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PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
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TRANSCRIPT

Dr. Boufford: Hello everyone. My name is Jo Boufford. I'm the Chair of the Public Health Committee and I'm happy to call our Public Health Committee meeting to order and welcome our members and participants and any observers that we have. This is an in-person meeting, so we're not operating with screens or otherwise, except for looking at the slides. I do want to give the usual webcasting advice here. We want to remind everyone that the meeting is subject to open meeting law, is being broadcast over the internet. Webcasts can be accessed at the department's website within 30 days of this meeting and will be retained for four months after that. Because we are being webcast, people are asked to not speak over each other because of synchronized captioning being confused, making it difficult. And when you first speak, I think anytime you speak, maybe if you could just indicate you're a member of the council, that would be great or staff.

And we also, these are hot mics. We're not turning them off and on, so any of your comments will be more broadly available, so please be conscious of that and also just paper rustling and turning. And if we have any audience members, please remember that you need to fill in a form that verifies your presence here. They're on the table outside this room and in future you could get them online so that, to meet the open meetings law regulations. So let me, I'll start by asking Dr. Liza Whalen, who is our leadership team link to the prevention agenda, Medical Director for the Office of the Public Health Division to make some opening comments. Then I'm going to come back and overview the agenda and then ask everyone to introduce themselves and then we'll get started.

Dr. Whalen: Thank you. Dr. Boufford, I appreciate it and good afternoon to the committee. Can you guys hear me?

Dr. Boufford: Yes.

Dr. Whalen: Okay. So very happy to be here today with the team to discuss updates on the prevention agenda. It has been certainly a very packed year and a couple years of preparation and getting the plan

prepared and released and now implemented. I want to give particular thanks to Zahra Alaali who's here today for the work that she's done, and you're going to be hearing today from Mark Waldenmaier who is next to me. You all did meet him virtually at a previous meeting, but this is nice to have him here in person. Mark, for those of you that previously worked on the prevention agenda and were familiar with Shane Roberts, Mark is in that role now as Director of the Office of Local Health Services. He is a very esteemed and long-term public health colleague. Many of you may know him from work that he did prior to this with the Office of Health Emergency Preparedness. He's going to be doing the PowerPoint today and providing the updates, and we're very happy to have him on the team and great to see you all. Thanks.

Dr. Boufford: Thanks. Thanks very much, Liza. I always like to start with a bit of context to remind everyone that the Public Health Committee on behalf of the PHHPC is meeting a statutory responsibility of the PHHPC to approve and oversee the implementation of the prevention agenda. And we'll be hearing, that's why we're here. That's what these agenda items are. That includes the overall prevention agenda itself, the inter-agency activities that are part of that. And you'll hear about those in the first presentation by Mark Waldenmaier. And also the committee has asked that we be kept up to date on community benefit. So those are sort of our standing agenda items for each of our meetings.

In addition, the core of the Public Health Committee works with the Ad Hoc Committee on the prevention agenda, which is group that was really put together initially, a couple of cycles ago to be the public consultation group for the accreditation of the state health department actually. And that group is a state-level non-profits, advocacy groups and professional associations. And there are some other agencies besides the health department that are also members of that group. And because we've been sort of having a little bit of turnover in management and also just in the issuing of their prevention agenda formally by the governor's office in July. We did not meet in December because there was not enough time to really get a good bit of traction on what's going on. So I think today's an exciting meeting. We're going to hear about that part of it, but also the Ad Hoc Committee is being refreshed, and those two meetings were canceled in December because of that.

So we're looking to make sure that, this is the terribly challenging but important work that Mark and his staff are dealing with, trying to figure out who's still in the same position they were, getting the new leadership of organizations, thinking about other organizations that

ought to be invited to join formally. So we'd invite anybody on the council to give us notions of non-profits, advocacy groups or professional associations with whom you work that you think should be on. Hopefully they are. At this point, we have a very long list. And so the idea would be to get those invitations out and get official nominees in hand sometime during this month or early March. And then the Ad Hoc Committee, which I think is now listed to be held the third week of March, we're going to get an extra week, I think, and try to get it done within the month of March, but it'll be announced going forward.

The other thing I want to thank Mark for is getting a schedule. Our committee's been asking for a schedule for a long time, and now we have scheduled meetings going out from here either in Albany or in New York City. So we're appreciative of that, and I think he has those dates at the end of his presentation. The community benefit update is, Bella is our new colleague as introduced by Liza, and she is in the Office of Primary Care and Health Systems Management, Doug Fish's office, and we've had several calls with them on, they are charged with taking the governor's budget message to ask hospital support to provide reporting on the prevention agenda, Schedule H. During this year, sort of the deadline for this would be that something needs to go into place by July 1st.

So you're going to hear not only getting your feedback on the implementation process to date, but also on some suggestions, some approaches, possible approaches for asking for the language on community benefits, specifically on the community health improvement and community building section of the Schedule H, which is what we have been interested in. And you'll have a chance to hear what the thinking is and hopefully give feedback on that. And then we'll have public comment if anyone comes. I'm happy to do that. So that is our agenda, and let me ask that we go around and introduce ourselves. Let me start, let's see. I'm just trying to avoid... Dr. Perry, you just sat down, but all we ask you to do is introduce yourself and your organization as a council member, if you don't mind, and we'll just go across the table.

Mr. Perry: Stanfort Perry. I'm the CEO at AHRC Nassau, and a member of the council and committee member.

Dr. Boufford: Welcome.

Ms. Farrell: And I'm Lindsay Farrell. I'm the President of Open Door Care Network. We're an FQHC and licensed mental health agency serving the Hudson Valley.

Dr. Eisenstein: Dr. Larry Eisenstein. I'm the System Vice President for Community and Public Health for Catholic Health, six hospital system on Long Island.

Dr. Soffel: Denise Soffel, a consumer advocate and member of committee and council.

Dr. Boufford: They're all live Sabina.

Dr. Lim: Oh, that ones on. It's Sabina Lim. I'm VP of Health Policy Strategy for the Mount Sinai Health System, and I'm also a psychiatrist.

Dr. Ortiz: Hi, I'm Mario Ortiz. I serve as Dean of Nursing and Health Sciences at Binghamton University.

Ms. Knoerl: Hello, Erin Knoerl, Associate Director, Division of Public Health Infrastructure at the New York State Department of Health.

Ms. Connell: Hi, I am Kathryn Connell. I'm the Senior Health Program Coordinator for the prevention agenda.

Ms. Alaali: Hi, is it working?

Dr. Boufford: Yes.

Ms. Alaali: Okay. I'm Zahra Alaali, Office of Local Health Services Research Scientist and the Prevention Agenda Coordinator.

Ms. Elogoodin: Hi, committee members. My name Bella Elogoodin. I'm a Director of Patient Advocacy, the new member of the team at DOH within the Office of Healthcare Delivery. Very nice meeting you all.

Mr. Waldenmaier: Good afternoon everyone. I'm Mark Waldenmaier. I'm the Director of the Office of Local Health Services as Dr. Boufford and Dr. Whalen introduced me.

Dr. Whalen: Hi Liza Whalen, Medical Director for the Office of Public Health.

Dr. Torres: Buenas tardes. Dr. Anderson Torres, President and CEO of R.A.I.N. Total Care, member of PHHPC and co-chair of this wonderful Public Health Committee.

Dr. Watkins: Kevin Watkins, Public Health Director for Cattaraugus County Health Department, member of the council and the committee.

Ms. Soto: Nilda Soto, PHHPC member and now retired.

Mr. Waldenmaier: Congratulations.

Dr. Boufford: Colleen. Go ahead.

Ms. Leonard: Colleen Leonard, Executive Secretary to the Public Health Health Planning Council department staff.

Mr. Stelluti: Hi, I'm Mike Stelluti, Health Program Administrator, Department of Health.

Mr. Bintz: Hi, Jacob Bintz, Department of Health, Program Aide.

Dr. Boufford: Okay. So Dr. Whalen, Mark, whichever. Mark. Over to Mark?

Mr. Waldenmaier: Thank you.

Dr. Boufford: What's your remark about the agenda item?

Mr. Waldenmaier: So, I think we're going to put up some slides for the first agenda item.

Dr. Boufford: The slides are in your packet for those of you like me that can't see that far.

Mr. Waldenmaier: So, this topic actually came up at the last meeting when I was first introduced by Dr. Eisenstein. Basically the Office of Local Health Services, where did that come from? Because that was not the name of our office, probably 12 months ago maybe, 12 months ago or so. So it is part of our Department of Health reorganization. So we did want to spend a few minutes talking about that. I know we kind of gave an overview verbally, but we wanted to kind of share with you kind of how we looked within the change of the department. I think many of you have worked with the department for a while and have seen the department change past the COVID pandemic and of course for our own organizational needs. So I may give them one minute.

I can re-go over my origins a little bit. So as Dr. Whalen said within the department, I just came from the Office of Health Emergency Preparedness, which works with all of the other state agencies and with the department and with the local health departments and

hospitals and other partners on emergency preparedness and planning. Before that, I was actually with Rensselaer County, so I worked in a local health department, again in the emergency preparedness program with Mary Fran Machounis, who also retired somewhat recently from her position and currently works with NYSACHO. And then getting into public health. Originally I actually worked as a faculty member at the university at Albany School of Public Health at the time under the preparedness program from the CDC. They were funding preparedness training centers across the nation. So University at Albany was one of them, and we worked with the local health departments primarily along with a lot of other community-based organizations on being able to work on preparedness, planning, training and exercises.

So I've been kind of moving from place to place in public health for about 20 years. Most of the focus was emergency preparedness, but I turned 50 last year and said, you know what? I fell in love with public health, not preparedness originally. So I was like, I needed a bit of a change as I progressed in my career. So thankfully this was actually one of my dream jobs. I had remembered throughout my years, especially when I was working for Rensselaer County, Sylvia Pirani in this role and then saw Laura Santilli and Shane Roberts on this role throughout time and I was like, this is a great position working with local health departments, working with public health. Really appreciate all the staff that I have been working with within the office, especially Zahra and her team for the prevention agenda.

Dr. Boufford: So, Mark, I think in the interest of time and they have the slides, why don't you just start and we'll go through the paper slides. This was literally up on the screen about a half an hour ago now-

Mr. Waldenmaier: Yes. Yes.

Dr. Boufford: Why don't we-

Mr. Waldenmaier: How it always goes.

Dr. Boufford: Keep going?

Mr. Waldenmaier: Okay. So-

Dr. Boufford: This is the organizational work. We'll get it by, hopefully it'll be fixed by the time-

Mr. Waldenmaier: By the time.

Dr. Boufford: You get to the actual prevention.

Mr. Waldenmaier: Okay. So have the title slide, we'll go to the next slide. So this is the Department of Health organizational chart. Right now there is the link, this is the most updated one, and just highlighting Office of Public Health that you're familiar with that Dr. Whalen is the medical director for with Director Laura Trolio, that the department is a very large department. This is something when I work with a lot of the other state agencies, there's always something I like to key in on in order to be able to really have the other agencies that we worked with understand all that we did, that there has been some changes. Next slide please. Within the Office of Public Health, some movement of some of the major centers within the office. So both the Office of Science and Wadsworth Center, which used to be under the Office of Public Health have moved out, but they are still major collaborators as we are with all of the major units across the department.

With that transformation, next slide please, was also a change to the Office of Public Health Practice and that was the office as it was called previously. So that has now been transformed into the Division of Public Health Infrastructure. So Erin Knoerl is our Associate Director, our director is Keshana Owens-Cody, and so that is kind of the new home unit of the Office of Local Health Services. So some of the activities that used to be part of the Office of Public Health Practice are still within our office, but there's a lot of different activities that have now spread to the division as a whole, as well as new activities that are part of the Division of Public Health Infrastructure.

I know Keshana has presented before for this committee. We are planning for the May meeting to have her present and give some updates on the division as well as workforce development. So you'll be able to hear more about the division as a whole in the next meeting. Next slide please. So again, we've gone from the Office of Public Health Practice to the Division of Public Health Infrastructure. Next. And this is where there's a lot of new units within this division that are working with the local health departments. 40% of the funding of the Public Health Infrastructure grant does go to the local health departments and many of these units are used to help support the local health departments and their activities. Next.

And then we're one of those units now within the division. So the Office of Public Health Practice has definitely transformed some, and now the Office of Local Health Services is very focused on a

few activities, which we'll look at in the next slide, which will be, I think if I can read it. Slide six? Yes. So slide six is the major activities within the Office of Local Health Services. The first one is Article 6 or State Aid. So this is a large program that supports the local health departments in all of the core public health services. It's basically something that looks to support financially the local health departments, and it's over $250 million a year that that program does give to the local health departments to support those core public health services. Along with that, there's another program within Article 6 called Performance Incentives. It's a little more targeted and allows local health departments to choose to engage in a specific activity each year, for example, which we do like because there's synergy with it, this year is oral health, which is actually one of the areas within the prevention agenda.

So we like when we can see kind of the different activities working together. Obviously you guys know that this is something where prevention agenda is one of the major activities of the Office of Local Health Services with Zahra's team working with Dr. Whalen and a lot of others within the Office of Public Health and across the department. But we are the office responsible for coordinating all that and Zahra does such an excellent job on that, working not just across the department, again, very large department, but working with the other state agencies, other community programs, things that you've all seen and been involved with as we've given updates to committee over time.

There's a few other activities that we also work on that I think were important. Obviously working with Dr. Boufford and the PHHPC, especially the Public Health Committee and the Ad Hoc Committee for the prevention agenda. We work very closely with NYSACHO, the New York State Association of County Health Officials, which is one of our primary roles is actually helping coordinate with different programs in the Office of Public Health as well as some other DOH programs like the Office of Health Equity in coordinating a training and education contract that currently NYSACHO holds to again support the local health departments as well as Dr. Boufford already mentioned this, a big part of the prevention agenda and what we work on with our office, although now the division has taken over, the overall coordination is the National Public Health Accreditation Board or PHAB. So a number of activities. Prevention agenda is one of the big pieces of that. Next slide please.

So just quick picture of when you're looking at prevention agenda and how it works across the department. Dr. Whalen's our overall lead with OPH, Keshana as our director of the division then

supports and we have a number of activities that I think we'll be talking about as we go through 2026 that the division is supporting that will tie into the prevention agenda. Myself as the new director of the Office of Local Health Services and Zahra, who you're familiar with, who is the CHIP coordinator or the prevention agenda coordinator for the state.

Dr. Boufford: We'll take a pause and see if-

Mr. Waldenmaier: Yes.

Dr. Boufford: There are questions about that and if they're not then we can move on with the review of the implementation today. Any questions for Mark? Denise?

Dr. Soffel: Yeah, I am always interested in Department of Health staffing because I know that for many years staffing was kind of on a downward slide because of budget cuts and funding freezes and hiring freezes and whatnot. So I'm curious how this set of offices are doing in terms of staffing capacity. Are you at the capacity that you want to be at or are there still gaps?

Mr.Waldenmaier: So, I would say we finally are at a workable capacity. I think Erin could actually speak more to the division and some of the efforts for that. And again, we will have a presentation in May to kind of go over some of that, but I know Zahra, when she came in was pretty much a team of one initially. So we now have built up a little bit. She has two full-time staff currently and a fellow that's helping her. We also have two staff, which I'll talk about some of those activities that are working more on the communications and other activities that we're trying to build up with the prevention agenda. But Zahra's team is the primary team for working with the local health departments and the hospitals and kind of the core aspects of the prevention agenda. So it's something, could we use another body or two? Possibly. But we're doing better.

Dr. Soffel: Slightly different question, and Dr. McDonald will tell you I ask him this question all the time, do you have positions that have been funded in the last several budget cycles? Because there was a big bump up in the Department of Health funding that has not yet been filled.

Ms. Knoerl: So, I can answer that. So right now, state funding wise, we have six state staff in the Division of Public Health Infrastructure. There's about 80 total. So the rest are funded via federal grants right now, primarily through the Public Health Infrastructure grant, but some

through the ELC, Enhancing Laboratory Capacity Supplemental. So some of those staff will be ending in July based on that federal funding added. So majority are still federally funded through HRI.

Dr. Boufford: Dr. Eisenstein?

Dr. Eisenstein: So just because you mentioned it, nine or 10 years ago when I was in my prior role as Commissioner of Health in Nassau and at one point president of NYSACHO, my department then became one of the early adopters to enter PHAB Accreditation, Public Health Accreditation Board. We did it. And I am being very honest when I say this because I'm hoping you're going to tell me things have changed. In the five years that we were accredited before we came up for re-accreditation then I left and came to my current role, other than a nice letter from the state health Commissioner congratulating us being PHAB accredited literally made zero difference whatsoever in our daily operations with regards to New York State. So I'm not talking about the Federal Accreditation Board now because they're not here to testify, but you guys are here.

So you mentioned that it's a, almost lost my coffee. That would've been bad. You mentioned that it's a relationship that you guys work on and tie it to the local health department. So has something changed that that's now of value or merit or a reason why local health department would apply for accreditation? Because I could tell you it was year's worth of work and other than, and I wouldn't say it was bad for us to internally look at ourselves and evaluate ourselves and get better, but when we were convinced to apply, it was you'll have preferential opportunities at grants and at funding and at other things. The truth is that never happened. It was yay. And there's a nice plaque on your wall. Is it now of something of substance since you mentioned it as such a high priority item?

Mr.Waldenmaier: So, I'll defer to Dr. Whalen as well and I know the commissioners made some comments, but I will just say that's actually one of our topics as well that Dr. Boufford and Dr. Whalen and I have discussed. We are going to hopefully have both our division lead for the department's, PHAB Accreditation process give an update as well as NYSACHO said they're willing to give an update on kind of the status of it with local health departments and how it's working with local health departments. So it is a topic that we want to talk more about.

Dr. Whalen: I think that's a great question, Dr. Eisenstein and I were at Albany County when we became accredited as well. So can agree with you of the amount of work that it takes for a local health department to

become public health accredited. I think that there's two pieces of this, right? There is the promises of greater preparation for grants and preferential treatment that I do think still we're waiting to see more on that. But the second piece is really the value that it brings to an organization in terms of how it functions. So I know when I was at county level, this introduced kind of a new framework for how we worked within the department. There was a tremendous shift from doing the work that we do because this is the work we're told to do to kind of creating a culture of continuous quality improvement to ensuring that we were looking at the work that we did every day in terms of the value that it provided the counties that we were serving.

And we do this at the state level as well. And to translate so much of the work that we do to transparency and accountability, which as we know is becoming more and more appropriately important within public health. We have to be able to demonstrate the value of the work that we do. And to my mind, accreditation does provide an incredible practical infrastructure for that. So that is, I think of value, but it also doesn't necessarily translate to dollars and cents. So I do agree with you, that it would be nicer for us to have more evidence that this does make counties more competitive for grants and grant fundings. I do think there is some pride in saying as a local county health department, as a state health department, that we are accredited and knowing the work that that takes and the infrastructure that you have to put in place to do that, I think is realistic, to feel very proud of being accredited. But we do need to see more in terms of how that translates. I agree with you.

Dr. Eisenstein: And I would just say if I were to assess this more time, I think I would agree with every word you said, but at the end of the day, and I do think it made, as I said, it made us look at how we operated and do some things better, but at the end of the day, if you want counties to buy in, the benefit has to outweigh the work going in. And to me, I was proud and was great, yay. News came, we're accredited now. I can't from, now, it's been four years since I left that post. I can't say that the work put in was benefited at the end. I'd like to see the shift to a way we can make it so that that's something really valuable. And for us, it was valuable as leaders running health departments, but the work was massive and the investment was massive to have no financial benefit. And yes, there was the benefits you described. So Liza, I agree with you 100%.

Dr. Whalen: Thanks. I want to say that I'm speaking not necessarily on behalf of the team at DOH who might have more information on this, so we

will certainly provide more when we have that. I don't know. Zahra, do you want to...

Ms. Alaali: Yeah, I just wanted to add from our rule at the Office of Local Health Services, we try our best to streamline the processes for the change the Community Health Assessment and Community Health Improvement Plans because they were one of the requirements or prerequisites for the PHAB accreditation. So we aligned it with the requirement of PHAB and also we aligned it with the annual progress reports required from PHAB. So this is what we did at our office here to encourage the pursuing of accreditation from local health perspective.

Dr. Boufford: Dr. Watkins has a question or comment.

Dr. Watkins: I just have a quick question. And I'm from Cattaraugus County and of course we also were accredited health department as well, and now re-accredited and we found some benefits of having a CHA CHIP, but I thought maybe Department of Health would talk about their performance incentive program where they have also instituted where if you are an accredited health department or seeking re-accreditation, that they do give you a bonus, incentive towards that performance incentive program. So that's what they've started to institute. So there is where some financial benefits are, but I'm sure there can be a lot more. With that being said, going back to the Community Health Assessment, Community Health Improvement Plan for local health departments that were recently submitted to the department, I'm looking to find out who is actually doing the review of those CHA CHIPs.

Dr. Boufford: That's the next topic.

Dr. Watkins: Oh, next topic.

Dr. Boufford: Next topic. So hold that thought. We'll talk about that. Any other comments on this? I think we have not as a committee in my recollection, really heard much about the accrediting for a while and the incentive program, the stuff in that other box Mark. I think it would be good to hear the other activities at the next meeting. So that's great. You've got some comments-

Mr.Waldenmaier: I have already written some notes.

Dr. Boufford: Here about what to talk about. Yeah, exactly. Okay, so why don't we move on then, because bleeding into the implementation. We're going to hear about implementation and I think Kevin's question fits

really nicely in that presentation. So Mark, why don't you move into the next set of slides?

PART 1 OF 4 ENDS [00:30:04]

Dr. Boufford: ... really nicely in that presentation. So Mark, why don't you move into the next set of slides if you would.

Mr. Waldenmaier: Sure. Thank you. Keep going. So we are going to move into more focused on just the prevention agenda. So again, we kind of plan a lot of this material at the end of 2025, but as Dr. Boufford said because of a number of reasons, we did cancel that, but we are going to be talking about a lot of the summary of 2025 as well as kind of what activities we're moving into 2026. And of course, Zarah and Kate are here and can give us even more details on some of those specifics if you have more detailed questions. Next slide.

So the three big areas we're going to cover today is the State Health Assessment as well as the local and regional level activities, including implementation activities. So that's where we'll cover the CHAS and chips as well as looking at some of our state-level activities that we're looking at implementing in 2026. Next slide.

So this graphic just shows a quick timeline representing especially the activities in 2025. Obviously it's easier to read on your slide than up on the screen, but we did have a lot of major activities as we've kind of talked about and looking at those and how pretty much it's almost month-to-month we had a major milestone occur throughout 2025, but each of those, I just want to always remind everyone and so much of what Dr. Whalen and Zarah are really working on, those are all tips of the iceberg when we're talking about next the State Health Assessment.

The document is one thing, but all the work that went behind the document as well as the state health improvement plan is so important and to kind of understand. So 2025 was just such an important year for us in meeting all of those milestones to move from the state planning level into more of the work with the local partners doing their own community health assessments and community health improvement plans. So we're going to be looking then to move into 2026 as we're transitioning from planning to more implementation and one of the key milestones for that will be the upcoming ad hoc committee meeting and we'll talk about that a little bit more towards the end of my session. Next slide.

We'll first start with the State Health Assessment or the SHA. Next slide. So I know you've all heard a little bit about this as it's progressed throughout its development in previous meetings of the committee. So this is just a high-level overview, but just to remind folks, this is based on a national model with ASTO and we do also, as Zarah already pointed out, both for the CHAs and CHIPS but also for the state level, we're making sure that our State Health Assessment and our state health improvement plan are meeting the requirements of the Public Health Accreditation board for DOH's own FAB accreditation as well. The SHA itself is mostly focused on measure one of the public health accreditation. So the key of what the State Health Assessment process did and then informed in the final document is the health of the population, some of those contributing factors of the health as well as the assets and resources that can be used to address those.

One of the things that really came to mind for me as Zara and I had a meeting recently with one of the community partners is the SHA and the SHIP are two key documents, the State Health Assessment and the State Health Improvement Plan. And the plan seems to be the next step document, but that being said that the State Health Assessment is still such a key document to the prevention agenda as a whole. So that's one of the things as we reach out to partners, we really want them to kind of look at both documents because it is the overall puzzle versus each piece. Next slide.

So again, as you're all familiar with, the prevention agenda program as a whole, this cycle is focused more and more on the social determinants of health. So you see within the State Health Assessment, looking at the demographics based on those five social determinants of health, it also looked at the key risk factors and outcome measures. And this also started looked at the different progress from previous prevention cycles. So specifically the 2019 to 2024 cycle, which was actually our third cycle. So we're on our fourth cycle now, which is amazing thinking of the time that's gone into this and that Dr. Boufford has helped shepherd throughout the years.

Next slide please. So again, not going to go into a lot of details on some of the key findings. This is in the executive summary of the State Health Assessment. But basically again, the health assessment as a whole looks at key information such as the aging and diverse population, as well as key information about different diseases, chronic diseases, other infectious diseases, as well as looking at different trends such as the life expectancy or access to healthcare. One of the things that's especially been important with

the prevention agenda program and the department as a whole as we moved out of the COVID pandemic is obviously disparities in health outcomes. We saw that a lot with the COVID pandemic, so that was something that helped inform it and obviously that's something within public health as a whole that we've focused on throughout the overall science and aspects of public health. Next slide.

So again, some of the other key findings, it looks at maybe some of the more modern aspects of what we're looking at in public health, such as the lack of social associations and disconnected youth. Again, something that we saw more and more with the COVID pandemic is people for health reasons were meant to social distance, what we're seeing with social media and other aspects that we're seeing having impacts and impacting different social determinants of health, as well as some of those kind of traditional enemies of health in public health such as smoking, lack of physical activity and obesity. So again, the State Health Assessment is really looking at a cross section of all the different aspects of public health and health and really trying to give a picture to then inform the state health improvement plan. Next slide.

Dr. Boufford: Just to say the State Health Assessment was presented to the committee probably a year or so ago. So as Mark said, it's in the beginning part of the prevention agenda, but it has been presented and discussed in the past in more detail. If you're looking for those slides, I'm sure they're on the websites.

Mr.Waldenmaier: Yes, they are on the public website. You always post them and Zarah help provide them. So just the general process. I'm not going to focus on this because again, I think you've had updates over time, but I did want to focus on kind of the last two steps. Next. So again, the State Health Assessment was finally approved. It did go through the department approval process and then through chambers approval process and we were able to post that on our website for anyone to take a look on October of 2025. Next step.

And one of the things working with Zarah and her team and others in our staff in the Office of Local Health Services that we did key in on when looking at this and seeing this finally approved was this final step, which is talking about sharing the State Health Assessment with the public. And so that's one of the things that we're going to talk about with state activities of where we're thinking of going with some of that. And definitely one of the areas we'd love to hear more from the committee on maybe some of their ideas or suggestions as well. Next slide.

So State Health Assessment, any questions? Comments? Go ahead, Larry.

Dr. Boufford: Dr. Eisenstein, I'll call you by name, but if you don't call my name.

Dr. Eisenstein: Yeah, Larry Eisenstein, committee member, council member all around great guy.

Dr. Boufford: No marketing, please. Just your name.

Dr. Eisenstein: Just as you discussed before, aligning the FAB accreditation requirements with the child and the SHIP. That makes perfect sense. More consistency would be really helpful. And right now I'm talking about you showed a slide on the social determinants of health. A year ago the state released a New York State 1115 Medicaid waiver, a multi-billion dollar process and dictated to everybody what social determinants screening tool we had to use word for word in order to qualify. And the topics don't match what you just presented on the social determinants slide. Now they may be sub-areas within the different categories. I get it, but we understand that, but you're not doing this really for us. We've got to take this outside of us and get our systems and get our local governments and get our leaders in the community to understand what we're doing. So my suggestion is something like the Medicaid waiver, the social determinant requirements should always match what we are presenting regarding social determinants because it looks like two totally different lists and it's confusing unless you're formally trained in this category. Just my opinion.

Dr. Boufford: Can I just comment on that? You asked my favorite question. The use of the term social determinants of health needs to be defined. In the clinical space, it tends to be social support services around individuals or individuals with certain diseases. And I think there are very targeted individuals that are being dealt with in the waiver and their needs are more what I might call social services. And in the prevention agenda, the social determinants are those that were felt to have a strong enough evidence base in healthy people 2030 to look at the conditions in the community that influences the health of individuals. So there are bit apples and oranges and I think as you say, Larry, there may be a subset under one or the other that are overlapped, but it wasn't... It's for a reason I guess. In some ways one could say the department within its healthcare delivery side is looking at the individual need and the department on its public health side is looking at the conditions in communities which created some of the illnesses that people are bringing into the clinical space.

So the differences are real and I'm glad you pointed it out because I think it's really important to think about the both and not to confuse the fact that if we're working on social determinants for individuals, we are not necessarily changing community conditions. And that's the tension we're managing here I think that's important.

Dr. Whalen: Yeah, I agree with that, and I agree with the dissonance of the whole thing, but from the prevention agenda standpoint, we're really trying to look at drivers, we're trying to look at root causes and how we can impact program services, collaborations across the state with multiple partners to affect those changes. Because as Joe just stated, when you're looking at a person in front of you, you are looking at the result of a community, but you're not looking to change a community. So I think there is a little bit of a difference there, but I understand to your point, we've had conversations with folks from Medicaid, they don't even always use the term social determinants of health. They use social drivers of health. And so the semantics can sometimes get a little bit difficult to resolve, but I think at the end of the day we're all looking at how we can improve health, whether it is at an individual patient level or at a community level.

Dr. Boufford: Just one editorial comment, I think we're now going to be embarking on a rural health initiative, which the federal government has given funding to every state to develop that. And I would hope that would be an opportunity to align more with prevention of gender social determinants, because I think that's more of the intent of that funding. One note, I don't know for sure, but I think Larry's point is a really important one.

Dr. Eisenstein: And could I just say what Liza and Dr. Whalen and Dr. Boufford just said. The semantics are really important in this category because very few people have the education of public health professionals when it comes to understanding drivers. In terms in my own system, we had a major disagreement among leadership over whether the simple term drivers or determinants, and actually it's not the same thing. And so I do think it makes sense, it's close enough to stay consistent and that's why we stayed with determinants because that's the term that's being used and presented most of the time. But I think we just have to recognize that the words matter very much in this work and linking it from a planning room like this to the actual activities that we do, the terminology is very important and getting buy-in at the ground level, they have to understand what we're talking about. So I think that what both of you said is really important.

Dr. Boufford: Thank you. Any other comments from Mark on the State Health Assessment or the stage moving from there into the local, and I think one of the issues to speak to Mark, going back to your timeline, was to remind the committee that the prevention agenda was actually released from the governor's office in July of 2025. So one of the issues that has come up in past discussions is the effort to try to apropos of the alignment the hospital deadlines, which were due in December with the local health departments. We sort of missed that synchrony because of the timing of the prevention agenda release, but there's a way to compensate for it. So Mark, explain that. I just want to raise that contextually as you move into the next section.

Mr.Waldenmaier: The next slide?

Dr. Boufford: Yes. Yeah, absolutely.

Mr.Waldenmaier: Go ahead. Next slide. Next slide. So yeah, we're going to talk about the local planning a little bit more, the CHAS and chips and how that's going. So as Dr. Boufford just said, there was the difference between the hospitals and the local health departments this year. Next. So we had the CHAS were due for the local health departments in December of 2025, but they don't have to have their community health improvement plans in until June of 2026. Next. Where the hospitals had both due in December. And Zarah's team has spent a lot of the early parts of 2026 working with the different partners, providing some last minute technical assistance for just providing a lot of guidance and a lot of communication with many of the partners in order to meet these requirements. Next slide.

So in comparison, so again, this was the last cycle, so 2022 to 2024. This is just a quick kind of overview of the plans that we're received for the overall local community planning. So the key next that I just wanted to focus on is one of the goals, and this is something Dr. Boufford is really impressed on me and I see the value even in my past with emergency planning is having that joint planning, having not just the local health departments worked with their own community partners, but worked with the hospitals in order to look at the betterment of the overall community health. So in that cycle we did have 38 joint plans. So those are plans where both the local health departments and hospitals work together to provide a singular plan in order to look at the actions they're going to take over that cycle, over that time period. Next slide please. So this is to date. So just to be clear, we're still in the analysis process.

We're still getting things in. And again, remember that break in the timeline is the local health departments did not have to get their plans in until June of 2026. That being said, we have seen a good number of them doing collaborative planning. At this point, we have 28 joint plans. So yes, a decrease from the last cycle, but we do have a good number of them that have taken the time to work ahead with the hospitals to get the due date in by December 2025, which I was very encouraged by. I think Zarah's team really worked to try to encourage that, but again, they did the local health departments through had requested having a little more time for their chip plans, so we also gave them that option.

So this is something that in future meetings we'll be talking a lot more about. Zarah's team is very much looking at how to do the review process, how then to provide review back to the different partners. I know there was a question about that, so we can probably bring that up at the end if Zarah wants to talk, Kate wants to talk a little bit more about what they are developing for the review process. But that will definitely be a topic we give more details on as we get to that point in June of 2026 and beyond where we have all of the plans in statewide and we'll be able to do the in-depth analysis.

Dr. Boufford: Can I just, again, I want to add one editorial comment. This is some history, but I think it's important for the committee to be aware of this. The idea of joint planning is a totally voluntary process. There is no one mandate, and that has been a discussion actually at each iteration of the phasing of the prevention agenda because New York, many states do require joint planning. Some states even carve out certain amounts of money, they have to be invested in local public health. New York does nothing other than the submission hospitals aligned with the federal law and local health departments encouraging them to work together. So I think this is going to be a really important, again, that discussion was held through our review in department, in the health committee and then the ad hoc committee. And the decision was to continue to make it voluntary.

And I think it's going to have it be voluntary. It's not, make it voluntary, have it be voluntary. So I think one of the issues when we begin to see, and as Mark said, Zara's team is working with local health departments that are preparing their plans. Hopefully they can after the fact in some ways if it's appropriate link up to what the hospitals are doing. But that number is going to be important to look at to see what the implications might be for the

next cycle in a couple of years in terms of submission. So I want to flag that part of it because it's important. Yeah.

Dr. Eisenstein: It would be very interesting after this cycle if we could maybe get a demographic report on where there was that collaboration and not, because when I was back in my health department days, I would think collaboration makes sense and is a great idea. Now as a hospital system, even within my own system of six hospitals, the demographics of the patient population of each is so dramatically different that sometimes it doesn't make sense that two of our own internal hospitals have the exact same plan if we're really going to try and make a difference. So when you add in on Long Island, there's 25-ish hospitals belonging to five or six systems, over 200 municipal governments with their own agendas. I would just be interested to see if there's some kind of geography that makes this work and some kind of demographic that makes this work versus the very diverse large communities where put them all in a room and you're not going to get an agreement. So just kind of on boots on the ground perspective, that has changed of mine as I've done this line of work also editorialized.

Dr. Whalen: I think that's a great idea and I think as we start to get into more implementation phase, one of the things that we've really highlighted with NYSEHO and our local health department partners is we want to hear about those collaborations. We want to make sure that we can bring them here to the committee or to other venues to be able to share and create best practices and ideas. I suspect that there isn't one formula to work. It is are we working on something that you think is important? And it's really about making sure that the local health departments and the hospitals have each other in their sights.

Because what we've found, and we've had many conversations with the hospital associations on this, is that there are some hospitals that are really invested and involved and other hospitals that have come to us and said, we don't need local health departments. We do this, that, and the other thing. And then when you say to them, well, do you know that the local health departments have A, B and C program? The staff at the hospital would say, no, really, we'd love to hear more about that. So it really is about just introducing that importance of communication and opportunity and hopefully we can find some best fits that will enable people to get more excited about potential collaborations going forward.

Ms. Alaali: I'll add to that. So last cycle, we did an analysis to see where it was happening and we found out that most of the... First, there's different forms of collaboration. So in general, like IRS or the Internal Revenue Services, they require collaboration in the process itself. So hospitals normally work with their local health department and the assessment process and implementation process, but not necessarily selecting the same priorities because they serve different communities. This is how they present it. Or we are having some issues also with the hospitals because some of them, they are functioning or operating in their system and the system, they submit their community health assessment and community health improvement plans for multiple counties. So they might be working with multiple counties, different regions and the needs are different. So here for the joint planning, but we mean whether it is really working on the assessment and submitting one improvement plan where they collaborate on the implementation phase itself and they have the similar priorities.

We found that during the 2022 cycle, many of the collaboration happened outside of [inaudible 00:52:56] State and [inaudible 00:52:58] State New York. I mean it is expected here, [inaudible 00:53:02] State New York. Basically they have almost 40% of the hospitals across the state and it is really challenging for them to align priorities with the local health department. It is challenging even to work with the Department of Health in one selective priorities because within the board itself there is different demographics and different needs.

Dr. Boufford: I have two council members here that are levitating, Dr. Torres and then Dr. Watkins.

Dr. Torres: Your comment, Doc, makes me think about the uniqueness of each population you mentioned within your health system. I immediately reacted by asking myself, how are these national data sets applicable to certain population shifts in communities? I mean, is it viable? Are we truly looking at each population uniquely because there are variations and I don't know that there is a national formula that fits into a cookie-cutter type of approach.

Dr. Boufford: Dr. Watkins?

Dr. Watkins: On this slide here, are we still waiting for local health departments to turn in their plans?

Dr. Boufford: They have until June now.

Dr. Watkins: Oh, and same with the hospitals?

Dr. Boufford: No, they had end of December that was.. They're following federal law, which is aligned with what New York requirements are. So theirs were due the end of December. That's why I made the comment about being a little bit off sync. We had tried to get the cycle the same. So a set of local health departments have until June. Some have already submitted and some have submitted jointly.

Dr. Watkins: I see.

Dr. Boufford: And that's what you're seeing there.

Dr. Watkins: Because I know we turn in our CHAS and then we turn in our CHIPS, but it used to be CHA/CHIP together. This plan.

Dr. Boufford: We have to figure out how to get that aligned again next round.

Ms. Farrell: I have a question. Where does community mental health fall into all of this? I'm on the ground and very often work directly with the hospitals, work with the health department and the community mental health people are kind of never there. And that's such an important population of focus that's so impacted by the drivers, by the determinants, and is so inadequately served in our health system. The hospitals, of course, are dealing with these folks in the emergency room and depending on the type of licensure they have. But we've done a tremendous disservice to people in need of supports with respect to community mental health. And I just think somehow that needs to be incorporated here.

Dr. Boufford: Well, it is. I mean, in terms of the objectives that are... We going to see the objectives under the domains, it is there as a mental health or avoiding suicide, some other, so the criteria, but the state Office of Mental Health Agency and OASIS have been closely involved in the previous iterations of the prevention agenda. In fact, one of the goals of the prevention agenda, one of the older ones was mental health and well-being was explicit.

Ms. Farrell: But it doesn't work well on the ground-

Dr. Boufford: And that's why I'm sort of bringing it up. But I think the issue, one of the challenges when we get into this sort of interagency conversation at state level is obviously there's local infrastructure for aging, for mental health and for substance abuse through Federal Pass-through, some of it I'm sure still there. And part of

what the goal was is Liza said earlier is trying to get these state agency entities at the local level that connect to each other. I mean, literally in previous years we've sent out the emails and the telephone numbers through people running the area offices on aging, the local mental health people and the local health departments. And sometimes they work really, really well together and sometimes they've never met each other. And so that's kind of really why we're doing this, is to try to figure out what's the best way to kind of achieve, and each of them are supposed to be bringing non-profits and other entities to the table for their planning. And that's been the challenge-

Ms. Farrell: The infrastructure is so lacking. In the mental health field, the infrastructure is lacking.

Dr. Boufford: It's actually more than local public health if they have regional offices. I mean, when you go into OMH and ask them, they do have local infrastructure.

Dr. Soffel: But picking up on Lindsay's comment, I think that-

Dr. Boufford: Dr. Soffel is talking here.

Dr. Soffel: ... OMH and OASIS have their own community planning processes and timelines and frameworks, and then they are not aligned with either the federal or the state planning cycle requirements. And it seems like that would be an obvious place to begin to bring people around the table and say, okay, why do we have an OMH community health plan, mental health planning process that doesn't happen alongside the community health planning process.

Ms. Farrell: And a population health approach in mental health that really doesn't exist. And ultimately it's the people that we serve that are not being served adequately.

Dr. Boufford: I agree. I mean, that's what this process is supposed to improve that. Mr. Perry. And then, we'll... Maybe Eliza has, or Dr. Wheeling wants to add a comment.

Mr. Perry: Just to add, and this came up in a prior meeting as well, that people with intellectual and developmental disabilities are grossly misrepresented in terms of the ability to access quality healthcare. And while we're grouped largely into the overall data in relation to disparities, there's no carve-out for these folks, especially those who are duly diagnosed with intellectual and developmental disabilities and mental health concerns. Those people are largely

we're finding falling through the cracks, not receiving the supports and services and not being charted anywhere. They're simply not showing up and the numbers continue to grow. As a result, they're not getting the level of support and services needed to thrive in their local communities. And that's a real big challenge as well.

Dr. Soffel: Am I correct that OPW also has its own community planning process and timeline?

Mr. Perry: But it does not connect in terms of the outcomes as it relates to healthcare,

Dr. Soffel: Right.

Mr. Perry: It does not.

Dr. Soffel: It's separate and it's yet again, a separate process.

Mr. Perry: Exactly.

Ms. Farrell: I'm really thinking about it just in terms of efficiency.

Dr. Boufford: I know what you-

Ms. Farrell: Just efficiency.

Dr. Boufford: Exactly.

Ms. Farrell: You've got this mental health department over here, this health department over there. They have their budget people, they have their budget people, they have their administrators and nobody talks to one another.

Mr. Perry: But the integration is the key word here. The integration is lacking and the ability to marry the multiple systems to better outcomes for people who we know are falling through the cracks.

Dr. Boufford: Yeah, no disagreement. And I think the other thing, just to be clear for the... Because this comes up a lot and it's an important point that you made while now, one of the domains, which was not in the previous version, is access to healthcare. So we have to attend to the issues you're talking about. Not necessarily once people get into the clinical system, but the access question is on the table.

PART 2 OF 4 ENDS [01:00:04]

Dr. Boufford: ... once people get into the clinical system, but the access question is on the table, and it had not been before because we were really trying to stay, as they say, slightly outside the examination room. The previous ones, but not now.

Mr. Perry: But without identifying these subgroups, they get caught up within the larger system in terms of groups that are underserved and we don't really get to the specifics as it relates to their needs. And that becomes a real challenge.

Dr. Boufford: Yeah, I think that's a big important issue. Dr. Ortiz.

Dr. Ortiz: I'm going to shift away from this for a minute. In the findings, I find it very curious that there's a negateful paradox in the findings. So you'll say we're ending AIDS, however, there's a crisis in SCIs where we have made progress in declining teen pregnancy and increasing breastfeeding, however. So I'm hoping that there is a part of the findings where we can sort of lean on the positive aspects of what's occurring in the state and then deal with how that could help us support the challenges. Because right now, as you read some of the clauses, the beginning is negated by the end of the clause.

Dr. Boufford: Part of the issue of the dashboard is being able to report, it is sort of like with healthy people where you're doing well, whether you're what hasn't changed, where you're not supporting. And I mean unfortunately the COVID, the focus of every all hands on deck for COVID for two years. And I don't like to use COVID as an excuse for everything, but it was incredibly disruptive to this process. And I think especially the historical links between OMH, OASIS, Aging, and the health department in terms of some of the alignment was really lost in some ways. And the good news is the other agencies developed their own strategic plans, including prevention, which they'd never had before. But the bad news is they weren't necessarily doing it together. So I think that's something we want to keep our eye on for sure.

Ms. Alaali: Based on some of the observations we noticed on the community health assessment lately, many of the systems they submit actually on behalf of their mental health hospitals, article 30. Those are not regulated by New York State Department of Health, but they're still collaborating at some level to assess the capacity of those hospitals and what kind of services they provide. So they are included in the assessment. They're included in the implementation of plan. However, at the state level really, or DOH level, we don't track those activities.

Dr. Boufford: Yeah, but that's one of the issues I think we have to talk about. We're going to talk about the interagency piece in a minute and get to that. Because that really has to do with the leverage and how are they getting to the table at the state level and is that playing out in locally, as you say, Lindsay, is the infrastructure, are the folks talking to each other?

Ms. Alaali: Right.

Dr. Boufford: It's a big challenge of this process. Liza.

Dr. Whalen: I just had a couple of comments because I think these are all such great pieces of feedback, and I think if we start with mental health and health together and the interplay, I think historically it's always been a bit of a challenge and there have been silos there. One thing that I think has significantly changed that is the opioid epidemic where mental health and health oasis came together and said, "We all have to focus on this." So I think that that paradigm is shifting and I think as those collaborations became organic, people started to say, "Why weren't we always working together? This makes so much more sense." So I think that now we're starting to see evidence of how those strategies could pay off. Even looking at things like maternal health disparities, we know that if you talk about a pregnancy-related death, a significant portion of women that die in the first year postpartum, it's due to either substance use or a mental health problem. We have to work together on this if we are going to change that metric.

And as we look more and more at strategies related to the prevention agenda, we really see unique opportunity for collective impact. I personally think of the prevention agenda as not a health plan, but as a real all-encompassing plan for how we can come together with the state agencies and the services and the local agencies that we have, including hospitals, community-based organizations and others to do more with less, to make sure that we're all aligning the strategies that we do. That is the ultimate goal of the prevention agenda and the work that Mark is going to be talking more about with our interagency task force is going to hopefully enable that. Originally we had OMH and OASIS at the table in the planning process, and some of the partners that came to the meetings were like, "Why are you guys trying to do this? We do this." And we said, "We're not trying to get on your turf, but we're trying to see how we can work together." And once that conversation shifted, we really started to feel more of a partnership and that there was opportunity for synergy.

Dr. Boufford: We need to kind of keep moving.

Ms. Farrell: I know. Can I just say one thing? There's something so fundamental about public health capabilities. You have scarce precious resources and you have to address a lot of problems and serve a lot of people, and that introduces certain capabilities just like accreditation does in a local health department. In my experience, that's missing in other agencies. That collective, we have to figure out how to get something done using scarce precious resources. How do we prioritize? That's I find what's missing in some of the other systems.

Dr. Boufford: We need to keep an eye on that going forward and see if we can make a difference. So why don't you move through rather quickly more to the agency work, and then I want to make sure there's enough time for committee benefit.

Mr. Waldenmaier: Okay, next slide. So I think all of what we talked about really is informing what we've already done with some of our resources. A big piece that we'll talk about more is this local health department health equity contract because one of the activities we're going to try to do to see where the local health departments and hospitals have those partnerships and then share the practices and how they built those partnerships. So that's a project that we're going to be talking more about in the next couple of meetings, and we'll be enacted in the summer and fall of 2026. Next slide. Let's move on to the state level. Next slide. So implementation, we've talked about, and we've shown this slide before. Bella is going to talk more about the community benefit aspect, but the focus for this next few slides is that final next block of interagency collaboration, which we just had a discussion about. Next slide.

Next, we do really look at partnerships. I know that's what the conversation was about. And I think that fits perfectly with this slide. And again, can't read it on the screen, but look at the links if you have a chance that's on these slides because actually, those links are leading to our DOH website and lists and lists of partners that we are trying to do the connections for. And again, that activity in the summer or fall of 2026, we're trying to go from identifying partners to connecting partners. That's really what we're looking at. The next ad hoc committee meeting is going to be focused on that as well with the different ad hoc committee members and trying to identify how can we connect it together? How can we have the synergy across different agencies across different goals, but still have the strategy together so that the impact of the community and individual level is able to be felt. Next slide.

Dr. Soffel: I'm sorry. Can ask what is meant by state regional collaborators?

Mr. Waldenmaier: So, the state and regional collaborators are really the focus of the ad hoc committee members. These are the statewide or regional organizations that cross over. So Haney's and I say SHO, those are some of our statewide collaborators, they're non-state agencies basically.

Dr. Soffel: And then CBOs would be their members.

Dr. Boufford: Yes.

Mr. Waldenmaier: Yes.

Dr. Boufford: Those are the lists we're refreshing. The difference is we have looked primarily for statewide, for exactly the local infrastructure that you're talking about with the idea that they could reach out to their members, get them involved locally, et cetera. Regional in some instances are also valuable, but the statewide partners, as Mark says, non-governmental partners, is really what the ad hoc committee is about primarily.

Mr. Waldenmaier: So, one of the things that I said was the goal of the shot was how do we reach more general audiences? And again, to me, that's how to build up people's awareness of the prevention agenda. So that if individuals in general public are talking about the prevention agenda to their CBOs, to their other people that they work with, that again, everything starts coming together from grassroots up from state agencies down. Next slide. So two of the activities that we're working towards is being able to eventually post on our website a more one-on-one modular training. Again, targeted more for the general public or partners that aren't as familiar with public health activities, to be able to at least give them a baseline understanding of what the prevention agenda is, why we're doing it, why we're working together as state agencies and statewide organizations and at the community level to try to improve things, to do that prevention strategy.

The other aspect of that is then a more static fact sheet. And the reason we really want to focus on the fact sheet as well as many of you are probably aware of, DOH does have a governor's executive order to look at different languages because we have such a diverse population in New York state. So that fact sheet can be that gateway of a public member or even a partner member who may not speak English as their primary language and they can at least learn the baseline and then be connected to language line services

or whatever to learn more. Next slide. So this slide, again, some links in order to kind of share with you some of the resources. But again, the general idea is all of these processes we're trying to build together is all based on that conversation we just had is we're trying to build that infrastructure to connect the partnerships.

It's still going to rely on those primary implementers, the local health departments and the hospitals to actually connect with their partners. But we're trying to build as much infrastructure as possible that they can know who those partners are, reach out to those partners. So all of our processes, our goals are then to either put it on our website that the LHDs and hospitals can look at or connect with them directly through activities like the contract that we're going to put out for the summer and fall. Next slide, please Go ahead. Next slide. So one of the activities that did occur at the very end of 2025 was we had mentioned before we had a partnership with the Office of Health Equity. They had developed a multi-agency interagency task force where they were willing to work with us on prevention agenda topics as well.

But based on their own analysis for their task force looking and working with other state agencies, it was discovered that there was an already existing New York state level task force kind of focused on the same goals, which is the New York State Workforce Diversity and Inclusion Advisory Counselor Committee. So based on that, our internal committee decided that they were going to shift over to that workforce because again, to that council and committee in order to keep establishing DOH's goals as well. So at that point, they have dissolved that task force. So this is not the form we're going to be able to use moving forward. So we are looking at other ways in 2026 to still establish that interagency connection with the different state agencies to keep on having those conversations, like we just said, with OMH Oasis, many other state agencies. Next slide. In order to progress the prevention agenda moving forward, the focus for 2026 will be looking at the ad hoc committee.

So the ad hoc committee will be a mix of those statewide nonprofits and as well as including additional ones. Those as Dr. Boufford said, we're refreshing the list. Some of the invites we were getting bounce backs from were re-inviting through their executives as well as we looked through a number of other important groups such as the New York Association of County Officials and are trying to bring those to the table in order to keep working with us on prevention agenda, as well as we're going to be including some more of the key state agencies that Dr. Grofer, Dr. Whalen and Zahrave identified in order to have both of the groups be able to discuss

together. That's the plan right now for 2026 moving forward, we may break those groups up again, but just based on our activity level and just getting this started at the beginning of the cycle, we're going to group them in the ad hoc committee.

Dr. Boufford: Yeah, let me just comment. We'd appreciate, again, you've got on the right-hand side a sort of tentative list of agency partners. Now this is the original, I would say my assessment of the internal group that had sort of sunset was it was very focused more on individual subpopulations and services to those populations. Whereas what we've historically been interested in for the prevention agenda are agencies like ag and markets like environment, others that have broader impact on community conditions. And so the right-hand side is a little bit of a mix, and I think as Mark said, it's a bit of an experiment. We don't want the state agencies to outnumber the non-state agencies on the ad hoc committee. And so we had had a kind of core group of state agencies, but I think the effort because of staff support and others is to see who sticks with this and then go out after the other one's retail if they don't want to participate.

But certainly OMH, Oasis, Disabilities Ag and Markets, Department of State has been super helpful historically with funding and providing small grant support for this work. Aging is really laced through everything. I know you probably didn't have a chance to take a look at this overnight as you were coming in this morning, but other agencies that you make work with that you think would be important to include in this refreshing of the ad hoc agenda that aren't on this list or agencies that you think would not make sense. But again, we're looking at the conditions in communities, agencies, the ones that have that transportation, housing, capital investment, economic development, education, that sort of stuff, more than the individual service types.

But this is our best effort at this point. But one of the things we wanted to do with you today is to get your feedback on those agency lists.

Ms. Farrell: I don't see justice.

Dr. Boufford: And then we'll have a list. I'm sorry, just the one other thing. Going back to Denise's point, I think what we'll try to do is also circulate a final, we're working on a final draft of the ad hoc, the-state agencies that would be part of an ad hoc re-invitation, circulate that for other comments. Some of you gave comments and ideas at the last meeting, I've tried to incorporate those in the working list. But this is kind of getting these basic lists together. Sorry, Lindsay, go ahead.

Ms. Farrell: I said Department of justice. I don't see them listed.

Dr. Boufford: Okay. And that would be, they do a lot of community work, a lot of prevention work for violence. And I think the issue is part of what we're looking at is within the domains and within the objectives, but I think that's fine. I'm not going to say no to anybody at this point. We have to make them see why they should be there as opposed to just thinking that they should be there. We have to look at the other sheet. Yeah, go ahead, Andy. Sorry.

Dr. Torres: So the Department of Justice has recently been making presentations in certain neighborhoods. They were just at Lincoln Hospital and we were talking about the violence, the mental health piece and empowerment. So I thought that that would be a great recommendation.

Dr. Boufford: Okay, good. Yep. Larry.

Dr. Eisenstein: Are we still introducing ourselves? Dr. Boufford, are we good?

Dr. Boufford: Okay. No, I think we're [inaudible 01:16:25]. If we haven't figured it out by now. We're not going to.

Dr. Eisenstein: Yeah. Well, I've been on both sides of this. And one thing I think there is common ground, which is it's utterly ridiculous, but it's a fact that 2% of the entire healthcare budget is on the preventive side and 98% is on the other side. So we're talking about the 2% and how to use it appropriately to bend the disease curve. I think that's where the commonality is. I think everybody wants to bend the disease curve all the way down to the boots on the ground providers. Our hospital system would love to not see the same congestive heart failure patient five times every whatever. We now get penalized for readmission. What's that?

Ms. Farrell: I don't believe that.

Dr. Eisenstein: Well, we get financially it's not worth it. We lose money from readmissions now. It's actually true. The payment models have changed to where the concept is not to fill hospital beds, it's to be there with hospital beds when people really need it. But there are many penalty diagnoses where it doesn't make sense for readmissions. How do you prevent a readmission? You make sure the infrastructure is in place. So they have transportation to their medical appointments, they can afford their medications, they can afford their food. One of the things that I think we have to make sure we do, and the reason I'm bringing this up now is we have to

find a way in this process that the very large agencies on the right are not out of touch with what's happening with the boots on the ground on the left side.

And I've been on both sides, and I still feel, when I went to the hospital system, one of my objectives is to break down that imaginary but very real wall between the preventive side and the treatment side and all the assumptions that come with, "Well, they just want this. And the other side just wants that." I think we all want our patients to be well, I mean everybody wants, that's why we're in this business. But I look at that on the right, and I think all those departments are great and necessary and leaders, but if we don't connect them down to what's ... sometimes they're out of touch if we don't connect them down to what the actual difficulties are.

And to Dr. Torres point beyond global for the state, not even zip code data is good enough. We use social vulnerability index to the point you brought up earlier, Dr. Torres, on how do you assess a community, that's after our assessment of the best way to try and help the most people. Even that doesn't do it because of the variation within one block, you could have variation of needs. So the point I'm just making is it's one thing to have that great list of who can help, and I don't disagree with that, but if that list of people isn't able to connect and understand what's actually happening on the ground, we're not getting anywhere. And I've seen that for too many years. So I just want to put that in.

Dr. Boufford: Yeah, again, I want to make the distinction between the waiting list for people to get Meals on Wheels and the availability of fresh fruits and vegetables in the community. But I mean, I think your point is exactly well taken. And part of what we learned, and I think we don't know the answer to your question with some of these other agencies, they haven't been involved up to now, is some of the ones that have been our stalwarts do have local infrastructure, and they're very keen to engage. I remember one of the issues that we were asking them to map, I mean when Ag markets came in and what was supposedly a food desert as a problem in a county, and they had eight or nine different setups there that nobody knew about and they hadn't communicated.

So I think that that's kind of a success story. And your point is well taken is figuring out, part of the conversation about recruitment is what infrastructure do you have at local level? Because a lot of things don't happen at the state. Like if you said what infrastructure of the city, I could tell you, or maybe, but the state doesn't have that

much on local zoning issues if you want to set up a bike lane or whatever. I mean, that's the kind of-

Dr. Eisenstein: I guess my point is when I was a commissioner of health, I had all these assumptions about the hospital system. Now that I'm on the other side, I look at my old self and say, "You didn't get it. You didn't understand." And I think I can do that in both directions. And that's what I'm trying to say. We need to understand at a deeper level.

Dr. Boufford: Yeah, the hospitals can't do these things. That's why these other agencies have to be brought in.

Dr. Eisenstein: But we are the most common touch point of the patient, and that's where the opportunity lies.

Dr. Boufford: Maybe. That's an interesting conversation we can have over a longer ... I think it's a both end, I think that's the challenge. That's the challenge of the prevention agenda, especially now with the inclusion of the access to care domain. So I think, let me segue over to community benefit because I think we're ... Sorry, Kevin.

Dr. Watkins: I thought maybe I could come up with one or two other agencies.

Dr. Boufford: Oh, please, other agencies. Yeah, please.

Dr. Watkins: How about the Department of Housing and Community Renewal?

Dr. Boufford: Okay.

Dr. Watkins: They tend to have housing stability.

Dr. Boufford: Okay. I wasn't sure what the state one was there. We were sort of struggling.

Dr. Watkins: I think New York state-

Dr. Boufford: Is there another one?

Dr. Watkins: ... division of housing. And then how about DEC, I mean, we haven't mentioned DEC, but we talked about climate-

Dr. Boufford: EC?

Dr. Watkins: DEC department.

Dr. Boufford: Oh, DEC. Yeah. Yeah.

Dr. Watkins: For climate.

Dr. Boufford: Environmental. Yeah, I think that should be there. Yeah.

Dr. Watkins: For climate control. All right, that's it.

Dr. Boufford: Great. Great suggestions. That's exactly what we need. Any others, while you're looking at this while we're finishing up the presentations and sending back and again, the ad hoc members as well to bring those up and get you to comment on them. So let me mainly move over. Thank you, Mark, very much. This is really very fruitful and thanks others for continuing to provide input. Bella is going to talk to us, she has some slides. I think one of them is the, maybe you might want to start with that one to remind everybody about the one slide that has all the objectives and the domains on it in the prevention agenda because the issue of how one addresses the reporting on Schedule H is quite related to that. But it may be easier to have that conversation after you show your last slide instead of the first one. So let me turn it over to you.

Ms. Elogoodin: Yeah, I don't really have a lot of slides, but I do have a few handouts that I'd like to turn your attention to, which is the Schedule H Form 990, part two. And again, wanted to touch on the fact that my name is Bella Elogoodin and I'm very new to this. Very excited to be here and to share where we are in terms of the update of the community benefit spending. My role specifically is aligned with the access to care that you all so eloquently had shared, and that is the patient advocacy that is aligned with the financial aid law that came out as of October 2024 in dealing with hospitals, local partnership, local health departments in identifying and aligning with the hospital billing and financial issues.

As I'm doing that also along with the key stakeholders and Dr. Boufford in initiating the guidance on community benefit spending. And as we all know, New York State DOH is committed to aligning hospital community benefit investment with proven models of preventative care. And on October 1st, 2025, the statute came along where hospitals will be required to report on what they report on the Internal Revenue Service. They will be reporting to us as well. And we're looking into obviously your feedback, your ideas, and your guidance on how we can put the guidance together. Specifically as we're putting this letter together, there are few data points that I'd like to make. Number one-

Dr. Boufford: Let me interrupt you just to say we don't have her slides for the screen. So you have her slides in your packet, so you want to be sure to be explicit and show them which ones you need.

Ms. Elogoodin: And so, number one, hospitals will submit spending costs, which aligns with the internal revenue service. Number two, hospital's annual update on the implementation of the community service plan must include an actual spending report. And number three data point is that we need to make determination of information request between the prevention agenda plans and community benefit categories. As we've had a few conversations with Dr. Boufford, and other stakeholders, we're thinking specifically looking at Form 990, which is in your packet, part two, and looking specifically into four specific categories. Number one, physical improvement and housing. Number two, economic development. Number four, environmental improvements and number eight, workforce development.

And provide details on how these categories are aligned in supporting prevention agenda. After they complete that part of the form, they, meaning the hospitals, they would be asked to provide more specifics on two of this. And if they don't fill it out on staff costs for any of those four, we may be contacting them and asking them on what they can provide in terms of details on what are they doing, how are they aligning on these specific categories. Which raises a question to all of you on what does the committee think in terms of what specific categories you believe will provide more context to help us in guiding the hospitals. We can wait until the very end because I have a few more questions besides that.

Dr. Boufford: Let's refer to this because this would be what we're trying to align with in terms of the prevention agenda. The effort has always been evidence-based interventions. We know hospitals are doing a lot of things in some of these areas, but some of them, I mean we've talked to some of them and I really don't want to imply that they aren't. I think probably what we want to do is we want to understand whether they're in fact evidence-based or valuable. I mean, a screening program twice a year with no follow-up is not as helpful as a screening program with follow-up or a farmer's market twice a year or a teen pregnancy educational session once a year.

Those are all legitimate things to be doing. But part of what we had wanted to do was to see whether investments in this category, and there are financial investments being made by hospitals, would be on more evidence-based kind of interventions that align with the agenda. So this is your objectives here and your domains are the

basis for trying to figure out how might you ask hospitals to further explain what they're doing in this sort of community-building, community health improvement area. This is, again, I say this all the time, but it seems to not ... we are not interested in their disproportionate share. We are not interested in their GME, we are not interested in their research.

We're just interested in this tiny little category on the Schedule H, which is zero. The last data point we had from a colleague who just finished his doctoral thesis, luckily out of Albany on this, we presented it in the ad hoc. Isaac Michaels, I think presented his report in an earlier ad hoc meeting. We want to get him back. 0.8% of aggregate community benefit paid by hospitals in New York is in this category, 0.8. It's still a couple hundred million dollars a year. And for public health that's not peanuts. So that's kind of where we're going with this. Just to clarify, because I don't think we've had an in-depth conversation with some of the new members of the committee, so sorry for interrupting.

Ms. Elogoodin: No, no, absolutely. Thank you.

Dr. Eisenstein: Could you repeat those four? You went through them very quickly. I couldn't keep up. I think all of us were trying to write that. You said number two, number four.

Ms. Bella Elogoodin: So when you look specifically on Schedule H, Form 990, part two, which should be in your packet as well.

Dr. Eisenstein: Yes, we have it.

Ms. Elogoodin: Yes. So it's number one.

Dr. Eisenstein: Number one.

Ms. Elogoodin: Number two, number four and eight.

Dr. Boufford: They seem to be aligned with the domains. And then obviously within the domains there are these objectives that have been placed there. But again, we want to hear what your thoughts are.

Ms. Farrell: Yes. So my concern-

Dr. Boufford: Ms. Farrell back.

Dr. Eisenstein: Yes, I'm Lindsay Farrell, member of the council. My concern is that they're going to go out and duplicate activities that are already being delivered by community-based organization.

Dr. Boufford: No, this is, what are they doing? This is what-

Ms. Farrell: Well, I know. I'm just telling you how it works in my neck of the woods and very often I'm like, "Why are they doing that? We are better positioned to do that." And so ideally you would like some sort of collaboration with existing community-based organizations. Give me the money. I'll do it. I have more reach. I have more capabilities. Right now, again, it's going to depend on the particular hospital, but the last thing that we want is competing with a hospital in a community-based activity where you have expertise in the community.

Dr. Boufford: This is a larger existential reality in the state of New York.

Ms. Farrell: Like housing.

Dr. Boufford: But anyway, I think you raise an interesting question if you were to ask them to describe what they're doing and which partners are you working with?

Ms. Farrell: Yes. So I don't know how you qualify any of this. I don't know what instructions they're getting on what counts.

Dr. Boufford: This is what we're asking you. We're at the 10,000-foot level now, we're trying to get the categories and then the issue is ... Mark has made some suggestions about drop-down menus and other things, but one question might be name the partners that you're working with on this area.

Ms. Farrell: Correct. I mean, you'd rather have investments in existing partners than a hospital going in and duplicating. It's not their area of expertise.

Dr. Boufford: That's for the waiver. That's a really important issue on the SCNs. I mean, I think we're not going to solve some of these huge problems this way, but the partner issue is an important one. Yeah. Why aren't you working with partners instead ... If you're not working in the area, that would be one conversation too. Sorry, Dr. Lim.

Dr. Lim: Hi, Sabina Lim, committee and council member. So can I take a-

PART 3 OF 4 ENDS [01:30:04]

Dr. Boufford: Sorry, Dr. Lim?

Dr. Lim: Hi, Sabina Lim, committee and council member. So can I take a question or questions just to step back for a moment. So what you're asking for, I understand that you were choosing from part two of Schedule H, four of those, right?

Dr. Boufford: Right.

Dr. Lim: You're also asking hospitals to also provide all of part one, line seven.

Ms. Elogoodin: Exactly what they would be providing for Internal Revenue Services-

Dr. Lim: Right, right.

Ms. Elogoodin: But also a little bit more narrative and a little bit more number in terms of what that Part 2990 and how it's aligned with prevention agenda.

Dr. Lim: So part of that, the key is I'm a little bit more focused on part one, which is what people traditionally think-

Dr. Boufford: And see that's not what we are focused on.

Dr. Lim: You're only focusing on part two.

Dr. Boufford: We're really trying to focus on the issue of prevention and conditions in communities, which is a smaller portion because I ... Well, just to be pragmatic, I think generally speaking, because so much of the money in community benefit is in part one. We're assuming there will be a lot of questions and interrogation around that. I mean, everybody should understand Schedule H to IRS is a public document. It is supposed to be posted on the hospital's website every year. So the difference here is that the governor has charged the commissioner to ask for that with slightly different language. I'm going to stay away from the 990 for the moment because I'm not quite sure how it fits into here. But the Schedule H thing, I think for our purposes, again, we are trying to inform the questions and the language that would be used for these sections of that, the small section of the Schedule H. I don't know if that helps, Sabina, because I mean, the GME and the disproportionate shared and all that stuff doesn't relate necessarily to what we're concerned about.

Dr. Lim: But I think what I just wanted to point out was just in part seven, there is one line, 7E, which is community health improvement services.

Dr. Boufford: Yes, there is.

Dr. Lim: And I think that is important to include because important-

Dr. Boufford: Very important.

Dr. Lim: ... because people may put more in that and to a certain degree, subsidized health services. Right? So I understand Medicaid on ... I can understand where you're not going to necessarily explain all of that, but I think perhaps 7E and I think in certain instances, 7G may be applicable. Yeah.

Dr. Boufford: Thank you. That's important. Yeah, I think we had talked about the community health improvement. There's been a change in the categories, which is a little weird. There used to be a category for community health improvement and another one for community benefit. Now they're merged, and they've changed the language. But those are two important points. Yeah, yeah. Let's see here. Dr. Eisenstein, and then ...

Mr. Perry: My question relates not so much to the categories, but who defines community? Does the hospital define that or ...

Dr. Boufford: Well, it's for IRS purposes. The guidance is in the IRS documentation.

Mr. Perry: And so do we know what that definition of community is?

Dr. Boufford: We're imagining as a community they are serving their service area.

Ms. Farrell: The catchment area.

Dr. Boufford: Good question. We could find out. We could find out.

Ms. Farrell: Definitely.

Mr. Perry: Yeah, because there are disparate groups within that community-

Dr. Boufford: Of course.

Mr. Perry: ... and you would want to ensure that those people who traditionally are unserved or underserved are indeed included in these opportunities versus those who are always at the front of the line.

Dr. Boufford: Yeah. Again, we're not, just to clarify, we're trying to figure out what they're doing now. Your question is very relevant, but this is a reporting on what you did the last year. So part of it is nobody's ever asked them to go into detail in this category before, which is what we're trying to do. So Dr. Eisenstein.

Dr. Eisenstein: One of the comments you made before, Dr. Boufford, I 100% agree with, which is whatever is being done in the community should be evidence-based. And randomly taking somebody's blood pressure, the literature is very clear. Unless it's emergently high and you're saving them from an immediate MI, is very little value of it. So just using myself and as an example, having been on both sides of this, I've basically changed what we do with screening to where the goal, I don't even care if we check their blood pressure if I can get them attached to ongoing care. But we also have to check boxes, and sometimes the boxes come from the state. Or other. How many screenings did you do? Nobody ever asks the follow-up, does it matter? What's the results? What's the outcome? How many ... We did 10,000 screenings. Yay, everybody cheer. No, the answer is what we should be doing, we should be doing with evidence-based impact. And I'd rather do fewer screenings and get people legitimately helped than check off a large number.

So please don't make this a check the box thing because too much of that has happened. But I genuinely think there are things that all of us, I'm speaking for hospitals now, but I think everybody. There are things we can and there are things we can't control. And I'm a little concerned on this list that we start to go down the realm of things that we can't control. So I absolutely can control nutrition of our patients. We can make sure that if they don't have food at home, we can bring them food. We can get them services. But if anybody here can solve the housing crisis on Long Island, there's a big reward and award waiting for you. And people smarter than me have failed at trying to resolve this. So making it something that you have to do, it just sets up the whole community for disaster.

So I think that, and we're not going to solve all this in the next 10 minutes, but please make whatever it is that we do doable. And I do agree with Lindsay's point, that if there are things already being done at an adequate level in a community, if it's already being done at an adequate level, asking more people to do it presents a danger of pulling resources away from the people already doing it

adequately. So I don't think necessarily this is a one size fits all. Again, it's going to go back to specific demographics of community. And the last thing is if you're going to put something like this in, we may all understand the implication. Don't assume that that trickles down to your 200 or so hospitals and the hundreds of thousands of employees and administrators who are going to lead this. There has to be education that accompanies this.

Dr. Boufford: Yeah, no question about it. I mean, I think one of the issues, I'm going to go back to the evidence-based issue for a moment because I believe the website and the dashboard guidance does provide evidence-based interventions for each of the objectives that's listed here. The health department is providing those. And so that material is there as they say. I think that the issue here is ... I mean, having been through community benefit, not with the state part, but a few years ago with the New York Academy of Medicine asking these questions. I mean one of the things, a couple of things were pretty clear. This is not a question of hospitals not doing things. The question is you have to fill out a form. And the form, which is what you have in front of you, asks you, the staff, they're involved in something. I mean there's guidance for each of ... We didn't make this up. There's guidance for each of these things.

So how many staff and how much money is in that category? And part of the obvious is that many of them are very clear, back to Sabina's point, what's the root to the number for GME? What's the root to the number for disproportionate share? What's the root to the number for the gap in Medicaid? They're really clear about that. This one we don't know, and staff have gone ... I know, when we were doing a report in 2015, literally went to hospitals and interviewed people trying to figure it out. And one of the issues was there are many responses to this, and I won't go into the details, but I think the issue is to try to get people, and part of what we're doing here is saying, "Hey, we're looking at this." And if you put a number and you may, whatever you put in there, you put it in there and you're reporting it to the Internal Revenue Service.

So what are you doing? What are those staff doing, and how much money are you spending on that thing? That's all we want to know at this stage. And then the question is how do we take it ... Then we have to come back and [inaudible 01:38:12] and figure it out. So nobody questions that there isn't anybody scrutinizing GME and Medicaid gap and all those things. But we've never looked at this and many hospital CEOs basically said, or people that we're doing the filling the form out as you said, Larry said, "I don't know." Or, "That's not real money." And my response, having had these

conversations with hospital leadership over the last decade or so, well, but you put a number in there. So you ought to be able to tell us as you would with at least the same level of rigor of putting a number into Medicaid and the number into GME, what are you doing? That's what we're trying to get at in asking you to help us think about that For this. Yeah, go ahead.

Dr. Lim: I think that's very reasonable because there's worksheets. There's detailed calculations, and it's explaining a little bit more detail. And so as part of the guidance, even the IRS instructions, they provide some examples of what you can include.

Dr. Boufford : Yeah, absolutely.

Dr. Lim: I do think that a lot of things will end up falling in 7E under, like vaccinations, mobile mammography, all those kinds of things which we traditionally think of as being done by hospitals would fall in that group. So hospitals should get credit for that. But things like if there's some examples given in the guidance of, what are you looking for in workforce development? Right? And so a lot of hospitals do workforce development types of activities. Physical improvements in housing, not so much for all those things. But if there's any sort of guidance or examples in keeping with-

Dr. Boufford: Using the IRS guidance as a platform.

Dr. Lim: Because it should all flow into what did you report to the IRS, right?

Ms. Elogoodin: Yeah. And we were thinking a fillable form could be similar, aligned with what IRS-

Dr. Lim: Something simple.

Ms. Elogoodin: ... and surely giving an example.

Dr. Lim: Yeah.

Ms. Elogoodin: Small and short to the point.

Dr. Boufford: Yeah. It gets back to some of this geographical location issue. I mean, I can remember Montefiore. Montefiore put a lot of money into housing development in the Bronx because if they didn't, they wouldn't going to have a patient base to come. This is back in the '80s. They were very active in that space in creating housing capacity and other things in that community for good reason, for their own good reasons or underwriting loans or underwriting

mortgages and things like that, which hospitals can do. I mean, local health departments can't do that.

So I mean, part of what if you said, okay, in this part of the Bronx here you've got a hospital that's working in these areas, how could you guys partner? This is a data gathering phase almost. And in some of them is with the potential again of taking a look at this and then figuring out how to do some of the things you've been talking about for the last while, instead of if you don't ask the question, it's like Lindsay was saying, if you don't ask the question, people aren't paying attention to the reality.

Dr. Eisenstein: I think the definitions of everything are going to be really important because even workforce development, so my system, most hospitals have, if you've been employed there and you want to advance your degree, we give you a stipend or we pay for your bachelor's degree if you're a community health worker. Does that count? Is that workforce development or not?

Dr. Boufford: You're hiring local. I mean that's the other ... That is a workforce development thing.

Dr. Boufford: Within the community.

Dr. Boufford: Yeah, within the community. Yeah.

Dr. Eisenstein: Just the definitions of where the people-

Dr. Boufford: Good point.

Dr. Eisenstein: ... come, where the resources come from, where the people that we're talking about come from that's going to ... My point is answering these questions not always as simple as you would just think.

Dr. Boufford: Of course. We understand that.

Dr. Eisenstein: Just why we have accountants to do our taxes for us, because it's not ... If it were that easy to do on our own, we would all just do it on our own.

Dr. Boufford: But this is pretty descriptive. I mean, I think it's not as complicated as some of these hundreds of millions of dollar issues that are largely in the finance line of the universe here. And at least the hope is. I hear what you're saying about not making it complicated.

Dr. Eisenstein: I fully support it if we don't make it so complicated.

Dr. Boufford: And I think Sabina's point about, let's start with the guidance from IRS. The other thing is they may mean this is a category they have to fill out. There may be blanks. They may not be filling anything out there. They may only put one thing in there. We'd like to know what that thing is if it's not one of the ones we're targeting, but we're targeting it to see whether there's stuff or not.

Ms. Elogoodin: The insurance.

Dr. Boufford: Yeah. Sorry for interrupting.

Ms. Elogoodin: I do have two more questions.

Dr. Boufford: Please go towards the mic if you will.

Ms. Elogoodin: So as we're going to start receiving the reports, we're going to compile the report and we wanted to know from this committee, where do you think would be important to upload the reports on DOH website? Is it on the prevention agenda side? Is it somewhere on profile pages within DOH? Where do you think would be more accessible and more visible to the community?

Ms. Farrell: Are you going to aggregate all this or is it going to be It's all going to be aggregated?

Ms. Elogoodin: Yeah, exactly. Yes.

Ms. Farrell: It depends on what you get back. I mean, yeah.

Dr. Boufford: It depends what you get. I mean, I think that's probably a reasonable point.

Ms. Farrell: Yeah, because ...

Dr. Boufford: One of the things that in the doctoral thesis, I mentioned the individual who did that, obviously it's a doctoral thesis. But really it is the amount of money by category, by hospital for the entire state of New York over the last seven or eight years. So we know what the dollar amount is in this general category based on whatever they're using. And Sabina's point is the right one. What's the guidance from IRS there? But we don't know what it is they're spending the money on. And that's what we're trying to get at a little bit in more detail here. So part of it might be geographic, it might be

otherwise, I mean it is an interesting question to think about. I don't know what the answer is. Maybe it's premature.

Ms. Farrell: Maybe. I am thinking of Northwell and all their gun violence. I mean they're very, very focused on reducing incidents of gun violence, and they do these conferences. And I mean I'm like, "Wow." They're obviously very deep pockets. So I'm wondering where would they put that? I don't know. And that'd be interesting to see how that gets reported.

Dr. Boufford: Sabina, go ahead.

Dr. Lim: Where the hospital submit their CHNAs and CSPs, is there a public link to that?

Ms. Elogoodin: [inaudible 01:44:16].

Dr. Lim: Because I mean I think it's in your time, what's in your CHNA and CSP should be reflected in your schedule.

Ms. Elogoodin: We have created an email which is going to be a shared mailbox between me and my specific team where we're going to be asking the hospitals.

Dr. Boufford: Can you go a little closer to the mic? Sorry. Bella, we can't hear [inaudible 01:44:38].

Ms. Elogoodin: So the shared mailbox we've created, we're going to put it in guidance and where they can email along the narrative and the fillable form. But to answer your question regarding where do they submit now, I think Zara can answer that question.

Ms. Alaali: Yeah. So for submission, normally we receive the plans and we store them or archive them in a he commerce system. So the liaison hospitals or anyone who has healthcare commerce system, they can access it, but it is not publicly available on our website.

Dr. Boufford: This hasn't happened before. So I think the couple things from this conversation that are really important, and I think to myself part of the hospital reaction over well to most things here, they do not want to ... They'd rather do things voluntarily then be regulated and made to do it. So I think part of the question is we want to ask these questions for the first time. Okay, somebody's looking at this. We're interested in it. We realize you may or may not be working any of these. That's okay. But part of it is just getting ... paying attention in some ways. I think I remember six or eight years ago, the

commissioner sent out a letter saying, "Send us your Schedule Hs." And everybody had, "Oh, my God." Even though it's a public document, it's supposed to be on their website, but it's that kind ... We're at that stage, and some of your suggestions are really, really helpful, I think, for figuring out what's the baseline you give them and then what else are you asking them to do in what form. So did you have other questions you wanted ask?

Ms. Elogoodin: My last question is as we're going to-

Dr. Boufford: Again closer to the mic. Sorry, we just can't-

Ms. Elogoodin: Of course. [inaudible 01:46:12].

Dr. Boufford: ... your mouth move, but we can't see your mouth.

Ms. Elogoodin: So report to this committee as well as to local health departments and local partner associations. We wanted to know if there are any other areas we should be considering when submitting this report.

Dr. Boufford: Well, Sabina suggested too, that we had chatted about but didn't include in this conversation, I think are useful. And again, some of them hospitals may not be working in some of these areas. So yeah, go ahead. Sanford, you want to just say something? Oh, I'm sorry.

Ms. Farrell: I don't know. I think the county executive would find it very interesting, for example.

Dr. Boufford: Well, if you give certain information to people who are in a position to pull people together and do things, I mean, it's an interesting question. I mean, some states actually having been because of having grad students around who do deep dives into things. I mean, some states actually when they're dealing with community benefit, they're very detailed. And in some instances, I know there are two states, I think it's Maryland and Massachusetts where the Attorney General examines the Schedule 8 submissions because I mean it's that much of an issue. And New York doesn't really ... they don't really, I don't know maybe if anybody's ever been called out, but this is starting to look and report and see what the next steps would be. That's what this is about here.

Dr. Eisenstein: And my view on that is a little opposite in the sense that I think what we make should last beyond the current elected official.

Dr. Boufford: Totally.

Dr. Eisenstein: And so while making, I have great respect and think the county executives of each county should know what's going on in their counties and should make it aware. I was there for four transitions, and I was able to survive that because the health department remained the steady force. And I think one of the great challenges speak to NICEHR, I think 75% of all the commissioners and directors of health in New York have overturned in the last five years. Think about that. How are you supposed to have stability in public health when three-quarters of your public health leaders in the state have overturned in the last five years, myself included? But some of that has to do with regulation of law. Usually it doesn't have to do with who the leader is, just the way timing. But that's just one example of how we're trying to create ... we should be trying to create a stable process in something that's inherently unstable.

My advice is if you could build this to last, that there are things ... People are always going to need to eat. People are always going to need shelter. People are always going to need to be able to get to jobs to pay their bills. They're always going to need electricity. If we can build this in a way that creates a structure that's free of whatever the current winds are, whichever way they're going, that's the best possible outcome for public health, in my opinion. So I don't know if that helps. I don't even know if I answered your question, but ...

Ms. Elogoodin: But this is an important comment.

Dr. Eisenstein: We're also, if you're going to talk to health commissioners and their partnership, CEOs at hospitals change, and that changes what happens, and so I mean, there's ... On Long Island, the county hospital in Nassau had I think eight CEOs in my 12, 11 and a half years as commissioner. How am I supposed to develop any kind of programs? So please build something that's infrastructure that can withstand all of that is my plea. Good luck, by the way.

Dr. Boufford: Your point is well taken. And I think on a serious note, I mean, part of, as Mark said, this is the fourth iteration of the prevention agenda. So part of the issue has been trying to create on a totally voluntary basis up to now a set of collaborations that would build some of that infrastructure. I mean, it start to some county leaders. I mean, I remember examples from Ellis Hospital, it's connected. I mean, people are doing really cool things, and in others they haven't taken it up. So all we can do is try to do that. And again, we've been through three governors since I've been sitting here, and the issue is the guidance and can we use it in a bigger way.

I think it's a big challenge on these domains and the interagency stuff across the state. I think it's a big deal, and it's starting to say, okay, election year, governor, this governor next governor. We had a vehicle for health in all policies across agencies that still exists on the books, but it was interrupted during COVID and hasn't been reconvened. So I mean, your point is well taken, and we want the enough of a footprint down so that people can find it in the sand, not in the sand on the beach in the regular soil. So really, really important, Larry.

Ms. Farrell: I'm just thinking in Westchester, certainly, I mean they're important advocates, but there's also business groups. And we have business groups that focus on healthcare resources in our county, for example. And so that would be a perfect group. And we look at it from the standpoint of jobs and economic viability in our county, for example. So I'm sure there are other examples in other parts of the state, but they're not the traditional folks that you would normally be thinking of in public health.

Dr. Boufford: Well, this is part of the ad hoc committee too. I mean, I think the New York State Business Council, we had them on for a bit of time, they went off. But I mean you're exactly right. And that they of course relate to businesses at local level. And part of one of the reporting requirements, which I'm saying this to Zara now because I don't know what's in it at this point. Once the plans are underway, is we used to always ask the local health departments to report, "Who's at the table when you have your meetings? What organizations have you brought into your conversations?" So that we could tell that. And it was people were saying, "Well, why would we want to report that?" Because for exactly the reasons you say. And I think, so that's got to be one of the metrics is, who's at the table if we're trying to get this local mobilization going? Then you could go back to an agency, "Why don't you send your mental health people or your aging people over here?"

Dr. Soffel: I would like to remind my colleagues at the health department something that I have said before, but I will say it again, which is it would be helpful to talk to the folks who ran the DSRIP program because they have a lot of knowledge about what projects work and what did not. Some of those projects went really well. Some of them were a fiasco, and they can talk to you with real on-the-ground knowledge about how you get hospitals and communities and local departments to work successfully together and what are some of the elements that contribute to those successes. And here are the ones that totally blew up, and here's why we think they totally blew up. But there is already in-house knowledge about

some of this, and I hate to see that knowledge not being shared because I think a lot of it is directly relevant.

Dr. Boufford: That was, I think one of the older lists on the ad hoc committee was the district health. It isn't there in that way anymore. So Mark's engaging some of the regional representatives of the department, and I think that's a really good point, is to reach out and try to find those folks that went through that and ask those questions are really important.

Dr. Torres: Lindsay, your comments actually point out economic development number two in part two. I don't have my glasses on. And the workforce development pieces, which are critical, which we had discussed as well.

Dr. Boufford: Thank you. Okay. We're way over time here. I don't think we have any members of the public who could be ... We have one member, but I don't know if she is a member of the public. Anybody want to make a comment from the public? Just to make sure we ask that question says is a committee meeting. It's open. Work in progress. We'll have more the next time. So anyway, thank you very much. As I said, these are big issues, big questions. Some of them are a little bit context-free.

We'll get back to you with I think the IRS guidance for the areas that we're interested in. It's really, really important relative to the questions that would be asked in addition to that. And Mark's been thinking about the drop-down thing, which makes it easier for people to answer. And then similarly, the members of the ad hoc committee will get those lists out, ask you to give us feedback and again, feedback on the agencies. DOJ is a good one.

The ones that Kevin mentioned, also Housing and economic are important ones. Okay. So we have our work cut out for us. Our next meeting is in May, and we'll turn this stuff around pretty quickly, I think. And the ad hoc committee we hope will be the last week of March where we wanted a little extra time to get the invitations out and make sure people have a chance to sign on.

Ms. Farrell: Is that one online? Is that one online, the ad hoc or is that-

Dr. Boufford: No, no. it'll be here-

Ms. Farrell: It's in-person?

Dr. Boufford: ... in Albany. We're like abandoning, I think ... I mean we may not abandon online for the committee itself, but for the ad hoc, we want to get everybody in the room, because we want them to network with each other. And then Mark had a really great idea, which is we'll develop. It'll be a set of action learning session for about three hours-

Dr. Soffel: And you will-

Dr. Boufford: ... and we'll have the staff from the department in and focusing on the domains and people in the ad hoc committee meeting with them and moving around a bit.

Dr. Soffel: And you will share the current list of ad hoc committee members with us so that we can take a look at it.

Dr. Boufford: We'll share the list of the proposed new members because the older ones we've collaborated, we've developed, we've found five or six old lists. There was an effort, I think that was ... Shea made an effort to revitalize, but it wasn't as complete as we'd like it to be. So Mark is working on that.

Dr. Soffel: Okay. Because when I looked at the last list, there were a lot of people who were either no longer in those jobs or-

Dr. Boufford: No, no, exactly. That's what we're fixing.

Dr. Soffel: So I would really like to take a look at that.

Dr. Boufford: That's what we're fixing. That's why it takes so long.

Dr. Soffel: No, I know. I know. Keeping mailing lists is hard.

Dr. Boufford: Yeah. Oh, great. Anybody, anything at this end of the table who's in my blind side? Okay, great. All right. I am not here tomorrow. Andy will be here reporting on our deliberations. You all are invited to comment. I have to teach at 5:00 so I can't come up to all of you. Whatever. Anyway, thank you. This is great. Really, really important stuff, and we'll be sure to stay in touch. I know you all will be responsive when we send out emails asking you for comment and stuff, so thanks a lot.

Ms. Elogoodin: Thank you.

Thank you.

Dr. Boufford: Yeah. Thank to the staff for all the work that went into this. Really. I really appreciate it. [inaudible 01:56:37].

PART 4 OF 4 ENDS [01:57:24]