitians. We also provide nutrition, education and counseling to those who are at risk. One of the things that we were able to innovate during the pandemic and again, I am going to give Commissioner Sullivan all the credit. We started a Facebook Live series after I was on hers right at the beginning of the pandemic. We have now done eighty-five programs that have reached over a million New Yorkers on a whole variety of issues. Nutrition and good cooking and etc is the most popular. We will reach well over to 300,000 people per episode where we have one of our live dietitians teaching people how to make healthy meals with things that you can get at the farmer's market, etc. On the farmer's market we oversee the senior farmers market nutrition program in coordination and partnership with agricultural markets. Healthy food, healthy food, access, transportation, getting people to farmers markets, teaching folks how to cook, good eating habits, etc is a huge priority for us. On the screenings, we do a very comprehensive assessment that would rival the UAS without the the clinical services. We know how many people we have, what chronic conditions they have, and the number. Our average person, 75% have four or more chronic conditions and 55% have six plus chronic conditions. We know what they are. We screen for things like that. We want to make sure that people are getting to their primary care doctor are taking up the annual Medicare wellness check and so much more. Early screening is a huge priority. I know there's a couple of key ones here that you're looking at, but we're looking at all of them. We implement forty-one of the highest-level evidence-based interventions with federal funding. We became the first state to do that

before there was any federal policy. Those are things like chronic disease, self-management, diabetes, self-management, Tai chi, powerful tools for caregivers. I could go on and on and on. Serving about 42,000 people. Built a at least in the CDC ME suite with health systems, etc. quite a large capacity of chronic disease self-management trainers because we wanted to build capacity in New York to be able to offer that everywhere. The built environment is a huge issue for us. I think Paul is going to talk about that. He's really the expert at the Department of State who's here today. We know that between 60 and 70% of all health care spending has nothing to do with the diagnosis. It has to do with your personal choices, behaviors and the built environment. Housing in New York State was built for 20-year-old men, not women, not women with children, and certainly not older adults. As we're talking about housing in the Master Plan for Aging, etc., individuals of all ages with abilities or disabilities. We need to be talking about safe, affordable, enabling housing that has design features that allow people to grow up and grow old successfully. Falls alone for older adults in this country costs $50 Billion a year. We became the first state in the country to partner with the National Association of Homebuilder to train our case managers and the Certified Aging in Place specialist training that they offer to architects and building designers. We do a safety check, a home check, a tech check, etc. when we're in the home to make sure that we can identify and mitigate anything that's going to possibly lead to a fall, or an injury resulted fall. We also have an artificial intelligence project with an animatronic pet company. They just developed the Walker Squawker. We've put 7,200 Walker Squawker out. What they do is they go on somebody's walker. You're sitting in a chair, and you get up and you forget your walker. The Walker Squawker's going to let you know that you forgot the walker. It's a great way, again, for people not to fall by forgetting their walker. I'm going to go through this quickly because I know we have a bunch of other... We're again, doing a lot of work with Office of Mental Health Oasis. You'll probably talk about the partnership that we have. Got the Geriatric Mental Health Task Force that we sit on and Co-Chair with OMH that brings in again veterans, health, aging, OMH, Oasis. We screen for anxiety, depression, alcohol. We need those local partnerships and state partnerships to make the appropriate referrals so that our folks can get the help that they need. Obviously, things like vaccination, whether it be for COVID-19 or shingles, you know, those are things that our case managers and our local partners are always trying to push to, again, maintain good health, manage chronic conditions and try to prevent again use of higher level of care. I think the prevention agenda has been great for us. It's something that we are highly motivated to participate in and really institutionalize these goals within our network across the state.

Jo Boufford Thank you very much.

Jo Boufford That's great.

Jo Boufford Now, let's hear from Commissioner Zuber-Wilson and Commissioner Bennett.

Ms. Zuber-Wilson Thank you very much.

Ms. Zuber-Wilson It's wonderful to be here.

Ms. Zuber-Wilson Thank you, Dr. Sullivan. First of all, I have to say thank you to Dr. Sullivan and Audrey. We've really built this partnership we're building. We continue to build the partnership between OMH and Oasis and having a division of prevention in OMH has really put this partnership on the prevention side on a fast track. It's truly been a delight to

work with your team to talk about programs in schools, what we can do together and reach across our agencies. We've been involved with a lot of things.

Ms. Zuber-Wilson as you can imagine, COVID brought a big challenge to us when working with youth and working in schools. When schools shut down...I have to say, we were almost. We had to take a guess just like everybody else did, but our prevention system was very much involved with school-based prevention services in schools. We quickly had to turn on a dime. We had plans. I don't want you to think we didn't have plans. Sometimes changing the system is like... What do they say? Turning a cruise ship around. Well, we had to go to a quick boat with a speed thing on the back. What we have done is really been focusing on a lot of programs that are related to social emotional learning and looking at how we can change entire environments within schools, teach young people how to make healthy choices, how to be resilient in their lives, how to make those choices when those challenges come. What decisions can I make? We really want to support not only the youth in the school, but we want to train everybody in the school. Not only the teachers. One of our projects works with a program called Positive Action. We do a year of training in positive action, where we train the teachers on how to implement the program, but also, we train everyone on positive action from the janitor to the secretary in the office. The whole tone of the school is supportive to young people. That has really been a big shift for us. Those are programs that really go from day one of the school year to the end of the school year, not just dropping in a program here or there. We have really been active in engaging and expanding our social emotional learning. We have a pilot this year where we're starting in Pre-K and Head Start to really build that foundation of social emotional learning to help kids communicate their feelings to really self-regulate. We're starting younger. We also have a pilot program working with State Ed, where we are working with the Wyandanch School District on Long Island, where they are going to start out with Pre-K with the program I just mentioned, Incredible Years. Do another program in elementary school, build upon it in middle school and then in high school, build upon it even more by providing not only a curriculum-based program, but also programs like Safety First, which is really a harm reduction model. We are really expanding how we do our work, looking differently at how we do some of this work in our schools. In addition, we are working again with the Office of Mental Health to look at where there is the mental health school-based clinics, but also where schools that do not have prevention services. We can really better coordinate that work and those services. What type of programs do we have? We want to have them no wrong door in our system. If a kid goes to a mental health clinic in a school. They may not have a diagnosis after an assessment. Maybe a kid who had some experimental use of substances. How do we reach that kid so we can make sure that there's an opportunity for cross referrals? We're really starting to talk about Department of Health, how we work with the school-based health clinic. No matter where that kid enters our system they're directed. Either they get the service, or they're directed to the appropriate level of service. That's important work that has happened over the past year. In addition, we have really looked at expanding our community-based coalition model across the state. This is a community wide approach to address social norms with substance use. I see as I look at the agenda and think about alcohol use. This has really been a strong partnership with communities. It brings everybody together. That is the beauty of our community-based prevention coalition model. We have twelve sectors. We have our local communities look at their data. They do a needs assessment. They bring in partners from the faith community to mental health organizations, to hospitals, to schools, to law enforcement, to look at how to address substance use prevention across their entire community. We've had a major expansion of Oasis funded coalitions over the past two years. We're at 30. Can't talk about it now. We're still in a blackout period, but we have an RFA currently out right now to expand the coalition model to focus on fentanyl, opioids and

reduction of overdoses in communities. We've also been the benefit of a federally funded grant from SAMHSA, the Partnership for Success Grant, where we are working through SAMHSA funding, which we're very grateful for to do more in the area of community coalitions. I want to add too about our coalition model. We're looking at ways to bring coalition work to schools in our state. We have several schools within our state that have coalitions on their school. These are coalitions run by students that really look at the data within their school, that think about a logic model within their school to engage them to really talk about how do they make a change in their school? They've really become ambassadors for prevention in schools. Barbara and I had the pleasure of going to Gloversville Middle School, where they have a coalition. The school is involved in that coalition work. It gets youth involved. And as a side note, its workforce development as far as we see it, because these are kids who are learning about prevention. They're learning about substance use. We're hoping that we trigger some interest so when they go to college that they consider going into the field of human services, social work. This is really something that we're looking at expanding and working on. Working on SBIRT, Screening Brief Intervention Referral to Treatment. We are expanding our work around SBIRT. We have a SAMHSA grant where we are working with four communities across the state.

Jo Boufford Can you tell us what SBIRT is?

Ms. Zuber-Wilson Screening Brief Intervention Referral to Treatment.

Jo Boufford Good.

Ms. Zuber-Wilson We're excited about this work of expanding SBIRT. We want to reach individuals where they have risky substance use. It's normally done in a medical setting. We are expanding the implementation of SBIRT screenings to where people are in the community. We realize that not everybody goes to the doctor. How can we reach individuals on a community level setting around SBIRT? We had one program that they were doing SBIRT screens in a barber shop. We're really trying to work on bringing SBIRT to the community. I just want to make sure I'm covering everything. Things within the prevention agenda I would like for you to think about. Cannabis. We are seeing increased use of cannabis in youth and the prevention agenda focuses on alcohol. We are doing work around prevention, working closely with the Office of Cannabis Management. We will be releasing a public awareness campaign in the next few months around parents talking to youth around cannabis use, but it's something we are focusing on. In addition, we are going to be training our prevention system in the Stamford University cannabis prevention and public awareness curriculum. That's out of the Reach Lab of Stanford University. We are hoping that this will educate youth in schools and in the community around cannabis, the effects on the brain, making healthy choices around cannabis use. We will happily get that information. We have a training coming up on July 27th and happy to have anyone join that training so you can hear from the folks from the Reach Lab at Stanford University. In addition, they're going to be doing some other webinars with us to talk about cannabis use, underage cannabis use. There's more to come with that. The other thing I want to point out is problem gambling. Since the prevention agenda was developed, we've had an expansion of gambling opportunities for individuals. The research and all the data. We're new to this. Everyone is new to this. I think a little ahead of us were New Jersey and Nevada. We are really looking at the effects of mobile, in particular mobile sports gambling because that is so immediate. You can gamble on your phone. You can gamble on your computer. We're really monitoring what's happening with gambling across our system. Again, thank you so much for this opportunity. Just one more thing. Partnership with for the aging we have implemented in eight communities. We're hearing requests for more

communities. A program called Wellness Initiative for Senior Education. This is a program that was developed by the New Jersey Prevention Council. It's being implemented in New Jersey. Ohio has joined us in partnership for implementing this program. It's a wellness program. They talk about not only healthy eating, depression, anxiety, but also substance use. Our initial reports from the pilot are the older adults love the program. As a matter of fact, they don't want the program to end. We're finding that this is really helping older adults think about their mental health, their overall wellness and their substance use. We are partnering that again with SBIRT. SBIRT is going to be key in reaching people. We want to make sure, just like you check the blood pressure, just like you check your heart rate and your blood glucose level, that people are asking those questions about substance use, about mental health. Thank you very much for this opportunity.

Jo Boufford Commissioner Bennett, did you have any comments to add?

Ms. Bennett What I would add is I'm not a commissioner.

Jo Boufford I'm sorry. You have the word Commissioner in your title. It's easier than doing every single rank. Sorry about that.

Ms. Bennett That's quite all right. I'm a research scientist in the division.

Jo Boufford That's true, you're a director. I'm sorry. You're not a commissioner.

Ms. Bennett I think Pat covered most of what is going on for us. I do have to say that we work on a risk and protective factor framework. The programs that Pat was talking about and the initiatives are driven by underlying risk factors. The prevention agenda has made it very easy for communities to access data and look at data and see how valuable it is to be able to make a case for not only other state funding or other community level funding, but federal funding as well to address substance use, misuse prevention in their community. The programs that Pat was talking about are really multipronged. Often, we can address risk factors on different level. An individual risk factor, family risk factor as well as sometimes community risk factor. We try to have a comprehensive approach. All of the different things that are going on are reaching the different levels because a person is not one dimensional, right? The data in the prevention agenda has also helped our providers to identify the actual need that they have. They can create a needs assessment and work with their communities to deliver the appropriate programs. It also has helped them in their evaluation of it. We follow the Strategic prevention Framework from SAMHSA. A big part of that is looking at data from kind of a baseline perspective and then evaluating it at the end to see have there been changes, etc? t's a long process, but it requires data. One of the challenges with the agenda the way it is, is it has several composite measures. It also really focuses on consumption, right? With our risk factors we're talking more along the lines of favorable attitudes towards substance use, misuse. Those are big influences. They're hard to get at. One of the things our communities struggle with and we struggle with is getting those types of data. Otherwise, the agenda has really made it so easy for communities to demonstrate and talk about the impact of different things in a very local level.

Ms. Bennett Thank you.

Jo Boufford Thanks very much.

Jo Boufford You raise a really important issue. I think that this question in the revision process of really getting the brains from the data folks across the agencies together to think about what's really measurable, what metrics should be used once the sort of decisions about the priorities and the objectives are made? It's really, really a good point.

Ms. Zuber-Wilson Can I also add that we're having discussion around survey data and how we can work together on survey data across Office of Mental Health, Oasis, Department of Health, State Ed. We all had challenges last year implementing surveys in schools. The YRBS survey that's done by State Ed. They did not get the participation that they would anticipate. We did not get participation in the Youth Development Survey. We're implementing a young adult survey right now, but it's really been a challenge. We're looking at ways to better work together and maybe do one survey or two in the state when we're talking about youth and young adults.

Jo Boufford One of the master plan conversations we've had around really useful survey of significant twenty something thousand older persons that NYSOFA has run. I think that's a really, really good point. The sort of data issue integrating, etc.

Jo Boufford We have a few questions here. We wanted to drill down on... I think Commissioner Sullivan touched on a number of them as you have, but I want to... It's kind of a maybe quick answer, kind of. I don't want to shorten it too much, but we do want to get your specific responses to two or three things that are issues for the prevention agenda going forward just to get you to elaborate a little bit or speak to it. The most important one, and I mentioned before, I think we've gotten feedback that communities have really and local health departments in others in the sort of prevention agenda stakeholder groups have really found the disparities issue challenging, the equity issue, challenging partially as sort of deals with community engagement, but also even more importantly, what are the measures one would use? What are the most effective interventions? We're hoping with Commissioner Morne's group to really get a lot of expertise focusing on that. I wondered, maybe just giving examples from your own agencies where you feel like you've got some good ideas about engaging on the question of equity or new initiatives that you're starting that are specifically focused on addressing health disparities, addressing health equity and vulnerable populations around the state. Maybe I'll start with Ann just because she's been sitting there waiting. You mentioned this Ann, but just to drill down a little bit on the equity disparities. What's working from for your own populations, that would be super helpful to hear.

Dr. Sullivan One of the things I think is data. People need to know what we mean by health disparities. They need to have something they can work towards and understand what's going on. I think it has to be at the level of the provider who's doing the work. To know that generally there's a health disparity across all of New York State is one thing, but to know that in my clinic that I operate on Black individuals are not getting their hemoglobin A1C's are not as good as the white population in my clinic. What does that mean? What do I do about it? How do I begin to address it? I think that kind of data is not easily gotten by most providers. I think the state and others should provide that. I think that's what's going on when, you know, as Pat was talking about Oasis and aging and getting that data all together so that people can see the disparities and breaking it down by race and ethnicity is critical, I think, to do it. The other I think is then what do you do about it? I think doing about it becomes the whole issue that again, talking about the coalition. How do you get into the community, share with them the fact that you're not doing so well and then engage them? I think that's been helpful for us. For example, in a pilot where we worked with the Black churches on Black youth helping young Black youth, where there's a spike in

suicides to really work with us on these issues. We can't go it alone. You've got to go in with a champion. You've got to do that hard grassroots work to get into communities where there are the biggest disparities because they don't trust. Well, some don't trust our system very well. If we're going to be helpful, we have to be out there. It's two things. I think it's data and getting people to know what the problem is and then getting in there with the kinds of things. I have to say, we all worked together on working on these coalitions and ways to engage people with us and the real people, the real community leaders to engage with us.

Ms. Zuber-Wilson Thank you, Commissioner.

Ms. Zuber-Wilson I absolutely agree. One of the things that we've seen with our community coalitions is bringing everyone together. We have been very purposeful at Oasis in how we develop our requests for proposals for the community coalitions. We look at data. Some of the early coalitions we looked at those counties that had the highest level of poverty. Those communities that had high levels of poverty. How can we go in and support community coalition work, but also support the work of our prevention providers in schools? We've been taking the opportunity to really talk to our providers and say, what are the challenges that you face in coming into certain communities? How can we help build some of those partnerships? In addition, we've been looking at social determinants of health. One of the things I didn't mention, we have expanded parenting programs because kids can go to school, get the best prevention program in the world, but if they go home and some of those principals are not involved in their family day to day life, it carries through. It is throughout their community and in their home. One of the things we've been able to do in some of our parenting programs is provide gift cards so parents can have dinner for their kids while they participate in a virtual parenting program. We've been doing Triple P, Familia Unitas, Strong African American Families, Parenting Inside Out for parents who were recently incarcerated. We really look at how we can support the entire family, the entire community.

Ms. Zuber-Wilson Thank you.

Jo Boufford Thanks.

Jo Boufford Greg.

Greg Olsen Diversity, equity and inclusion access has long been a priority of ours. It's required under federal and state law. When we submit our four-year plan to the federal government, we then require our counties to submit a four-year plan to us following that. The plans really line up and match. We have a designated staff person that just does this for a living, which is provide technical assistance to the counties. We fill in. I mean, we look at everything from cultural and ethnic to rural to low income to age. Those are all required targeted priorities for us. Her job is really to work with them on how to meet or exceed, because you don't just want to do bare bones. These communities that are really hard to serve. I agree with Commissioner Sullivan 100%. Trust is the issue. I think that there's really an opportunity with the pandemic. Our network is no different than anybody else. We lost a lot of individuals to retirement, not coming back to work, volunteers, etc. In the hiring process, it's really, really important to have members of staff, wherever they are in the state, represent their community. I think that that has, outside of a few pockets of places in our network around the state, that is not how our network looks. They look like me. That really needs to change. She's absolutely right. It's the local partnerships, whether it be faith organizations, foundations, others that are working in the community to start to build those

relationships. It takes time to do that because of the trust issue. We have been trying to put together a library of quality cultural competency trainings that are easy to access. They're not always easy to find. If anybody has things that are already done. We want to create one spot where we can do that. We have been reaching out to certain population groups to do quick interviews from their perspective on if you're working with a particular group or regardless of where you are in the state, what do you do and what don't you do? That's the kind of thing that I'm interested in. I've been to cultural competency trainings, but it's never from the voice of the communities that we're serving. We've done four of those already for the Yiddish population. We're looking at Spanish, Korean, etc. There's a variety of nuances there, which is why the local partnerships are so important. We have local long term care councils for our New York Connects programs, advisory groups, etc. Those really should be reflective of what the community looks like. I'm pleased that there is a federal and state focus on hard-to-reach populations. It's a work in progress. There's no question about it. It's starting and building relationships and not telling people our view of what they think that they need. It's really the other way around.

Jo Boufford It raises some really interesting issues for the prevention agenda because part of the structure assumed there would be there are sort of... We have used the term coalitions or alliances or groups meeting. Obviously, the structure of the prevention agenda sort of laid out with the local health, the health care delivery system hospital and the local health director partnerships with other stakeholders in that community. I think early on we've really and maybe you could comment on this relative to all of us have activities in communities or entities that are front line with communities, but they're all sort of organized in their own sort of circles addressing their own issues. I think Ann mentioned or others have mentioned the data question, the survey question, how might one kind of make those connections? I think early on, we know their area office is on aging. There are obviously groups through Mental Health and Oasis and others and obviously our other agencies have their own as well. Paul Byers have been great and sort of helping us understand how the Department of State is sort of everywhere in some ways. The economic development issues there are crucial. Let's talk a little bit about the challenges of trying to organize at the local level relative to community engagement. Do you see any ways forward there? I mean, just very kind of quick responses. Is that an agenda item that deserves attention? Because it sounds like it's become a priority for everybody, certainly in public health and sort of doing it. How do we do it? How do we do it together across agencies?

Greg Olsen I mean, I think there has to be a focus on it. It's not easy to do. There are organizations like ours. I would assume local Oasis and OMH, etc. that also have relationships of partnerships with every nook and cranny of the state. That's more organic grass roots. I think that in my experience and I'm sure all of yours as well. When you have good leaders, good things happen. When you have poor leaders, it doesn't matter what level you're at. Poor things happen. I think that, you know, organization leads, whether they be county government, private sector, etc. that really get this and understand it and are working on this in earnest are going to have a lot of different results than somebody who doesn't believe in it and just doesn't pay it any mind. I think it should be an agenda item because it permeates everything at least from agency perspectives, everything that we do.

Jo Boufford Patricia.

Ms. Zuber-Wilson One of the things that we did with our community coalition work is we're doing special population coalitions. Normally our coalitions are geographic. We

looked at a demographic community. We have coalitions that are working specifically with LGBTQ community. We have a coalition that we've recently funded working with the Asian American Asian Immigrant community in Lower Manhattan throughout the state, rural. What we're planning to do is look at lessons learned from these local community coalitions on what was effective and how we might bring those lessons learned to the entire state. We're very excited about that opportunity to really find out what's happening locally and get that local input.

Jo Boufford That's great.

Jo Boufford Thanks.

Jo Boufford Ann.

Dr. Sullivan I would just add that I think every community there are commonalities, but they're also all different. I think it's so important. You've got to begin, I think probably with working with the counties, whether it's the Department of Health in the county or the Department of Social Services but getting them together to talk and trying to get feedback. You can't stop there. You've got to then look really for the grassroots organizations in the community, the community-based organizations, the social service organizations. You have to work the county to figure out what is needed. Some counties know and have already established these coalitions. Others are more fractured, just like the rest of our system. I think that's got to happen. You can get all sorts of advice from all the agencies. The agencies across the state need to work together. It's not just us, the health agencies, it's agriculture and markets where we're doing some food stuff. It's transportation, which is a huge issue when you talk outside of New York City is transportation everywhere in terms of whatever it is your need is. All the economic development. There's just one other thing I wanted to say about the previous question, which we all sort of mentioned about health disparities, but it's paying attention to where the money goes. I think that this is really important. The RFPs and the RFAs that we are putting out what the dollars are focused on communities that need the help. Anybody who is responding has to address those issues. We didn't always have that in our RFPs and RFAs that went out. Communities that were better at doing certain things would get money. First of all, we're targeting areas, but in addition to targeting areas we're requiring people to explain to us how they're going to deal with health disparities in those RFPs and RFAs. That's something that Oasis and OMH have worked very closely on and we're really together on. I think that it's that kind of message, getting it out there that we've got to pay attention to this. We don't have all the answers, but the newer dollars that are coming out have to be focused on helping to address these disparity issues.

Jo Boufford Thanks.

Jo Boufford I'm going to keep moving because I'm just conscious of the time and I really want to get a couple of others. We may have to come back to you to get more elaboration on some of these. You've all mentioned broader determinants of health. One of the conversations if you talk to clinicians, people that provide services, their definition of broader of determinants of health, social determinants is sort of social services or social support services that are needed by the individual patient. From a public health perspective, social determinants are how do we change conditions in communities a little bit? That's obviously the evidence base for what may work in terms of interventions in communities is a lot better than it was five years ago when the current objectives were put together and it's something all of us are kind of dealing with. I wanted to again try to drill

down a little bit on what each of you as agencies are doing in this to change conditions and communities. You mentioned social support, socio emotional learning, which I think is a technique that sort of has been proven to work really, really well. What are the other agencies you work with most frequently, for example? How does that go? Who do you work with most frequently and why to get into sort of changing community conditions? Not only on the needs of an individual patient, but more broadly. The answer maybe we're just getting started we're thinking about it. That's okay too.

Jo Boufford Patricia, you want to start?

Ms. Zuber-Wilson Yes.

Ms. Zuber-Wilson We've been working with the Office of Children and Family Services. We're looking at opportunities to bring in some of these curriculum based social emotional learning programs into schools that are located at the voluntary agencies. Many of the voluntary agencies with OCFS have schools on their campuses. We're working with those schools and looking at building those partnerships, in addition, partnerships with detention centers and providing prevention services to those detention centers and supports to parents with some of our parenting programs.

Jo Boufford Greg, you mentioned before you're working with everybody that moves, but can you talk a little bit about just because those relationships develop at interagency level. Part of the challenges we've talked about is how do we get them down at the community level?

Greg Olsen You're right. I mean, we do work with everybody. I don't know who most frequently. It's a long list. We are organized differently. I think our organization really matters. What I mean by that is how our network was structured was really grassroots oriented. It was obviously a partnership with us. Because the offices for the aging, their contractors are providing specific services. We look at people holistically. We're constantly making referrals and meeting with all the local county counterparts that we've talked about here, the District Attorney, State Police, Sheriff, Office of Court Administration. You could go on and on. Department of Social Services. APS. Those are the types of folks that we see. We have a local long term care council in every county as part of the New York Connect Systems reform that we built out collectively a decade or so ago that has over a thousand people from a variety of public and private agencies. I think at the at the local level, they are used to coalition building. They are used to partnering. I think we constantly hear soloing, etc. I think we all understand we need to connect the dots a lot better. There's a lot going on out there that people don't know about because we're not always that good at connecting the dots. I think they're used to doing that and more can be done to really implement this prevention agenda at the local level.

Jo Boufford That's great.

Jo Boufford Ann.

Dr. Sullivan I think obviously schools is one big group that we've been working with. The other is in many communities, the church organizations. I think we've been doing a lot more work. We now have a model that we've been using with a couple of Black churches in Harlem, which we've now expanded up to working with churches Upstate in some communities, especially some churches that have been a little reluctant to deal sometimes with mental health issues. That's where we're expanding, working with. The other is we will

be soon initiating work with barbershops. We haven't done that yet, but that's another group. You look for the ways to reach into communities. Something we've worked with for a long time where there's been something called Life is Precious Program with Community Life, which works with afterschool programs. For example, for young Latina adolescents who are dealing with serious issues. Basically, we've expanded that now to Poughkeepsie and Yonkers. We're looking at those kinds of programs that really get into working with the different groups in the communities. Again, our communities are unique, but working with the respected programs, respected people there to help work the agenda. It's not just mental health. It becomes a whole social. It becomes a whole social thing. What activities? What do young Latina women need to have to increase their self-esteem to be part of society, to see themselves differently if they're depressed that kind of thing? That's not just mental health. That's everything that they do with relationships with their families. We're getting into that more and more. I think that that's with gold is. I mean, I think we do a lot of other stuff, which is good, but I think the more we can do that, the more effective we're going to be.

Jo Boufford That's great.

Jo Boufford Let me ask you, do you have a structure on the ground either through because of federal pass-through funds or others local offices similar to the offices on aging? I'm going to ask the same question to Oasis. Do you have people on the ground in communities or in counties that are designated structurally as part of your operation, or is it more?

Ms. Zuber-Wilson We have what we call field offices. Within those field offices they do all kinds of things. They do prevention. They do the prevention work. They do a whole host of things. They're set up across the state. They've put their fingers into the community. When I talk about these big initiatives, that kind of folds down through those field offices out into the community.

Jo Boufford Do you have a structure like that or another one?

Dr. Sullivan We have regional offices throughout the state. Our regional offices are our connection to our local communities. We work with the LG use, of course. They're one of the things we look at is what's happening in the community through our local government units. We work with our provider system. We also have some other funded boots on the ground. I just wanted to mention one other collaboration that no one's talked about, and I think Commissioner Cunningham for this innovative work is an internal cross system partnerships are we were siloed in many ways where it was prevention, treatment, recovery, harm reduction. We have some projects going on around the state where our prevention, treatment and harm reduction system are working together. If you have a parent in a treatment program, they'll get a parenting program from our prevention provider. If you have a kid that doesn't meet the assessment for treatment they'll be referred. It's across systems work and that's really been an important part of our work.

Jo Boufford We have structural units at more or less local level in all of these departments that we're talking about here. Health Department obviously has local health departments working key roles with the county executives' offices, at least play kind of critical roles there. We'll come back to that.

Jo Boufford Last question, because we want to get you while we're here. We have this as Dr. Bauer said, we have time at the end. We're going to have the part of this reason we

want our Ad Hoc Committee, which represents all the people that you're probably working on the ground. Part of the role they played historically is using their statewide status to link to their local chapter's local members and others to help us take on these challenges. We want to get their questions and reactions. Going forward, as you look at the sort of evolving landscape of emerging health issues that are either in general or related to your specific population of interest or your area of interest, what areas do you think ought to get greater emphasis or maybe higher priorities in the prevention agenda than the ones we've been working with up to now?

Jo Boufford Greg, you're leaning forward. I'll let you go first.

Greg Olsen I don't know that I would not prioritize any of these. I think that there's some new things that we've learned over the years to focus on. I just want to make a comment first. There are many things in here where there have been for years and years existing task forces that are working on recommendations to improve. I would highly recommend. I'm having the same conversation with the Master Plan for Aging. We have a Hunger and Food Nutrition Inter-Agency Task Force. We have a Geriatric Mental Health Council, a Suicide Prevention Council. I could go on and on and on. Why recreate the wheel when people have been looking at these issues again across the spectrum for a long time? There's no need to do that. Some areas that I think you should consider is gun violence. Now that gun violence is the number one killer of children. That passed automobile accidents, caregiving. What we learned during the pandemic is that for somebody who's providing some level of uncompensated care for somebody else, 75% had mental health issues due to their caregiving role. 52% who are caring for an older adult and a child contemplated suicide. There's just a lot of other data around that. Because that's across the age spectrum has to do with economic security, food security and so on and so forth. I would mention that maybe something a little more focus on intergenerational local programming. There are huge benefits both to the older adult and to the younger individual. We're seeing some, things that like Oasis is doing and New York City school system to actually bring intergenerational folks together. Addressing social isolation has to be in here. That's huge. Isolation, loneliness, depression, we know what the costs are. We have the data in terms of what it actually means. Like I said, we've implemented ten or so innovations that are being replicated all over the country that are showing huge decrease in depression, isolation and loneliness by using some of the things that we've launched. Also, some of the things that we've launched are free. Our Get Set Up Platform, for example. Our Caregiver Platform. We are subsidizing those for anybody in the state of New York who's a caregiver or who is over 50 years old. Top ten classes. There's been over a million classes taken by 200,000 people in New York State. Nine out of ten of them are all health and wellness, tai chi, exercise, hydration, nutrition. That's free for any New Yorker over the age of 50. Those are just a couple of thoughts.

Jo Boufford That's great.

Jo Boufford Ann.

Jo Boufford New issues or issues that aren't getting enough attention or dropping any that you think are.

Dr. Sullivan I think we've been talking a lot about youth because I think it's a vast one. I also want to just emphasize what Pat said about parenting. Parenting is something. We train people for absolutely everything, but we don't give a lot of assistance to parents and to young parents. We're an interesting society that we somehow that's magical. We all

know how to do it. I think that parenting and youth and that early, early intervention to really try to make the difference. There's a lot of the social determines you have to worry about economic and poverty and all the bad things that happen in society. The resilience of individuals, even in those states, is something that we can maybe spend more attention time to. I think that involves parenting, early youth experiences, socialization experiences, cultures that talk about kindness. I just love some of the people just say kindness might be important. Pushing that kind of thing out early, early on. A small thing, which I don't know, this is just one of the biggest preventers of long-term disability for individuals with serious mental illness is employment. One of the social determinant factors that we often don't talk about is having disabled individuals get themselves jobs. I think that that's something that can be done on a cultural and a statewide basis. If you really want to put that dent in the long-term disability group, I think that's something that needs more emphasis and it never kind of appears anywhere, but I think it's very important.

Jo Boufford Great.

Jo Boufford Thank you.

Jo Boufford Oasis colleagues, Patricia.

Ms. Zuber-Wilson I think it's important that a key part of the work that we're doing at Oasis under the leadership of our commissioner is in the area of harm reduction. I think it's something that needs to come to the table so that it is part of the work. We talk about, in essence, teen pregnancy work that happens in the world of the health world is harm reduction. We don't talk about it really in substance use. We really don't. It's something that we're working on. We need to continue. I don't want to leave it out of the realm of this conversation because there's a lot of work that we can do to save lives. We have now an Associate Commissioner for Harm Reduction, and we're talking about how we work together in the world of prevention and harm reduction to bring out healthier outcomes.

Jo Boufford That's great.

Jo Boufford Thank you.

Jo Boufford We have five minutes. I'm going to invite my colleagues on the Public Health Committee that are on the line to see if they have any questions. Maybe we can zoom out. We have a very nice big picture of Ann Sullivan.

Jo Boufford There we go.

Jo Boufford We're back to others.

Jo Boufford Let me see if any of my colleagues on the Public Health Committee have a question. I'm going to ask all of you, the broader membership, to write down your questions because you'll have plenty of time at the end.

Jo Boufford I see Kevin. I see Denise saying no.

Jo Boufford Anyone else have any questions at this point?

Jo Boufford Let me ask each of you for just final comment. Final piece of advice on sort of especially moving forward in revising the prevention agenda, rethinking it.

Jo Boufford Greg.

Greg Olsen I was just going to say connect the dots. There are so many things that New York State, the agencies in public private partnerships do that are just disconnected. Like I said, you have a lot of really important pieces to this agenda that are being worked on elsewhere. Hopefully, the two shall meet. That's my takeaway.

Jo Boufford Patricia.

Ms. Zuber-Wilson to build upon with Greg said, I wrote down mapping. We really need to do program mapping and financial mapping. Many times, when I get into meetings with other state agencies, we find out we're doing the same thing.

Jo Boufford In the same places.

Ms. Zuber-Wilson in some of the same places. It gives us an opportunity. We've already seen this with our work with OMH to say, okay, where you doing parenting programs? We'll do some in another community. I think that is really a key thing, piece of work that we need to build upon.

Jo Boufford I'm so glad you mentioned that because having had one experience previously with AG and Markets responding to a food desert complaint of local health department. They said, wait a minute, we have nine programs in your county. You don't know about them? It's a huge issue. There's nothing like a map. I completely agree with you.

Jo Boufford Ann.

Dr. Sullivan You can tell how aligned the three of us are, because we all have the same...

Jo Boufford I know. I love it.

Dr. Sullivan This is where the state can really get us all together. I think there's a different way that you can do that. There are so many agencies that are involved if you're really to move this agenda. I think the Master Plan for Aging is an example of having pulled together so many groups. I think the prevention agenda should do that. Think about pulling in all the others, the social determinant agencies out there that are part of the state calling them into this conversation and everybody doing their piece of moving it. I know that's what Health in All Groups was, but I think it needs to be pushed again in a big way. I think everybody wants to do this. I agree with exactly what was said by my two sister agencies that that's what we're all thinking. We would just love to do it on a bigger scale across the state.

Jo Boufford That's really great.

Jo Boufford Thank you very much.

Jo Boufford Ursula, do you have any final words on this panel before we move on to the next topic?

Dr. Bauer This was a fantastic discussion. Really appreciate everyone's input. I'll just share a couple of takeaways that I heard. The need to scale programs. We all have a number of pilot programs in different areas or small-scale programs. How do we expand our reach across schools, across local aging agencies, and so forth? The emphasis on resilience, social and emotional learning. I heard a lot about youth and building resilience in youth in particular. Really engaging deeply in community. I think everybody said that multiple times, and especially in our sort of post-pandemic world, rebuilding trust, re-engaging with communities, talking to communities about what they need and what they want. That's an area where the prevention agenda can really strengthen. I heard a little bit about trust, which I think goes to the community engagement. I was pleased to hear. Ann, I think you summed it up very nicely in terms of pulling in the social determinants of health agencies. I haven't heard them referred to as that, but that's a really great expression. Helping them to do their part to build those thriving communities and build that that community resilience. I heard about employment, which isn't something we talk a lot about in at least in the health department in terms of an intervention, but employment has such a powerful impact on a person's health wealth, certainly, and well-being. Really wonderful discussion. Really appreciate all the ideas that were lifted up.

Dr. Bauer Thanks so much.

Jo Boufford Please let me thank you all very much. Also connecting the dots and I never thought I'd say this because I never do, but data. We don't want to leave out the data issues and basically kind of integrating data and integrating data collection methods, of which there are many. Wouldn't that be fantastic if we could get our data geeks and brains together across the agency to think this through. This is really terrific.

Jo Boufford Thank you so much, Commissioner Sullivan and Greg Olsen, Acting Director of NYSOFA and our Commissioner, Zuber-Wilson and Barbara Bennett, Director. Oasis, we've gotten us off to a great start. Just for the purposes of the Ad Hoc committee, an important segment of each of our future meetings will be inviting other commissioners in. Some of the other agencies you've talked about. I know Paul Byers sitting here, Department of State, which has been crucial friend of ours from the very beginning, to bring them in. We'll obviously be wanting Commissioner Morne to come back explicitly and really help us dig into this equity question. Thank you so much. Really great start.

Jo Boufford Let me applaud.

All (Clapping)

Jo Boufford As you can see, we're marching forward. If anybody has a bio necessity in your own home office or here, please feel free to take advantage of whatever resources or facilities or near you. We do want to move forward because we really want to get these items out on the table in these first few meetings and then really preserve that last forty-five minutes to an hour to have a really good Q&A session. I do want to move on and invite Shane Roberts, who's Assistant Director for the Office of Public Health Practice, and Zahra ALaali , who is coordinating the office in the private coordinator of the provider agenda. She's our point person within the Office of Public Health Practice on the Prevention agenda. They've been working on analysis that Dr. Bauer has commissioned. She may want to say a word or not about it. She'll be okay. She thought it would be really useful for us to look at what other states are doing in the area of the state health improvement plan and see what lessons we have from those. This group was presented to the Public Health Committee at our last meeting, and we wanted you to have advantage of it. Obviously,

may be going through it a little bit quickly. Shane and Zahra, but the full slides that will be available to everybody who's been a part of the meeting.

Jo Boufford Shane, over to you.

Shane Roberts Thank you, Dr. Boufford.

Shane Roberts As Dr. Boufford said, I am Shane Roberts for the Office of Public Health Practice. I'm joined by my colleague Zahara. What we're going to do is today we're going to talk a little bit about state health improvement planning, which is a framework which is used by states across the country for setting their priorities across their health departments. I'm going to give a brief background on state health planning and then Zahara is going to go over the analysis that we did of the fifty-state health improvement plans and then also Washington, D.C.

Shane Roberts Just some background. State health improvement planning is a framework for states to assess and address health priorities through marshaling a broad coalition of stakeholders and resources and implementing evidence-based data driven interventions. As Dr. Boufford said earlier in the day, the prevention agenda is New York State's state health improvement plan. The reason why the state implement plan is important beyond just setting the priorities for the Department of Health is that accompanied with the state health assessment, the state health improvement plan and the department strategic plan they are a criterion for public health accreditation. Maintains a comprehensive guidance on the framework and actually within that guidance on New York State's prevention agenda dashboards are held up as the example of how data should be shared with communities.

Shane Roberts Describes the state health improvement process as follows. State health departments should address the needs of all citizens. It addresses the leading health issues identified by the state health assessment. The purpose is to give direction in how the health department in the community can improve the health of the jurisdiction. Stakeholders set the priorities and develop and implement projects to address them. The plan is more than just the responsibilities of the health department. It is reflective of the contributions of a multi-sector team of stakeholders. In our case, that is this Ad Hoc Committee.

Shane Roberts Before we talk about the analysis of the state health improvement plans it's probably important to talk about the nation's health improvement plan. That is Healthy People 2030. The vision of Healthy People 2030 is a site in which all people can achieve the full potential of their health and well-being across the lifespan, and to promote, strengthen and evaluate the nation's efforts to improve the health and well-being of all people. A little background on Healthy People is that the 1979 was the first Healthy People report issued by Surgeon General, Julius Richmond. Healthy People is now currently in its fifth iteration. They are ten-year intervals. Each build on the knowledge gained and the lessons learned to address the latest public health priorities. Healthy People culminates in an end of decade assessment, similar to how the prevention agenda is a six-year cycle here in New York State. It is preceded by and culminates with a state health assessment.

Shane Roberts A little bit about the structure of Healthy People. Healthy People is at its core. The framework is at the core of the framework. Healthy People has its own priorities and objectives. 2030 has five categories of objectives. Those are health conditions, health behaviors, populations, settings and systems, and the social determinants of health. There

are also three priorities for Healthy People 2030. That is health equity, the social determinants of health and health literacy. As the Ad Hoc Committee considers both the priorities and framework of the 2025 to 2030 cycle, we did set about analyzing the fifty states self-improvement plans. What we looked at was their goals and objectives. We looked at the priorities. We looked at the guiding frameworks. We look for any innovation within the plans themselves. My colleague is here is going to review the analysis now.

Zahra Alaali Our team reviewed fifty-one state health improvement plans. This includes fifty states and Washington, D.C. We assessed each for the goal statement, priorities, guiding framework and innovation. For the analysis, we conducted preliminary thematic analysis to identify the patterns among the priorities.

Zahra Alaali You can see some examples of our legal statements. Since we are planning for the new cycle of the prevention agenda it is really a perfect time to review and perhaps revise the goal statement of the current for the future prevention agenda. You can see the New York State current prevention agenda goal statement or vision. New York is the healthiest state in the nation for people of all ages. The next example here is California State. They have the same exact goal statement. We are competing on being the healthiest state in the nation, basically. The third example here is Vermont. Like New York and California, Vermont focuses on health equity. Their statement is all people in Vermont have fair and just opportunity to be healthy and to live in healthy communities. The last example here is Mississippi. Mississippi focusses more on the collaborative role of the citizens and partners. The statement is all Mississippians living healthier, longer lives due to a thriving public health effort supported by active and committed citizens and organizations.

Zahra Alaali In this slide, you can see some of the frameworks and guiding principles used by other jurisdictions. Our results shows that the guiding principle and the framework used for the development and implementation and monitoring varied from one state to another. The majority of the states selected the social determinants of health as a guiding principle, followed by Healthy People 2030 model. Some states selected different frameworks such as health equity, mobilizing for action through planning and partnership, or the map model. The last one here is collective impact models. All of them address health equity one way or another, but in different ways.

Zahra Alaali New York State's prevention agent didn't use any of the previous aforementioned models. We use what is called county health ranking model. This model is basically a population health model that explores the measures that influence how long and how well we live. The model consists of health outcome and health factors. Health outcomes tell us how long people live on average within a community and how much physical and mental health people experience in a community while they live in. On the other hand, health factors represent those things we can improve to live longer and healthier lives. They are the indicators of the future, the future health of our communities.

Zahra Alaali In the figure here, you can see that health outcome again, basically is concerned about the length of life and the quality of life and the health factors they have for subdomains. This includes healthy behaviors such as tobacco use and exercise. Clinical care is this a concept domain. It has access to care and quality of care. The third domain is social and environmental factors such as education, income and community safety. The last domain is physical environment. We will go back to this model in a few minutes.

Zahra Alaali For the priorities, we identified 253 priorities across all the fifty-one jurisdictions. We grouped them into forty-seven unique categories. We identified twenty-eight priorities included in two or more state health improvement plans and nineteen priorities unique to a single plan.

Zahra Alaali In this table, you can see the top ten selected priorities across all the fifty-one jurisdictions. At the top you can see mental health, mental wellbeing or suicide prevention as the top selected priority across all the jurisdictions. 65% of the jurisdictions selected this as a priority, basically. The second top selected is maternal and child health, followed by health care access, chronic diseases and substance misuse. Nearly all the jurisdiction and included health equity as a central guiding principle for their plans. However, we identify a total of nine plans selected health equity as an individual priority. Among all the top ten selected priorities, 50% were health factors, while the other 50% were health outcomes. In general, the priority focus varies across all the states in which some states health improvement plans exclusively focus on health outcomes, while others exclusively focus on health factors. Some states have more interesting model. They have a hybrid priority in which they have a mix of health outcomes and health factors.

Zahra Alaali In general, if you look at the map here, the blue states compromise 82%. They offered at least one priority that contain health factor. The states here are the states that have exclusive model or basically focus on health outcome. New York State is one of them. As I mentioned a few minutes ago, the prevention agenda depends on or was guided by the county health priority measures our model, which contain both health outcomes and health factors. However, the prevention agenda has only health outcome priorities, and none of the health factors were included in our current prevention agenda priorities.

Zahra Alaali Here we have a few examples from different states. We have in New Hampshire. They have a health outcome focused priority. They have ten listed priorities such as tobacco control, diabetes prevention and others.

Zahra Alaali The next example here we have Connecticut. They have a health factor focused priorities. This includes access to health care, economic stability, healthy food and housing. The last one is community strength and resilience.

Zahra Alaali Ohio, on the other hand, has a hybrid health hybrid model in which they have health outcomes and health factors. For the health factors priorities, they have community conditions, health behaviors and access to care. For the health outcome priorities, they have mental health and addiction, chronic disease, maternal and infant health. This is one of the most interesting models actually we have reviewed.

Zahra Alaali In this slide, we are looking at the top ten healthiest states in 2022. Basically, we were looking at their priorities as well. Among the top ten healthiest states in 2022, we have New Hampshire and Utah. They have a health outcome focused model. The remaining eight states have at least one health factor in their priorities.

Zahra Alaali In this slide, we can see the nine states in the map, the red states, which has a health outcome focus model. We were looking at their rank in 2019 before COVID. They rank also in 2022 after COVID. In general, four states had improved rank in 2022.

Zahra Alaali Thank you.

Zahra Alaali If you look here at Delaware, it was ranked number 30 in 2019 and then improved in 2022. However, the remaining states, they either didn't change or they had a lower rank.

Zahra Alaali New York States has fallen from 11 in 2019, which is pre-COVID era to 2023, post-COVID and 2022. The change in New York State's ranking was influenced by adding new measures and changing existing measures to account for health disparities post-COVID era.

Zahra Alaali I will hand it back to Shane to go over the recommendations.

Shane Roberts Thanks.

Shane Roberts Just in summary, the plan model encourages a multi-sector collaboration in drafting a plan that incorporates the social determinants of health in addressing identified health priorities. A significant majority, 82% of states have adopted plans that either wholly or in part consist of priorities that address health factors and the social determinants of health. New York is one of nine states using a primarily health outcome, disease-based mail. Not to say that we don't address the social determinants of health at all, but that our focus is really on a disease-based model. What we're recommending is, is that the prevention agenda on New York State's health improvement plan be a bold and innovative agenda grounded in health equity and built upon a framework that addresses the social factors that determine health status and that includes meaningful community engagement. At the Ad Hoc Committee to support the New York State Prevention Agenda, be given charge to advise the department and how to ensure that health equity and social factors determining health are foundational to the 2025 to 2030 New York State Prevention Agenda.

Shane Roberts Thank you.

Jo Boufford Great.

Jo Boufford Thank you very much.

Jo Boufford Let's open this up to questions. I think everyone here, I don't know, hopefully there had a copy of the slide set, which is really helpful. I see the recommendations sort of along the lines of the discussion we've just been having for the last hour and a half. I think one of the really important things to remember is the last time these objectives were revised was 2019 and the evidence base has improved. Clearly, the kind of discussion we were talking about before in terms of a broader engagement of agencies in the creation of the of the objectives, priorities, objectives and measures is really important.

Jo Boufford Let me open it up for questions on this presentation during question.

Jo Boufford People with a question, if they could say who they are and their department. I didn't read out the required language at the beginning of this meeting around the fact that we're being webcast and people are asked to identify themselves in their departments when they speak so that we can have a record of that.

Merrill Rotter Merrill R. Rotter from the Office of Mental Health. Obviously, there's a commonality to all that you described, but you called out Ohio as actually being particularly

interesting. I'd be interested, given the fact that you had some elements, what was it about Ohio that was sort of more unique or that we can learn from?

Shane Roberts Thanks.

Shane Roberts What we found unique about Ohio, not suggesting that we want to use this model, but just looking at it, that it really used a combined menu of health outcomes and health factor-based priorities. The way Ohio does it is that they have a menu of options that their constituents can choose from when developing their own community health improvement plans. We thought that that was an interesting model in the sense that it's not all of one or the other. They had some innovation in the way that they work with their counties. I think that that was just one example. I mean, there are a number of states that follow a similar model. I think North Carolina was one that we had looked at, and then a couple of the other states that really focused on looking for ways to work the social determinants of health into their state health improvement plans in a way that was more prominent than just as a guiding principle.

Merrill Rotter That's consistent, as you said, with what we said earlier today, which is this also to suggest that the prevention agenda that includes not just a focus on social determinants or the factors, but the outcomes we're looking for. It's not just look. We're going to talk about. Let's say, pollution and the outcome is less asthma, but rather the changes in the social factor itself could be an outcome that we bake back in that then creates a little bit more, if you will, accountability for that social determinants, focus, prevention work.

Jo Boufford It also addresses the sort of upstream downstream question. I think it's a really good point that both the impact on what you're intervening on is a social determinant as well as potential health outcomes, which may come later. That's really, really helpful.

Jo Boufford Thank you.

Jo Boufford Other questions, comments.

Jo Boufford If you raise your hand on the Zoom, will be happy to call on you.

Paul Beyer Paul Beyer, Department of State Smart Growth. I see that many of the states you highlighted have referred to something like community conditions and a variance there. Does that include, say, brownfield contamination, the state of sidewalk and park infrastructure, those sort of aspects of the built-in transportation environment?

Shane Roberts I think for some states, absolutely. Each state defines that a little bit differently. They use a lot of common language there. They're very diverse in what they include in some of those categories. Another thing that I would point out is that a lot of states when they were developing their priority areas. For instance, some would separate out specific chronic illnesses versus having a general chronic illness. Some would combine mental health and substance use together. Some would use them separately. I can't answer that question very well, but I can say that was included with some states and we can probably get more information, if that would be helpful which ones did.

Jo Boufford Well, I'll ask a question as well. I think just in terms of the other states looking at you. You mentioned some of them. They use the equity. They're concerned about equity in equity measures. I wondered again, it's a bit similar to Paul's question. Could you

unpack what was underneath the equity measure? I mean, is it race, ethnicity? Is it race, ethnicity, economic status? Some of the issues I know when Joanne Morne's presented and we've talked about over time, trying to really add certainly the economic status of individuals as a critical variable in terms of not in addition along with race, ethnicity. I wondered if you had any more information on that and that thinking in particular states.

Shane Roberts Most states when they're doing health equity use health equity as its own priority. They also included health disparities along with health equity. They were looking at education. They were looking at employment. They were looking at housing. They were looking at housing segregation. The other things that were included were health literacy. Health equity was a very broad category for most plans. Again, I think it was depending on which state it was it had similar to our own state had very different definitions of what health equity entailed. It could be urban versus rural, or it could have been under a racial or other identifying characteristics.

Jo Boufford It speaks to what Commissioner Sullivan said earlier on. It's going to be really important for us to define that. What do we mean by health disparities in this work? What do we mean by health equity? What are the measures that be really clear, because I think it is. I mean, CDC defines it in a national way. Again, everybody, if you want to repeat that, that's fine. We also need to really be clear about what we're what we're talking about. It's back to the social determinants. Are we talking about individuals or communities? I think the answer is both, but we want to be really clear about it.

Jo Boufford Other questions?

Jo Boufford Yes.

Anthony Feliciano Anthony Feliciano, Housing Works. We were talking about coalition building and coalition. I'm wondering how much you were able to assess in terms of what the community partnership looks like. Because I think it goes back to defining community engagement in some ways, but it is also about what is operationally was done in those states.

Shane Roberts Coalition building is core to the state health improvement planning process. Looking at all the plans, it was very similar to how we have this Ad Hoc Committee set up. It was really an engagement of local and state partners. It was state agencies, it was academia, business and other coalitions. I think that we did see some variation on how different health departments chose to engage partners, whereas some did us a single survey or they reached out to partners through focus groups. Others had an ongoing sort of committee that was advising their state health improvement planning process, similar to how we do it here in New York. Was there additional detail you're looking for in terms of the consistency or what constituted engagement?

Anthony Feliciano It'll take a long time to go through all that kind of conversation. Can I just say, in terms of data collection, were there like creative ways where departments were sharing data and aligning data so they can get a real good scan of was going in terms of the drivers?

Shane Roberts We didn't really look at that category when we were doing the analysis, only that they we were just briefly looked at what they were doing in terms of developing their coalitions. That is something that we could go back and look at in terms of what kind of data collection they used. These plans are... Again, they're very diverse in the approach

that they took. That was outside the scope of what this analysis was. It's certainly something that we'd be willing to look at and bring back to this committee.

Jo Boufford I think it speaks to the special interest, certainly in the equity disparities question and in the community engagement questions that maybe there are a few of areas we do want to dive more deeply into the data, the sort of integration of data across agencies is really important.

Jo Boufford Dr. Moore has his hand up. I had to walk up to the screen to see your name. Sorry about the delay there. I can't read it from this distance.

Dr. Moore Thank you.

Dr. Moore Just a comment.

Jo Boufford Just introduce yourself.

Dr. Moore I'm Jeff Moore, physician. I've been on this Ad Hoc Committee for years now. I'm glad to see it going. I'm sorry I missed the first meeting. I missed the first part of this meeting. Just a comment which is in my work experience. I'll echo some thoughts that were expressed in the first Ad Hoc meeting, which is about connecting the dots and from a physician's medical practice standpoint, it's really, really difficult to engage all the different stakeholders, the community-based organizations. The truth is, if we're going to address social determinants of health practices, can't do that when we're measuring health outcomes. We do have this challenge where we need to be able to have ways, easy ways, non-overhead inducing ways for primary care, especially to be able to make use of community-based organizations and community resources to help people address their deficiencies in social determinants areas. That really is an area where it's I hate to use the word silage, but I think we have. There are silos. It's hard to overcome. That's really what I think the next step is. I think this is all moving in the right direction. The challenge is, is figuring out how to get people connected and how to get all of the stakeholders collaborating and working together. I missed a bunch. I'm sure you've been talking about that, and hopefully I will be able to be on time at all of the future meetings.

Dr. Moore Thank you.

Jo Boufford Thank you.

Jo Boufford Other questions or comments on the review, other things people would like to know.

Charles Williams Charles Williams, State Office for Aging. New York's mission goal is the healthiest state for people of all ages and the previous iteration of the prevention agenda did a fantastic job of addressing the experience of older adults holistically throughout. I want to know whether the review of other states took a similar approach or if they had a specific call out for the experience.

Shane Roberts I mean, it's reflected in a majority of, I would say, the state health reform plan goals that we reviewed, where it is called out specifically across the lifespan in so many words. Aging itself, you know, I don't have the table right in front of me, but it wasn't a specific priority in I would say a multitude of plans. It is incorporated sort of like that golden thread approach that New York takes through many of the priorities in the states.

Again, we really looked at the categories of the priorities and then sort of the overall scope of the plans themselves. We didn't get too far into the details of what the interventions were within each priority. I feel confident saying that we observed... Aging was represented in the majority of plans that we reviewed.

Jo Boufford Other comments, questions.

Dr. Boufford Seeing none, then I think we can Segway into our sort of final open mic session. Nobody sings, please. Other than that, we'll just be talking. Dr. Bauer is going to kick us off. As she said earlier, we have some questions we'd like to get you all to address, but we also may have more questions about the presentations earlier or this review of other states or other comments that you have been thinking about. Many of you I know have been involved in the prevention agenda for some time. This would be a chance to begin to surface some of these areas.

Dr. Boufford Ursula, over to you.

Dr. Bauer Great.

Dr. Bauer Thanks so much, Dr. Boufford.

Dr. Bauer Thanks again to all our panelists and all those who have brought questions forward. I did want to just point out at the outset that we do have in New York State Law definition of health equity and health disparities. That's probably a good reference point for us as we start thinking about how we more intentionally and purposefully integrate health equity and health disparities into our prevention agenda work. If you Google the Office of Health Equity and Human Rights New York, you'll come to our web page and you'll find those definitions there if you want to look at it quickly. We can certainly send those out to you as well.

Dr. Bauer In the last hour that we have together this morning, this is really your opportunity to share with us your recommendations for what the next six year cycle of the prevention agenda might look like. We've had a robust discussion from some of our key sister agencies regarding how they have used and experienced the prevention agenda. We've heard an analysis of how other states approach their state health improvement plans. We have an opportunity to pick the best from the prevention agenda and hold on to that going forward to add new items where we might see gaps to start over from scratch, to keep everything as is. We kind of have the waterfront in terms of our opportunities for the next cycle. We'd really like to hear from you today how the prevention agenda can be most helpful to advancing our state goal, our Department of Health mission, your state agency missions, your voluntary missions to improve the health, productivity and well-being of New Yorkers. I do have some questions which I'm happy to ask, but I'll just open it up right now for your recommendations to the committee and to PHHPC and to the department.

Courtney David Hi, everyone. Good afternoon. I think it's afternoon now. Courtney David. I'm the Executive Director of the New York State Conference of Local Mental Hygiene Directors. I know that there was obviously, as we move the conversation along this morning and into this afternoon and mental health is taking top billing, I think in a lot of the discussion with our state agency partners. I just wanted to, you know, when we talk about that local connection and how do we make that local connection, how do we bring those folks to the table. The conference is comprised of the directors of community services, also

known as the local governmental unit. I think that's a more familiar term than our DCS term, and that's obviously through the county mental health departments and that is represented for the fifty-seven counties and the City of New York. Our DCS's have a statutory responsibility under mental hygiene law to plan and have oversight and management of the local mental hygiene systems that encompass mental health, substance use disorder and intellectual and developmental disabilities for individuals and families in their communities. Our DCS's also have mental hygiene authority for local planning of services. When you're talking about looking at cross systems planning across those three agencies, that's where our DCS is kind of your entry. They all have community services boards where some boards have policy authority approval. Some are just engagement. Engagement venues for community providers and agencies, school districts to come to the table to talk about mental health policy and planning needs. I know our Commissioner from Genesee County is on the line, I believe, I think virtually, and she oversees the conferences Mental Hygiene Planning Committee. I think she can speak a little bit more to the DCS role in the community and how that looks like for planning. As far as the planning of annual local services plans that the DCS is engage in every year, you know, they work really closely with our state partners at Oasis and OMH and OPWDD. We've really enjoyed that close relationship with our state partners in planning of these services. Outside of that unique role of the DCS, they also have those connections with criminal justice and engage with our public health officials and our DCS commissioners. On the behavioral health side of things, I think that's where you, you know, I think when the state is looking to engage in those local conversations, it would be through the DCS role. I don't know if Lynda is on the phone, Lynda Battaglia.

Courtney David There she is.

Lynda Battaglia I am.

Lynda Battaglia Hello, everybody. Good afternoon. Thank you, Courtney, for the introduction. Lynda Battaglia. I'm the Commissioner for Mental Hygiene for Genesee County, which is more of a rural county. I'm sandwiched between Erie County and Monroe County, but I heard a lot of incredible information today. It's the first time I'm attending. I appreciate that. Some of the common themes that I heard in this discussion this morning was really tapping into the local level, tapping into really getting a deep reach into the community and utilizing the grassroots organizations that assist with the development and in identifying needs of what our community needs. As Courtney said, you know, as commissioners, we are responsible for creating the local services plan. How we do that is by tapping into our community by utilizing the subcommittees for mental health, for SUD, for developmental disabilities, working with providers, working with individuals with limited experience, so that we have a really well-rounded perspective of what our local needs are. Working with DOH and DSS, OFA, you know, Commissioner Sullivan mentioned suicide prevention coalitions with Chemung County. Brian Hart is incredible with the work he does in Chemung County. All of the counties utilize and develop coalitions for, let's say, suicide prevention on the local level. I wholeheartedly agree that mapping would definitely assist with that. Not duplicating services. Not working in silos. At the local level is really where you're going to have that implementation of what the prevention agenda is. For example, in Genesee County, we have a suicide prevention coalition. We work with harm reduction. We go to the gun and rod clubs to assist with gun locks. We work with the VA and work locally to just try to get that information out there. I also just want to just touch really quickly on when it comes to the local services plan, what all of the county commissioners can do is identify what the needs are based on the community providers input, some of which is anecdotal, some of which is certainly data driven, but promoting the overall health and

social well-being of our county residents is essential. I think decreasing the stigmatization of needing help, of talking openly about suicidality and asking for help or decreasing the stigmatization when it comes to mental health and SUD and needing to get services should also be a focus of the prevention agenda. Knowing that they need help and not feel comfortable going to get help, making accessibility to services is also essential. Like I said, this was my first time. Incredible information. I appreciate the invitation. Please utilize the directors of community services, utilize the local services plan that we have to create. We already work with partners on the county level, and we get into those grassroots out into that deep reach into the community when we're developing our local services plan. That's really all I wanted to say. There's so much information I didn't. There so much to cover. I wanted to just highlight some of my thoughts that I've heard here today. Thank you.

Dr. Bauer Great.

Dr. Bauer Thank you, Lynda. Thank you, Courtney.

Dr. Bauer I'm hearing we absolutely need to engage with our local DCS partners. I wonder, though, speaking of connecting the dots, are you really connected with your local health departments? As the local health departments are putting together their community health needs assessment and their community health plan, are you at the table as partners with the local health department?

Courtney David Absolutely. I mean, counties all operate uniquely, right? Because you see one county, you see one county. I'll speak for Genesee County. I do know that this is accurate for a lot of my colleagues. We do work very closely with the Department of Health. The Department of Health Director is one of our subcommittee members. We work on opioid settlement funds. We work on trauma informed care and how to get that out into the community. We work with the community assessment that is provided on the county local level. Working with the Department of Health in suicide fatality review boards on opioid task forces on homicide, trying to figure out, get into the grassroots and root cause analysis of some very intense issues like homicide, like opioid overdoses. That's done in conjunction with the Department of Health. We can't work independent. We can't work in silos. We won't have enough information to do the job that needs to be done. It won't be good enough. The only way to really get that outcome is to work in collaboration with one another. I know firsthand that working with the local Department of Health and even their epidemiologists, it's crucial for the local services plant and for the development of identifying what the needs are in the communities.

Courtney David Just to piggyback on that, I think, you know, I think Greg made mention of it earlier when he was here about, you know, there might be some different relationships, whether strong or maybe some weaker ones, depending on the county. As far as... You know, the conference is concerned, we work really closely with Sarah Ravenhall at the New York State Association of County Health Officials. Why there might be stronger relationships that need to be built between the public health departments on the county level and the mental health departments. I think out of most of the county departments, those tend to work more closely hand-in-hand.

Dr. Bauer Excellent.

Dr. Bauer Thank you so much.

Dr. Bauer Other recommendations, other input for us.

Dr. Bauer Yes, please.

Anthony Feliciano Again, Anthony Feliciano, Vice President for Housing. The obvious that I would want to re-emphasize what Patricia said about harm reduction, particularly philosophically, how we invest within equity. I think it's important not just around substance abuse, but in general how we're looking at harm reduction. I think gives opportunities to learn from years of needle syringe programs and where are we going to safer consumption sites as we start thinking about this moving forward. The other point I want to remind us. The last of the meetings that we've had, we've talked about how overwhelming the buckets are in terms of how many things we need to do. Given what Greg said is to look at some of the task force. Someone's looking at poverty right now. Not about duplication, but where do we align? Reemphasize, reinforce. Figure out what we shouldn't be doing because we know task forces are moving on that. I think we should have more mutual support there. The other thing I just wanted to bring up, it was about resources. I think we talked about community engagement, but also around committee engagement when it comes to resources and who's getting the resources and to have a deeper thinking and look at as folks are going through RFP and RF5, what are the assistance we need for those organizations that don't necessarily can really connect with the RFP? We asked about showing evidence or showing how you address the issue, which is critically important, is a big move and is important. Are there disparities in our thinking or biases coming into that as well? I think it's important to think that through. The other I think areas is when we're talking about food insecurity or food justice. We talked about meals and all that. Are they being culturally relevant to the communities? What is the implementation in the way we should be doing that? That's challenging. I know that's not easy. What are managed care organizations are being mandated already to do even around diabetes management and what those look like moving forward. I think we sometimes have to do even deeper scans of what's out there and what's going on so we can just reinforce again. The other aspect, I think in community engagement just in general is having a definition around communication that we can share. We can tweak it according to agencies and what we're doing. One lesson I think we learned from the waiver is that we were all over the place on community engagement. There was real focus and some that were weaker than others. It may be about defining community engagement, knowing that not to get stuck in the lesson, but to actually think about it from a function, not just from a definition. I think those are areas I think we need to discuss as we think about priorities not only in the prevention agenda, but as we're working with other areas. One last thing is we don't think about informal groups. What I mean by that is who are groups that are not necessarily non-for-profit, maybe not CBO? We talk about faith based, yes, but there's so many other informal groups. I don't think the prevention should tackle it, but they should put it in principle so then it becomes something that we're sharing to do as we bring it down to the local level.

Dr. Bauer Thanks so much.

Dr. Bauer Paul.

Mr. Beyer Thank you.

Mr. Beyer I'd suggest that we expand and enhance some of the measures that relate to the built-in natural environment. Some of those measures used to be fuzzy, and they're not so much anymore. For example, we have walk scores that we can determine for each community. That's not just about sidewalks and trails. It's the connection to life's daily amenities, like public gathering spaces, which has a tremendous impact on overcoming

isolation. I bring that up also because it might be one of those areas of confluence with the Master Plan for Aging. I'm Co-Chairing the Community Design Community Development Work Group, and we're drilling down a little further into these issues that we see every day, but we might overlook. Sometimes we take it for granted that we can walk to a park, but that's not the case in most communities in the state. If there's a way to expand the drilling on that, I think we can dovetail with the master plan.

Dr. Boufford Could I just ask Paul a question?

Dr. Boufford One of the other things the Department of State is involved are the regional Economic Development Councils and the sort of.... I always get the name wrong. It's not the city in power. The city development program that you do.

Dr. Boufford Downtown revitalization, right, which are separate programs, but they're from the Governor's budget. I want you to talk a little bit about what those are, because one of the big issues, economic development is an important issue. Employment came up earlier just for people to be aware of those a little bit and then how some of what we're talking about might be linked up.

Mr. Beyer Yes.

Mr. Beyer Well, that brings up a very powerful example of connecting the dots. The regional Economic Development Councils are connected with our agency in our community development smart growth Downtown work because they reinforce one and another. Vibrant, healthy communities in a region contributes to economic development. Economic development contributes to vibrancy. What we've done with a number of programs with DOH, DOS, and co-funded by the Health Foundation for Western and Central New York, is to bring those two worlds together with the service folks like the Offices for the Aging and the county health departments. Right there you have a mini network that I think is pretty powerful. We have a whole presentation that we've done to these regional economic development councils about the value of health and healthy aging to the economy. I'd love to get my boss, Secretary of State Rodriguez, here to present in more detail for two reasons. He has embraced these programs and the connection to our work here tremendously, but also, he has a history, as Dr. Jo knows, with the prototype for age friendly, healthy communities, and that was Age Friendly East Harlem. He was the Board Chair when that really national model was developed. These worlds are coming together, and I think we can play off of that here.

Dr. Boufford He's first on our list for the next meeting of this group, so I'm glad you mentioned it.

Dr. Rotter I want to just... I'm not going to repeat, but just to underscore a couple of things that were said earlier, just further support for the neighborhood based sort of developing sort of a framework for a neighborhood planning in a sense that we can maybe underscore that community based planning, as well as the idea of the alignment and mapping some idea so that because there is so much overlap, which is great, but also challenging in terms of efficient use of resources. Two things I want to sort of add to the mix maybe for more, which gets to Paul's area perhaps is maybe a more explicit focus on climate and the effects of climate change really in two ways, one of which is working on the effects and the resilience aspects of it, but also, obviously, there are built environment issues around green spaces and trees and I think as the world heats up, etc. Climate may be an area of a specific focus for prevention, I think for us. In terms of the alignment is, as I mentioned

earlier, about getting people connected to having their social needs addressed is certainly a challenge. I'm not sure where this fits into the prevention agenda model per se, but both the social care networks that DOH is developing as part of the 1115 waiver, which may not be for everybody, but certainly for the Medicaid population, but also then just in general, how we might promulgate or call attention to some of the available internet access referral networks. At the state level, obviously from a procurement perspective, we have to be careful about sort of aligning with a particular company that's doing that, but there are several that are doing some very robust referral and close referral networks for it to address the issue that was raised earlier by the gentleman on the screen about how we get our clients connected to that in an efficient way. Because one of the things we're hearing from our providers a lot is social network. The social determinants are great and they're important. I can't add that to my workload. Finding efficient ways of making sure people can make those connections and address the needs that we're identifying is critical and there are some opportunities to call attention to those.

Dr. Boufford You said the magic word business. I wanted the private sector. I think we really want to get them more involved. I notice we have two members that have joined the New York State Business Council and the Northeast Business Group on Health, and both joined the Ad Hoc Committee. We really want to get... Because at the local level, private businesses, local businesses are so important in terms of supporting these kinds of efforts. They were just fundamental in age friendly work that we did in New York City. It's really important. Then, of course, we have not brought in the hospitals and community health centers and others and Lloyd Bishop is here, I know from Greater New York. We have to call on him. He's so shy. He usually doesn't speak.

Lloyd Bishop I actually turned on my mic. Lloyd Bishop, Greater New York Hospital Association. Just to bounce off what one of my colleagues just said. I wanted to say the same thing I said last time about we should make sure... I hope we can stay aligned with what is going to come out of the 1115 waiver, especially those social determinants of health networks. I think that that's a structure that will be there with a funding that is going to be very important. The other thing that I like that I heard was and I will be doing tapping into what I'm going to call the state agencies and how these social determinants of health agencies. I like tapping into those. You'll all be getting a call from me as well.

Lloyd Bishop That was it.

Lloyd Bishop Thanks.

Dr. Boufford Lloyd, could I ask you one of the concepts that is going on in the hospital industry is really focusing on hospitals as anchor institutions in their community relative to issues like obviously pollution is one thing, but hiring local, sort of buying local. Has that kind of caught on in the state or in the city? Are there examples that you could give because that speaks to hospitals looking sort of outside their walls to have an impact on community conditions?

Lloyd Bishop I mean, there are hospitals that are part of formal networks of anchor institutions. We're going to be supporting our members in that area by helping them talk about in an organized way what it is they already do for their communities, being the largest employers supporting local businesses just by the virtue of them being in those communities. There is work to be done there. I think that some are better than others at talking about what they do, and that's what we're going to be helping our members do more of in terms of working on those issues. I'll just call out a colleague of mine, Ben

Gonzalez, who is new to the Greater New York team in the audience, and that's one of his projects.

Ms. Zuber-Wilson I would be remiss if I did not mention a very critical problem that we're having in our system and that's workforce. Without the workforce to do these wonderful programs, to push forward a prevention agenda, it's not going to happen from just those of us in state agencies. As we think about what we're going to do, how do we recruit people to join our fields, especially the mental health and addiction fields? We are really struggling. We are starting to look at ways we can engage middle schoolers and high schoolers and use that STEM Program Youth Conservation Corps model to start talking to young people about being in our profession. I want to drill down just one more piece about working in communities. We need to make sure that we have meetings and provide support for individuals when we go into communities. People work multiple shifts. People have challenges within the community. It's great. We're going to go in the community and we're going to talk to various organizations but talking to and having conversation with people that we're serving, people that we want to connect and make sure are part of the discussion doesn't happen in the middle of the afternoon. We have to think differently about how we connect with communities.

Dr. Bauer Thank you.

Dr. Bauer Molly.

Molly Fleming How do I turn this on?

Molly Fleming Yes.

Molly Fleming Hi. I'm Molly Fleming from the New York State Association of County Health Officials. We've been actually working with Dr. Bauer and Shane to survey the local health departments about their thoughts about the previous agenda and what they want to see moving forward. We're still collecting results, but I just want to share some of the preliminary trends we're seeing reflect a lot of the themes that have come up today; greater focus on primary and early prevention, addressing factors that influence health outcomes, a focus on poverty and social determinants of health, living a healthy lifestyle from the start, and parental education. A few other areas that came up that are currently in the prevention agenda are gun violence and climate change as well. I just wanted to share what we're seeing so far in those results.

Dr. Bauer Thank you so much, Molly.

Dr. Bauer I'm going to turn to Dr. Moore, and then I'll come back to the table.

Dr. Bauer Thank you.

Dr. Moore Yes.

Dr. Moore Thank you.

Dr. Moore I'm going to pull up my notes.

Dr. Moore A couple of touch points that have been brought up here. I just want to reinforce them. I live in Tompkins County, and so certainly our hospital is an anchor in the

community. I perceived it that way, a long way and then the Upstate and then rural areas. Absolutely that's going to be the place in many counties. It should be that way in urban counties, but I can imagine it's a slightly different scenario. I want to point out that if the hospitals. I understand why we use hospitals for health planning as the ship and so forth, but if we're using hospitals that by definition, we're really kind of looking at secondary and tertiary prevention. The good news is that's when you catch people is when they go to the hospital or when they have a chronic condition. Really, we're talking about managing chronic conditions as disease management and so this then becomes this is why as a physician sort of representing medical practices, it has to Segway with what medical practices do. It was pointed out that that's structurally difficult for medical practices to address. There's more and more emphasis on that. We have to make that something that's efficient and easy to do and not a huge additional overhead. My other last concern is brought up by just very last speaker was bandwidth. Do our community resource organizations? Do they have the bandwidth to handle all of the referrals that are going to come their way? How are we going to address those issues that we really need to be collecting and understanding what that is?

Dr. Moore Thank you.

Dr. Bauer Thanks, Dr. Moore.

Dr. Bauer We've been thinking a lot about the hospital's role in the prevention agenda. In part because in New York State statute, again, the hospitals have to produce these community service plans every three years. We're really trying to get those focused on what's the investment in the community that makes the community healthier? We just talked about the anchor institution role of a hospital and whether you're an anchor institution or not hospitals as employers, as purchasers of services can have a big impact in community. Even on the business side, not the health care side, there's an opportunity for the institution to look at the community. What businesses am I supporting to meet my own hospital needs? How can I recruit some of my staff, maybe not my neurosurgeons, but some of my staff from the local community? There are huge employment opportunities in health care. What are the ways that the business operation can really engage and help to transform the community?

Dr. Moore If I could follow up.

Dr. Moore I totally agree. I have in my professional memberships, societies, I've been saying for a long time, my colleagues, academic colleagues have wanted to get physical activity is a vital sign. They wanted to get a variety of those kinds of things. My point has all along been that if it's not supported by the business model is not going to work. It has to be the business model doing it. I agree. I think the use of the hospitals, the way we've used it in the prevention agenda with the community health improvement plans is astute. You can do it because you can. At the same time, I'm not affiliated with the hospital now, but I feel their pain. COVID really put them back on their heels. They're just beginning to come back from that. The other consequence, I think everybody probably knows primary care practices, especially like some of the independent primary care practices are just selling their selves to the hospitals. Because in one case, my colleagues in Ithaca, they concluded that were there another pandemic, the practice couldn't survive it. They sold out so that they would not be personally, financially at risk anymore. Doctors are now many much more employees than they were independent practitioners. That probably empowers because they're owned by a hospital. There are ways that then maybe the hospitals can be leveraged to do things through their practices. Again, they're swamped. We are really I

think one of the things that was important thing to do is to figure out how does it fit in the workflow of medical practices and in a workflow that either they get credit for or that they build for whether it's fee for service or whether it's a value based purchase. One of the things we've learned in my other advocacy work is that CMS, in their wisdom, never imagined. This is hard for me to believe, but I know how that world is. Never imagined the annual wellness visits would be a triage tool for lifestyle intervention, disease management services. Nor did they imagine really that the same thing would be true for transitional care. Those are obvious opportunities hitting in the workflow of a medical practice to be able to say, here are these community-based resources that might be able to help you. To me that's the obvious linkage to help break down the walls between the medical practice silos and what we're trying to do in the prevention agenda.

Dr. Bauer Go ahead.

Dr. Erazo-Trivino Good afternoon. Dr. Erazo-Trivino from the Office of Mental Health. I'll bring the discussion back to data. While I think quantitative data is awesome, I think we also need to look at the qualitative side, right? Really engage in conversations that can probably aid in community engagement. Kill two birds with one stone. Really follow the motto of nothing about us without us, which is, I think at the underpinnings of our prevention agenda. How can we do that? Can we leverage academic partnerships who are focused on issues related to social determinants of health or health equity, and really have those partnerships where they can help us with the analysis and the evaluation of our initiatives.

Dr. Bauer Thank you so much.

Dr. Bauer Lloyd.

Lloyd Bishop Lloyd Bishop, Greater York Hospital Association. I'm just going to say that no matter what the future of the prevention agenda, the structure is, hospitals will be part of it because of they're in the communities. They provide health care. They are economic anchors. Many of hospitals already have higher people from the community and most of the workers are from the community. That sort of built-in sort of baked into the system. It's a matter of how we talk about it. That's sort of our job. I just also want to just get back to the social determinants of health networks. My colleague on the screen, I'm not assuming that hospitals will be the lead on that. I assume they won't be, but they'll be part of those networks along with other entities. Those social determinants of health network is going to be very, very key because again, with them comes a structure and funding from the federal government.

Dr. Bauer Go ahead.

Dr. Bauer Thank you.

Anthony Feliciano Anthony Feliciano, again, Housing Works. We're always talking about health equity now more than ever and that's great. We're all in this place where we want to fix problems and issues that are going on. How do we bring in a local level? I think sometimes we also forget we get into a deficit model too many times and we should talk about the assets that are already here and the communities that are really doing that resilience work, that ability to get now even from and obviously the lessons from the pandemic in that way, but the mutual aid groups that were created, all these things that were done are assets. The ability to understand more of the assets so then we can

strengthen those and make them more sustainable because they are impacted by those social drivers. Those determinants of health. The idea of thinking about it also from a social determinant of hope is an important piece of that.

Dr. Bauer Thank you.

Dr. Bauer We have two hands raised online. I see Terry. I can't read the other person's name, but it's the other person who had your hand raised first if you would go first.

Dr. Bauer Thank you.

Dr. Erazo-Trivino Thank you very much.

Lauren Wetterhahn My name is Lauren Wetterhahn. I represent a large network of community-based organizations across seven counties in Upstate New York. We are those CBOs, those human service agencies, the social determinants of health organizations. There is greater awareness in the health care sector of the way that our organizations impact social determinants of health. It's really great to have an opportunity to be part of these conversations, but to meaningfully engage CBOs. It would be my recommendation that there is a... Whereas the fact that there tend not to be statewide entities. They're more regionally based. Were this ad hoc work group I was fortunate to be able to join, even though we're not statewide. That would be one potential change in the way that you include representatives, because these networks tend not to be quite as large scale as like a state hospital association. One other point on data that I would like to raise, some of our network attended the CMS Health Equity conference in June. We learned that CMS is beginning to produce reports that show some of their data broken out on urban and rural lines. If that is something that New York State is able to do, I think that would really help engage some of the Upstate rural counties in the cause of health equity. We often don't see ourselves in the data for that reason. That kind of location-based approach to disparity is something that I would also record.

Dr. Bauer Thank you very much.

Dr. Bauer Terry.

Terry Fulmer Thank you so much.

Terry Fulmer Terry Fulmer from the John A. Hartford Foundation in New York City. Currently, I'm on vacation in Old Forge, New York if any of you hail from that area. I've seen John Rugge there. I wanted to make two points. One is I'm so proud of what's going on in the state of New York around age friendly health systems. Our foundation, along with Norah O'Brien's and others in the city have been funding that. The amount of energy and effort that's going into that is just very, very exciting. Also, our work that we fund with Trust for America's Health on Age Friendly Public health systems, talks about the connectivity that we've been hearing about today. I am so delighted to hear this conversation about getting the area agencies on aging, for example, along with the Department of Health talking, so that we can reduce duplication and improve the connectivity. My only other point, I haven't heard the term nursing home on this call yet, and I promise you we will continue to see nursing homes close in the state until we have equal pay for equal work for nurses. I happen to be a nurse. I would do the same thing if it was physical therapy. I just have to tell you that there will be. If you have a mother in Buffalo, she will probably get offered a bed in Albany. This is just tragic, along with the fact that so many nursing homes

are now for profit selling the land for rates. You all know this. Once those rates remortgage. That's my only thing that I want to specifically enter into the record. I think this is a fabulous call.

Terry Fulmer Thank you.

Dr. Bauer Thank you so much, Terry.

Dr. Bauer Yes.

Dr. Rotter Sort of a question about prevention agenda process. I'm very excited that we're looking to reinvigorate or re-establish or re-energies the health across our policies, because as we've said, it's really an inter-agency effort. The answers don't come from certainly from the health agencies all the time, particularly in the structural companies in the systemic areas. I was wondering how the health across all policies, as it gets established as an interagency group, overlaps with the prevention agenda how it feeds into the prevention agenda, or vice versa.

Dr. Boufford I probably have been involved longer than a lot of the people that are leading the health right now because there's been so much turnover in the leadership. The answer is the prevention agenda... I mean, partners like Paul, the Department of State and others precedes the creation of the Executive Order but was really important in creating the 2018 Executive Order with the previous Governor that established the interagency group to focus on health in all policies and also on the impact on aging, age friendly policies. The good news, I think, is that with the Governor, the current Governor Hochul, in her Executive Order, she references. She's not clearing the decks and starting something completely new, but there is similarly an interagency council for the Master Plan on Aging. I think your question is a really timely one back to what we've been talking about earlier today, at some point there may be a kind of interagency council fatigue for dealing with separate issues. The other agency council established was co-chaired by the health representative and the Governor's Office and the Commissioner of Health. Met several times. The last meeting was canceled right before COVID hit and has not met again, but the structure has been there, and I think we've had as a consequence of that, there's been a really over the years, again, not embedded in the objectives in the way we're talking about it now. But there's been collaboration with ag and markets, with energy, with the Department of State and others. Laura knows because she was in that process. I think it's an interesting question as reactivating perhaps it on an integrated fashion, because I'm involved with the Master plan on Aging and we're asking a lot of the agencies the same questions, because my view is that if you make places healthy for older people, you make them healthier for everybody. It's a universal. It pre-existed the current master plan process and hasn't been activated, but it's sitting there. Talked about that in terms of the new Commissioner of Health and how that might happen relative to this redesign question.

Dr. Bauer Yes, Eli.

Eli Rosenberg Hi. I'm Eli Rosenberg, Office of Science here at the New York State Department of Health. Our team provides a lot of the data resources that supply the prevention agenda process, dashboards and so forth. We've been talking a lot about the state health improvement plan, but I wanted to call attention to another document that's a little bit of a precursor, which is the state health assessment document, which is something that we produce or that the team here produces that's to help inform the process, sort of help inform the next prevention agenda so that there will be outputs from the development

of that, that will inform future meetings and so forth. I wanted to just raise that this is the opportunity to assess ourselves, get our data together and really provide information. There are so many great ideas today that have been discussed. If we want to bring data on those ideas to help inform the next wave of prevention agenda, we welcome that input. Left to our own devices, we will produce something that's in the mold of the 2018 state health assessment. We want to make sure that we have a document that's useful, relevant, will be read and used by this committee to really inform the next work. I just wanted to call that out. Just yesterday we were talking about some new kinds of measures to add, so I was really pleased to hear about workforce and really assessing what's the state of our public health delivery workforce and should that be something that's in the health assessment? What are the kinds of inputs that would be helpful to this committee? I wanted to raise that. Another thing that's part of that health assessment is actually what's called the assets map or assets framework or something, but it lists the DOH units that speak to all the issues in the prevention agenda. Hearing all the inputs from all the other agencies, we really might want to broaden what that asset directory is to say across state government or across other areas, what are all the assets that we have to make a change that's relevant for the prevention agenda? I just wanted to put that out there that there's the ship, but there's the Shah, and the Shah is what we're sort of entering into first. Just have that on the mind.

Eli Rosenberg Thank you.

Dr. Boufford I think it would be really interesting to hear more about that at both the Public Health Committee and otherwise, because I think it's a really important point in the essence, the reason the sort of five priority areas were identified were because they were areas coming out of the state health assessment that showed these were the primary focuses on preventable premature mortality and morbidity. I think it's more than guiding. It kind of has been the foundation, but it raises really interesting questions. If you could get input from more of the other agencies into that data source that would be spectacular.

Eli Rosenberg That's a really good point. Right now, a lot of what's on our dashboards or in the Shah is sort of DOH generated information.

Eli Rosenberg Absolutely.

Eli Rosenberg Just hearing today about the wealth of programs and data collections that are happening outside of this building or above us, the building, bringing that information and have it reflected would be excellent.

Dr. Bauer Thank you, Eli.

Dr. Bauer Michael.

Michael Sassaman Hello. Michael Sassaman from the American Cancer Society. I'd like to support the DOH recommendation to incorporate more of the social factors into the next iteration of the plan and ground it in health equity. That certainly makes sense given everything we've been talking about, and it certainly helps us move into more of a focus on social determinants of health, which we discussed at the previous meeting as well. In terms of identifying some of those factors, I think that will be critical to what we're talking about with data. Can we get the data on these factors? You could be looking at educational factors, which of course brings up when you're thinking health and all policies, can we get State Ed to be around the table as well and then something around housing.

That brings up homes and community renewal a very important partner trying to address housing needs in the community. Something in my world of cancer control and prevention is transportation, which we know definitely affects the ability of patients to not only get to treatment, but also screening. Think about the person who maybe they're able to do at home cancer screening, but for colorectal cancer screening they may have a positive finding and they have to actually go. They're in a rural area. They don't have access to transportation. They require somebody to actually take them and physically drive them home. It can't just be a bus or something like that or even a taxi. How do we measure access to transportation, I guess is the bottom issue, but something to think about in the cancer space? That was all I wanted to say. A very good discussion. It's great to hear about all of the collaboration that gets further upstream in the prevention effort. A lot going on, clearly that I wasn't aware of. But then it also brought up, well, these are things that are going well. Where are the gaps in some of these efforts? I know we have a lot of them. Some of them dealing with some of these agencies that aren't around the table that could be perhaps, and then figuring out what those metrics are.

Michael Sassaman Thanks.

Dr. Bauer Thanks so much, Michael.

Dr. Bauer I do not see any hands at this point.

Dr. Bauer I see one hand.

Anthony Feliciano I'll be short on this.

Anthony Feliciano We keep speaking about data, and we talk about all the things that we're discussing, ideas and how data can support it. I want to reemphasize if we've learned anything from the pandemic just aggregating the data is also important. Also, by what is important for the rural versus the city in terms of disaggregated data as well. It's not just by race, which is highly important, but all the other area, disability, age and so on. I know that is a challenge for us, but we really can't sustain or assess without it in many ways. We end up lumping groups and people that sometimes visually we see what the problem is, but we don't have the data to back it up or we have data but is not aligning with the state or the city or the county. I just want to reemphasize this aggregation of data and I know there have been bills and there are rules in place about disaggregating data, but we need to continue doing a better job in that area.

Dr. Bauer Great.

Dr. Bauer Thank you.

Dr. Bauer I appreciate those comments. We've come back to data a number of times. I can see that that'll be a future agenda item for this committee.

Dr. Bauer We have a hand online.

Dr. Bauer Is that Dr. Gildemeister?

Dr. Gildemeister Yes, but I think that Jeff Moore was in front of me.

Dr. Moore I don't know who was first. I would only have to say that in my work, I have called a library of questionnaire items from the RFSS and other organizations that are public domain items. If you're interested, I can send you a library of items that address I think all of the about twelve domains that have been mentioned here, if you're interested in those.

Dr. Bauer Thank you.

Dr. Bauer Amy.

Dr. Gildemeister I just wanted to make sure that nutrition, again, was officially on the record as being an underpinning of so many of these health disparities and health conditions. We have specific issues associated with urban areas; different disparities associated with rural areas. We just went through a period where there were quite a number of resources pushed out during the pandemic. Some of those resources are not in place in the same way that they were. Some of the barriers that were removed during the pandemic are barriers once again. I know that we talked about it at the beginning of the meeting, and I know that there's a strong understanding of the importance of nutrition, but I did just want to make sure that that was sort of officially on the list of things that were discussed and should certainly be addressed in the upcoming prevention agenda.

Dr. Bauer Great.

Dr. Bauer Thank you so much.

Dr. Bauer I think we are at the close of our discussion. I really appreciate everyone joining us. I appreciate all the rich input that we have received.

Dr. Bauer Going to turn it to Dr. Boufford for wrap up and next steps.

Dr. Boufford Just to reinforce the thanks, this has always been such an incredibly rich process. It's so exciting to see it continue to be, because I think it's a really important area. I think the challenge for a lot of us is one of the roles of the members of the Ad Hoc Committee in the past and this may be coming further down the pike, is to use the fact that one of the comments earlier about trying to at least have state organizations working statewide be the major criteria for membership, but obviously nobody's excluded is the idea that they have their tentacles into local communities through their membership. One very important step that had been involved in previous iterations were really asking them to present to their constituencies the sort of thinking once it gets a little bit more involved and getting feedback closer to the community level. We've had a lot of other ideas about how to do that better this time around. The idea is that this was a two-way network we're setting up. Not just one where information comes out and we sit in the room and ask questions, but we're going to probably come back to all of you to ask you to just do more work as the time goes on. Again, many thanks for now and for what you'll do for us in the future with us in the future. The other thing I just want to come back and mention, as I mentioned last time, in terms of next steps, we will be planning three to four additional meetings of the Ad Hoc Committee over the next six to eight months or so. We'll try to get those dates out as quickly as we can. I would only say that obviously, depending on people's schedules, the sort of three entities that have been mentioned a number of times that we had wanted to hear from soon would be Joanna Morne from the Office of Equity Department of State. Paul Beyer mentioned Secretary Rodriguez. If you're if your material is finished, if you're finished, otherwise we can plug it in later. We'll be developing others.

Those of you that, obviously, this is a sort of open conversation. In terms of presentations, I think the message has been let's get some of the other agencies. It seems to me, given timing, maybe our colleague running Medicaid for the Medicaid waiver would be someone to try to get in in September before it's... I mean, it will be done and dusted, hopefully everyone hopes, but nobody's talking about it. We don't know what's going on. The fact that there's something called social determinism networks is still there, I think really, really important opportunity. Again, a lot going on contextually. It's a very exciting time and I think these fits together hopefully. I love the connecting the dots thing. I think that's always the hardest piece of work to do. Anyway, we'll do our best.

Dr. Boufford Thank you all very much.

Dr. Boufford To be continued.