

**NEW YORK STATE DEPARTMENT OF HEALTH**  
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**  
**PUBLIC HEALTH COMMITTEE MEETING**  
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**ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY**  
**TRANSCRIPT**

Dr. Boufford:

Information that we go through for webcasting, reminding council members, staff and audience that this meeting is subject to the open meetings law. It's being broadcast over the internet. The webcasts are accessible on the Department of Health's website, and the on-demand webcast will be available no later than seven days after the meeting for 30 days. And a copy will be retained in the department for four months. We ask you, because it's synchronized captioning, it's important that people do not talk over each other. The mics are generally live. The first time you speak, we're asking folks to give their name and briefly identify themselves as either a council member or staff to help the broadcasting company. And then again, the sort of hot mics caution, be sure your mic is off if you're chatting with your partner at the table. And then for those in the audience to remind you that a forum needs to be filled out, it's out on the table, outside the room.

And those of you that are listening to it on Zoom, please go onto the department's website and under certificate of need, fill out the form prior to the council meeting. This is not formal council meeting, but technically speaking, we're following the rules of the FIPIC. So, I think that's all for the introductory remarks. I wanted to ... Dr. Whalen is post-surgical. I think she may be online or not, but as well, I understand from Ms. Trolio, thank you for being here. And let me just make a few opening remarks. I think first of all, I want to thank Mark Waldenmaier and Zahra Alaali for fantastic work preparing all the materials before the meeting, for this meeting, and for the ad hoc committee think meeting. I think it's not the first time, but first time I can remember such complete materials being available in advance in time enough to actually read and digest them. Although the 246 pages of the prevention and it's a bit of a lift, at least there's a really nice executive summary for those that want to familiarize themselves with it.

And also, I want to thank the public health committee. Since our last meeting. They had asked that they be involved in sort of reviewing the invites for the sort of revitalized ad hoc committee, which will meet this afternoon. And I really appreciate those that responded with names of organizations and individuals as contacts to make that list richer. Just to

repeat for everybody as a reminder, I think one of them is that the public health committee sort of works on behalf of the FIPIC to meet its requirements, statutory requirements to oversee the implementation, the preparation, implementation of the prevention agenda.

And the other thing we have been doing over the past years and have done again is we always pick one priority area in public health that we're particularly interested in working on. I think a few years ago, it was maternal mortality. And this year it's public health workforce, which we'll be hearing about later on. And so, our goal is to partner with the staff in the department and use the sort of public forum and other opportunities for discussion to bring visibility to an issue that's of importance.

Today, we're going to hear from Mark Waldenmaier about the sort of progress on implementation, sort of starting the action steps on the prevention agenda. The final, final deadline for submissions is July 1st, and he'll explain that process and the cycle. As part of that, the committee had also asked to stay up to date on the engagement of other agencies in the work of the prevention agenda because working with the five domains of social determinants, many of those are, I think there's one that's probably in the gift of the health department, which is maybe accessed to care. The rest of them require partnerships with other agencies that have responsibilities for housing and economic development in other areas.

So, we're interested in that particular issue, which certainly is part of the prevention agenda portfolio. And then the final activity related to the prevention agenda is community benefit. And so, we're going to be hearing about all of those today, sort of progress on those activities. And then Kishana Owens-Cody, who is here leading on the public health infrastructure, I guess it's called now, but the workforce and infrastructure is going to give us an update. And as we talked earlier about a sort of call to action, how she feels the committee could be useful to her staff and advancing attention to and support of the public health infrastructure. And then this afternoon, we will be having a meeting of the ad hoc committee and we're going to be hearing a sort of official role.

That original committee was set up a number of years ago, really as a public advisory committee to the accreditation process. I think New York State was one of the first large states that went for voluntary accreditation. A number of county health departments or local health departments have done that since then. But I think that renewal is up for this year. And so, we wanted to hear about that formal process and the role we may play, or the ad hoc committee may play in it. So, I don't know. Laura, do you want to make any comments on Eliza's behalf?

Ms. Trolio: No, you reviewed the agenda for today and I just, looking at all of the components of today's agenda, just want to thank all of the staff that are working on behalf of the department to be able to share the good work that is happening to move this work forward. And Liza sends her regards. I recognize that today is an in-person meeting. She is watching but is unable to make comments. So please accept mine on her behalf. Thanks everybody.

Dr. Boufford: Thanks, Laura. Maybe introduce yourself to those who don't know you.

Ms. Trolio: Good morning, everyone. My name is Laura Trolio. I have worked with the department for over 13 years. I am currently sitting as the deputy director for the Office of Public Health. I'm in the acting deputy commissioner role as we are in the process of recruitment for a deputy commissioner. And it's my honor to be here. And hello to all of you who I have not had the chance to meet.

Dr. Boufford: Okay, great. Thank you very much. I think we all ... It's always good to go around the table. Kevin, start with you, welcome. Just quick brief introductions, council members or department.

Dr. Watkins: Kevin Watkins, member of the council and member of the committee.

Ms. Soto: Good morning. Nilda Soto is a member of the council.

Dr. Soffel: Denise Soffel, also committee and council member.

Ms. Gilulli: Good morning. Gina Gilulli, New York State Department of Health in the Office of Local Health Services.

Ms. Knorel: Good morning. Erin Knorel, Associate Director, Division of Public Health Infrastructure at the New York State Department of Health.

Ms. Owens-Cody: Good morning. Kishana Owens-Cody, Director of the Division of Public Health Infrastructure for DOH.

Ms. Edgar: Henrietta Edgar, accreditation coordinator for the Department of Health.

Ms. Ravenhall: Sarah Ravenhall, Executive Director at the New York State Association of County Health Officials.

Ms. Elogoodin: [inaudible 00:07:29] Elogoodin is working very, very closely with Doug Fish and others, and very excited to be here today.

Dr. Fish: Good morning. Doug Fish, deputy commissioner in the office of healthcare delivery. And is anybody else freezing? Do we need to turn the temp up?

Dr. Boufford: Feels good for now, but ...

Dr. Fish: We can work on that. I know we've worked that miracle before, so we'll see if we can do it.

Dr. Friedrich: Good morning. Marcus Friedrich, council member.

Ms. Lim: Hi, Sabina Lim, committee and council member.

Ms. Farrell: Lindsey Farrell, committee and council member.

Dr. Eisenstein: Larry Eisenstein committee and council member.

Mr. Waldenmaier: Good morning. Mark Waldenmaier, Director Office of Local Health Services.

Ms. Ngwashi: You met the two of us, Mart. Good morning. Marthe Ngwashi. I'm an attorney at the Department of Health.

Ms. Leonard: Colleen Leonard, Executive Secretary of the Public Health and Health Planning Council.

Mr. Stelluti: Mike Stelluti, Health Program Administrator, New York State Department of Health.

Mr. Bintz: Jacob Bintz, Department of Health.

Dr. Boufford: Okay, great. All right. Thank you all very much. And we'll start with updates on the, I would say the portfolio of the prevention agenda. So, Mark Waldenmaier, you want to take over?

Mr. Waldenmaier: Yes. Thank you, Dr. Whalen. Again, I'm Mark Waldenmaier. I'm the director of the Office of Local Health Services with the Department of Health. So, I'll give updates on the prevention agenda today. But as Dr. Boufford did say, Dr. Whalen is our overall lead on the prevention agenda. And Zahra Alali, who is our programmatic lead and is often the force behind a lot of the work here, I just wanted to give a shout-out to her because going forward as she works with the committee, she will officially be Dr. Alali. She just finished up her PhD. So great fundamentals for her as an expert in her field and an expert with us in our efforts with the prevention agenda. So today I'll be going over three aspects of what we're doing in the implementation of the prevention agenda, socializing the

prevention agenda to a larger audience, some of the local partner planning updates with local health departments and hospitals, as Dr. Boufford already talked about, the revitalization of the ad hoc committee as we're moving into this implementation phase.

So first off, with some of the outreach and engagement of how we're trying to socialize the prevention agenda, I mentioned this a little bit at the last public health committee, but our team is really working on getting requests and also looking for opportunities to provide more information about the prevention agenda to numerous different types of partners. And partnership and the prevention agenda really go hand in hand. So, part of the people that we have worked with is bodies similar to this one, such as the AIDS Advisory Council and the Health Equity Council. We've recently gone and done briefings with them and given them more information about the prevention agenda. We've also worked a lot with Regional Department of Health staff so that when they're out in the local and regions, they're able to work with different partners and be able to provide some basic information to the prevention agenda and be able to bring it back and connect it with our team in order to give a fuller picture if they need to.

One of the other areas that I'm actually kind of really proud about is a lot of universities have been reaching out to us and wanting to teach their students, whether it be undergraduate or graduate, to learn about the prevention agenda. And to me, having gone through two pandemics, knowing that pandemics happen pretty much every 10 years or so, I really think the next generation of public health is so critical and important. So being able to kind of build a strategic mind frame in the next generation of public health officials is really important. So that being said, I'll end it as we did, based on Dr. Boufford's advice, actually reach out to all of the Public Health Partners Conference, which occurred in April up in Lake Placid that folks like Ms. Ravenhall from NYSECHO and other great organizations put together. And the start of that conference actually was focused on the prevention agenda.

We gave an overview as well as worked with Suffolk, Ulster, and Cortland County to kind of provide a panel on the different aspects of the prevention agenda. So that conference alone had over 500 people. So, trying to get the word out and trying to build grassroots understanding of what the prevention agenda is and how we're working strategically to improve health across the communities of New York.

One of the other things that I did mention last meeting, but I wanted to look at a little bit again and would always love input from the committee on, is with one of our goals that was identified in the state health assessment of trying to bring more awareness to the general public about

the prevention agenda, we are developing some materials for that. And Gina Giluli here with us today is our leader on some of those materials.

So, we are looking at a basic fact sheet in order to provide the information for a public understanding of what the prevention agenda is about. And we're also going to be translating that into the 12 top languages of New York so we can really have the ability to give the basic information about the prevention agenda to all of our communities. Also, we will be working on what is going to be kind of 101 training that again could be a resource for university students, be a resource for the general public, or be a resource for other community partners who are just learning about the prevention agenda. Are there any questions or comments about the socialization efforts before I move on to the next area?

Dr. Boufford: I think the others or suggestions about upcoming association or network group meetings over the summer that if you are aware of those, please let Mark know about them. You might have an inside track of getting a slot on a panel or a presentation or a workshop. Any comments? Yeah. Nilda -  
- Dr. Soto -- Ms. Soto.

Ms. Soto: You've mentioned a couple of times coordinating with public health programs. Has any outreach been done to the 17 medical schools in New York State?

Mr. Waldenmaier: Not directly, no. At this point, just because of staff limitations, we've kind of been more of a have them come to us than we've been doing too much active outreach. But when there are suggestions, we do try to reach out. I know Dr. Whalen and I right now are, speaking of associations, already planning on reaching out to the health plans association. They requested us, so right now it's more by request, but that's a good suggestion and definitely something to look at as we move forward.

Ms. Soto: My former place of employment, which was Albert Einstein College of Medicine, recently I reviewed applications for a scholarship and there was a big interest. Students demonstrated how they had done community outreach and also prevention. And unfortunately, they were not aware when I asked about New York State AIDS Health Prevention Agenda, but these young people, because of the nature of the scholarship, have been very much involved.

Dr. Boufford: There used to be, and I don't know if it's still active, an association of deans of medical and dental schools, New York State. Marcus, do you ... I don't know if they're still ... I'm not in that sort of world anymore so I don't really know if they're still there, but it may be just a one stop shop for access to at least the dental and medical deans.

Dr. Fish: I think they are.

Dr. Boufford: There had been a notion that the nursing deans were going to join, but I'm not sure they did. Doug?

Dr. Fish: Yeah, I think they are still.

Dr. Boufford: Okay. So maybe we could get that information. That would be one way to address Nilda's concern without having to go retail across the state.

Mr. Waldenmaier: Oh, that is, again, why we're trying to look at some enduring resources as well. So even we can maybe do a presentation at the association, but then also provide recorded webinars and other resources that then the students or teachers can even implement into curriculum if they'd like to. So great suggestion. Thank you.

Dr. Boufford: Any other comments, thoughts, ideas? Okay. Why don't we keep moving then, Mark?

Mr. Waldenmaier: So next will be local planning updates. So, as you all are familiar with, a big part of the implementation phase of the prevention agenda is we move from the state health assessment and state health improvement plan to the local health departments and hospitals working on their community health assessments, their community health improvement plans, or on the hospital side, the community service plan. So that's a big effort of technical assistance and guidance that was provided in 2025 and continues in 2026 with a lot of the plans being turned in at this point. One thing as a reminder is at this point, the hospitals had their assessments and plans due in December of 2025. The local health departments had their assessments due in December of 2025, but their plans are not due until June of 2026 coming up.

So at this point, we're not able to give a deep level analysis because we don't have all of the plans in from the local partners, but I did want to give an update on what we do have, which is we do actually have 34 of the local health departments who already turned in all of their material, even though the plans aren't due until June. Actually, excuse me, I'm getting confused with the joint plans. We actually have a total of 31 joint plans provided that is the connection and the collaboration that we're really looking for between the local health departments and the hospitals. That's actually up from our last briefing where we said it was 28. So, we had three more as more come in that we're able to see of those joint plans come in.

So, it's been something we'll be giving more briefings throughout all of the meetings going forward in 2026. And then towards the fall, we'll be able

to give more details on the different kinds of elements and priorities across the state that the local health departments and hospitals plan.

Dr. Boufford: And I think one of the notions you had mentioned last time, Mark, was that even though there is this, we're a bit off sync because of the timetable for the release of the prevention agenda as far as the local health departments are concerned, the hospitals have a federal requirement to meet their deadline by the end of December, that there is an opportunity and encouragement by the department of local health departments as they prepare their plans to take a look at what their hospitals may be doing locally and see what kind of synchrony they can develop in that process.

Mr. Waldenmaier: Any questions or comments on the local planning efforts? Again, we're kind of in mid-stage right here. There will be a lot more to come throughout 2026. Okay. Hearing none, the last agenda point is the ad hoc committee and the changes that we've made for the implementation phase of the ad hoc committee. So as Dr. Boufford already mentioned, one of the big focuses of the prevention agenda is the five domains, which are based on Healthy People 2030 social determinants of health. And with that focus, we are looking to incorporate a lot more variety of partners to help address those social determinants of health. And that upstream approach and looking at health problems is why we've really looked to revitalize the ad hoc committee as we move forward into 2026 and 2027.

That's in part with the inter-agency task force that we've been looking at with the development of the prevention agenda. We were originally looking to work with our Office of Health Equity and Human Rights or OHER because they had a task force, but they actually moved their group to combine with the New York State Workforce Diversity and Inclusion Advisory Council. So that's where for 2026, what we've actually decided to do is incorporate the state agencies with the statewide, state level organizations of the ad hoc committee and have combined conversations between the organizations like NYSACHO and HANES and Greater New York and other associations that have been invited, as well as with the state agencies that many of you gave some suggestions last meeting and even in 2025 that we've incorporated in the ad hoc committee. So, at this point, we do have 13, not counting DOH state agencies that will be joining us this afternoon to talk and learn more about the prevention agenda.

This afternoon's meeting will be very focused on those social determinants of health. We do have new membership, along with some of the old members who are already state level organizations that we're bringing together, we have about 36 total organizations that will be looking at different aspects of the prevention agenda and three different areas. Which if you attend this afternoon meeting, you'll hear more about, but basically what are their organization's priority areas that are aligned with the

prevention agenda, what activities, resources, services, staffs, their programs that they already have that may help support the priorities of the prevention agenda, as well as, and this is a part that's important to us, what would they like to see from us in DOH that we could provide resources in order to help their membership or their local partners be able to be more integrated into the prevention agenda and help the overall strategic ability to meet the prevention agenda goals.

So, we will have breakout groups amongst the 36 state level organizations and 13 state agencies, and then we are planning on doing a written report to be able to provide more information to this committee if you're not able to attend this afternoon. With that, the only other thing I will mention is that just remember our next meeting is June 23rd, and Colleen, correct me if it's changed. We are looking to have that in Albany for space and consideration. So, June 23rd, probably in the afternoon will be our next meeting. So, any other questions or comments?

Dr. Boufford: Dr. Soffel?

Dr. Soffel: Yeah. I have a question. I asked Dr. Whalen about this at one of our meetings. I appreciate the Inter agency council, but I'm also concerned about an intra-agency collaboration because it seems to me that the Department of Health has pockets of real depth of knowledge and about many of the issues that are coming up as part of the prevention agenda. And I worry that because of silos and people being overworked and stressed, that that may not be shared as much as would be helpful. So, I would like to reiterate that it would be in everybody's best interest if the department sorted about who else within DOH works on issues that are part of our agenda and let's make sure that we talk to them and understand what they're thinking about.

Dr. Boufford: I would say the design of this afternoon is in fact each of the breakout ... There's going to be two rounds of breakouts and each of them will be staffed by people from across the Department of Health in the particular areas of expertise that are reflected. I think that your caution is always a good one. I think, Mark, do you want to maybe talk a little bit about the mobilization with Dr. Whalen's support of within the department of the areas that have been traditionally involved in sort of informing and shaping bringing the evidence base to the priority areas and the domains that have been chosen?

Mr. Waldenmaier: Yes, of course. And I mentioned already kind of our external partners that we've been doing socialization with, but we are also doing it with a lot of internal to DOH as well, with Laura and Dr. Whalen, with our division, and with really any of the internal programs within DOH that are interested, we always do make the effort to provide them with that

socialization as well. I will say that is when we've moved from the planning phase of the prevention agenda in 2025 and before into the implementation phase, yes, this afternoon's meeting is looking at a little more focus of inter-agency and inter statewide organization, but we are definitely maintaining all of our contacts of all the DOH programs who had helped us with the planning phase because like you said, that incorporation is going to be needed again for all of those different experts across the Department of Health and to be able to bring them back on board.

And that's even true with any of the regional or other local partners that may have been more part of the planning phase, we're maintaining all of that and we will bring them back in as we kind of get to other activities. But just to start off with 2026 with some of our goals, we're kind of keeping it more at the state level and the interconnection between the agencies and organizations.

Dr. Boufford:

I think just to kind of comment on the state agency thing, we had talked in some committee meetings going back a while, and Mark mentioned this sort of evolution of trying to focus on using the existing inter-agency mechanisms, even though instead of starting a new one, those of you that were involved in the master plan on aging or others, every time there's a new initiative, there's a new inter-agency activity because that's the way the world works these days. It's important. You can't get anything done by a single agency, but rather than sort of impose another sort of bespoke, if you will, inter-agency group, we, in discussion, decided to add them as members of the ad hoc committee. And I think it's selected agencies. It's not every state agencies, it's those that kind of have the potential for leveraging change in the domains that have been selected as part of the healthy people.

And so, we're keeping our eye on that. We didn't want them to outnumber the state level nonprofits, professional associations, advocacy groups that are really the idea for the public advisory part of the ad hoc committee. So, I think we're seeing how that's going to work. I think it's good to bring everybody together and that's sort of the first round is this afternoon. And I think the important thing is there will be wide involvement within the Department of Health, but they are sort of being asked to identify themselves as staff experts in support of the prevention agenda, not members as such of the ad hoc committee. Otherwise, we'd have 30 or 40 staff members from government agencies, and they would sort of outnumber the others. Not that there's a contest, but we just want to be sure there's enough airtime in what sort of short meetings are, three to four hours to have 30, 40 people involved because it's really important they have input.

So, we're keeping an eye on it, Denise, I think in terms of the intra, but as well as the intern. So good comment. Any other comments, questions?

Ms. Trolio: Dr. Boufford, if I could just interject and also address Dr. Soffel's point, the department right now is currently working on a public health strategic plan. It's going to address the next three years of public health programming and really high-level coordination of public health priorities across the department. And one of the activities that we're going to be launching soon is putting out a survey to our internal partners as well as to external partners to have input on what our next three-year priorities will be. And the development of this public health strategic plan is putting documents like the prevention agenda, as well as our accreditation goals as forefront for developing that strategic plan. So, I think that your point of making sure that internal public health focused programming and experts will be utilizing the prevention agenda as part of identifying the three-year priorities moving forward and ensuring that that is part of the focus of that activity.

So, I just wanted to tie that in so that you're aware that we are ensuring that all of our public health programming internally is using the prevention agenda as a guiding focus toward our work.

Dr. Boufford: What's the time devil for that, Laura? Because we may want to hear a briefing on it in the next month.

Ms. Trolio: Yeah. It's currently being developed. We are wrapping up an office of public health strategic plan at the end of this year, but we realized that we wanted to ensure that all public health programming within the department is included. So, we've expanded that scope and we're looking to initiate this new strategic plan as of January 1st, 2027, through end of 2029.

Dr. Boufford: So, we might want to hear about it more in September at one of our meetings. June is too soon probably, but the one after that, I think that might really helpful. Denise?

Dr. Soffel: I just think about all that we learned in district and all that we are learning through the federal waivers around social determinants and how they affect health. And I would hate for all that hard work and sweat and knowledge to not be built upon because a lot of us spent a lot of time and energy on those efforts and learned a lot.

Ms. Trolio: Agreed. And now more than ever, as we are losing resources, we were just talking about the fiscal COVID cliff today at our agency leadership meeting. It's important to leverage the partnerships now more than ever so that we can keep that momentum going. So completely agree.

Dr. Boufford: I'd also put it in a plug for bringing in the master plan on aging report as part of this because one of the goals of the prevention agenda is making sure we don't leave older people out of the areas we're working on.

Ms. Trolio: And that is also included in the work that we're doing for the strategic plan.

Dr. Boufford: Oh, that's great. Any other comments, thoughts? Okay. Then that's great. So, I think we'll move on. Speaking of partners in the other parts of the department, we're happy to have an update on community benefit, which was the third area of the public health committee's interest. I'm happy to have Doug Fish here as deputy commissioner of the Office of Healthcare Delivery and Bella Elogoodin, who's been our point person designated for closer eyes on and work with Mark and colleagues for the prevention agenda. So, Bella, I don't know. Doug, Bella, which one of you want to take the lead?

Dr. Fish: I just want to thank you, Dr. Boufford, and also just recognize Bella. We're really fortunate to have ... I remember Dr. Soffel when you asked me at a FIPIC meeting a year or two ago, when is the department getting your patient advocacy director? This was a statutory piece, so we needed that. And so, it's really great to have someone who can now focus for the department on this critical element of community benefit spending and other things related to consumers and the consumer experience of care, and she has a lot of experience with that. And before I turned it over to her for her report, I just wanted to give Jackie Sheltry a chance to introduce herself. Jackie has been our lead on material transactions for the department of the governor's office and is kind of deeply into these topics related to the spending and finances and so on and many other strategic health initiatives.

So, Jackie.

Ms. Sheltry: Thank you, Dr. Fish. I think he did a better job introducing me than I will. I'm Jackie Sheltry. As Dr. Fish said, I am the director of the Center for Strategic Health Initiatives at the Department of Health under Dr. Fish and Mark Hennessy in our Office of Primary Care and Health Systems Management. So, I oversee the material transactions program, as Dr. Fish mentioned, as well as our statewide grants and our data division kind of linking policy and data analysis and our office of primary care. But I work very closely with Bella on helping implement all the great stuff she's about to report out on but thank you for the opportunity.

Ms. Elogoodin: Well, thank you both Dr. Fish and Jackie. I'm very excited to be here. Thank you, Dr. Boufford and Mark. Work very, very closely with Mark and our work group that we are developing this community benefit and

reporting as New York State Public Health Law Section 2805 was amended to require all voluntary nonprofit hospitals, including critical care and emergency rural health hospitals, as well as public hospitals to report on how -

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Ms. Elogoodin: Oral health hospitals as well as public hospitals to report on how they provide support to services that they are around with. We wanted to make sure that we provide that information to you how hospitals are reporting specifically on the prevention agenda that Mark just had shared. This requirement six to clarify how hospitals are contributing to community health and guide future state decisions on how the spending is going to be to improve public health, reduce healthcare costs, and make communities a little bit healthier. So, these reports are due on July 1st of this year.

And because of this short timeframe this report is due, the department is evaluating an approach on how we can gather the information that is necessary while also avoiding the redundant reporting requirements. Right now, we're considering the following. So, all hospitals that have already filed IRS will be submitting the IRS form, Schedule H (Form 990) to the department. And public hospitals that do not file, will be completing a form, it's called SMART form, which is the survey management response too. They will be pretty much completing this form to let us know how they're doing and what kind of services they provide.

For the 2027 submission, all hospitals will be required to use online form, that same form that I just mentioned. We know there have been a specific request to provide additional information reporting on how hospitals are doing, and what kind of support they're providing. As we transition into next year, gathering this information, we call this 2026 as the data gathering right now and just to see how hospitals are reporting, to be able to then provide this information and initiate specific reports online. As usual, obviously FEPIC will be involved in any regulatory development, and we'll make sure that we get all the feedback from each and every one of you. And again, I just want to share that I'm very, very excited to be here today with you and provide this information.

Dr. Boufford: Thanks, Bella. Maybe Doug, you want to comment. We had a useful meeting yesterday actually, just to dig into this a little bit. And I think for purposes of the committee, the reality testing the job of starting to collect this information and analyzing it rather than just collecting it, which is a challenge. This idea, Doug, maybe talk a little bit about the two categories of hospitals. Bella touched on it, but I think the idea, I know this committee I had mentioned had wanted to give some input into the language that might be part of the community health improvement

category. And that opportunity will not be available this round, but for '27, it will be available. And maybe we could expand a little bit on Bella's really nice presentation.

Dr. Fish: Yes. Thank you. And just really thanks to Dr. Boufford for her leadership here. And this has been a long game, right? This has not been a short-term delivery. She's been advocating for this for a decade, working even back with the Medicaid team, Amir. They had a white paper that they had drafted. I don't know if it ever got published.

Dr. Boufford: I have a copy of it, but I haven't held it against him yet.

Dr. Fish: So that goes back to 2019. Also, Dr. Isaac Michaels, who recently got his PhD, was still engaged in this work and has been a resource to us. We met with him and got his ideas and picked his brain here too as how we can go about this. So as was mentioned by Bella and Dr. Boufford, it's a phased approach. The first year we're just setting up a way that we can intake the information. So, the general hospitals are required to submit already this Schedule H (Form 990). We will be intaking those forms, but the public benefit corporations are not required to submit that form. So, we've designed this additional data collection tool that those hospitals will be able to complete this year that will incorporate some of the questions that are related to the community benefit spending. And what specifically in the statute is community health improvement services and community benefit operations, which shall include costs associated with planning or operating community benefit programs, but shall not include activities or programs if they're provided primarily for purposes of marketing or if they're more beneficial to the hospital than to the community.

Dr. Soffel mentioned DSRIP. We've been working for a decade here trying to break down the walls between hospitals and the community. And your part of the community, your economic drivers for the community, and how can we partner together on this community benefit spending and support that many of them are already doing. And we're just trying to learn about what the hospitals are doing and all that great work that we know is happening so that we have better visibility and transparency. And then these documents and an annual report will be developed by the department as required by the statute that relates to this.

Dr. Boufford: Thanks, Doug. We had looked at the last committee meeting. We had looked at the Schedule H... Yeah, just a second. We have looked at Schedule H and that particular segment, I think it provided some input on thoughts about what data might be collected. And as I understand it, when the document that's going, the separate document that's going to be submitted, requested from the public hospitals around the state is submitted, then we'd be able to take a look at that as a draft that might be

the baseline draft for the next round of these discussions. So, I just wanted to clarify that because I know the committee members have been very interested in having input during the process of developing the request for reporting. Larry. Dr. Eisenstein?

Dr. Eisenstein:

Thank you. Dr. Larry Eisenstein, committee and council member. Thank you for the discussion. And I think factually, I don't have a disagreement with anything I heard, and I appreciate all you're doing. But there's one thing that I think is very misunderstood, and it impacts hospitals, it impacts government agencies, and I think it has to be part of the message. Bella, when you started, you said we want to show what hospitals are doing for the community. And I've been on all sides of this discussion. I don't disagree with what we're trying to do here at all, but I do think we miss some of the stuff because not everything that is done by hospitals for the community counts as community benefit under the law. So, if a hospital, if I'm in charge of community benefit, I'm making this position up for a hospital and I get a foundation to support work that otherwise we don't have in the budget to do, but it serves the most vulnerable because the foundation may be paying for it. It doesn't necessarily count as community benefit, yet the hospital is using it to help the community.

The Medicaid waiver, this is actually a question. The funding that we get paid for capacity building or infrastructure money from the Medicaid waiver, which we grow staff, and we do new work in line with the prevention agenda, but it's paid for through the waiver. Does that count towards community benefit? That's actually a question for you guys, I don't know the answer to that. Would that count? I guess the point I'm making is, this report of community benefit is not the sum of all that hospitals do to serve the most vulnerable in the community. It's the sum of what comes out of one funding stream. And I just think it's really important as we go through this... I'm not saying we shouldn't do this. I'm not saying that what you're reporting is wrong. But especially when the public tries to understand this and they hear this is what hospitals do for the community, it's not a whole picture.

And I think the things that we do that are funded by grants, the hospital hires somebody to go get grants and those grants pay for operations to serve the community, that should count as community benefit. The law is what it is, I'm not saying we should change law, but to show the whole picture and be transparent to say, this is the document that's the summary of all hospitals due for community benefit. I understand legally that may be true, but it's a misinterpretation and not a complete picture. So, I would just ask, and like the Medicaid waiver is an example. My place is in the process of hiring community health workers to do screening for social determinants of health, do the assessment eligibility and navigation. We're growing our staff, but the fact that they're paid for through the Medicaid

waiver means it won't count on community benefit. It doesn't mean we're not providing a community benefit, it just means the payment source is somewhere else, so it doesn't count in this discussion. And I just want the picture to be whole is my point.

Dr. Boufford: Thanks, yeah.

Dr. Fish: Yeah, I think it's an important point too. I mean, we didn't make the IRS rules, but we are trying to live with them and work through them and utilize them and get some additional information around point H, around the community investments. So, your point's well taken, and I think anything we do will be better than what's been done in the past to make it available and transparent to the public about all the good things that hospitals are doing to break down those barriers in investing in communities.

Dr. Eisenstein: Thank you.

Dr. Boufford: Yeah. And I would mention, I think part of Dr. Soffel's earlier point, part of what we're also focusing are since DSRIP Category 4, which was supposed to be linked to community engagement. Then with the prevention agenda, some hospitals certainly did do that, and others did not do it. Especially, I just want to mention the community health improvement category, not a lot of the other issues about unreimbursed care and GME and research and other things. So, it's a small portion of Schedule H, but I think it's really exciting that we're going to be able to dig into it and to address some of the issues Larry's raising, I think. Other comments or questions? Yeah, Sabrina? Dr Lim? Sorry.

Dr. Lim: I agree with Larry. And I think just another way to think about it or say it is, there is a federal definition of community benefit, which is actually just part one of Schedule H, right? And I think we have an opportunity here to, yes, acknowledge the federal definition, but how does New York state sort of define community benefit in a more general way?

Dr. Boufford: Yeah.

Dr. Lim: And so, it can be a win-win opportunity for both patients, the communities and the hospital providers.

Ms. Elogoodin: And Dr. Lima, I'm glad that you mentioned that because that's something that in the smart form that we just mentioned, we're going to be asking those questions. So, we can definitely evaluate that and provide that recognition to the hospitals that specifically do outside of that federal definition. So, thank you for bringing it up, Dr. Lim.

Dr. Boufford: Other comments or questions about this? So, this will be an ongoing agenda item as we had committed. And you can see, I think it's exciting that the committee will have a chance to be more deeply involved over the next month. So, we appreciate that. Doug?

Dr. Fish: Great, thank you.

Dr. Boufford: Yeah, thank you very much. All right. So, we'll move on to our next item, which is reminding us. I don't think we've actually ever had a presentation or maybe it was so long ago, I don't remember it, but on the public health accreditation process, because the first time when voluntary accreditation was set up across the country, I know New York, as I mentioned earlier, I think one of the early states in one of the first large states that actually went for it. And one of the requirements at that time was to have a public advisory committee for that process. And that was where the ad hoc committee came from originally to do that.

So, it is an instrument of this public health committee on behalf of the FIPIC and it's to be advisory. So, we'll see what it's supposed to be, I guess, in the next round of the accreditation process and what that's going to involve. So, I think we have Henrietta and Sarah. Sarah's well known to the committee, she's been with us, head of NYSAHO. So, we have the central and periphery government, the decentralized health department leadership here to tell us about this. Edgar, are you starting out or?

Ms. Edgar: Yep.

Dr. Boufford: Okay.

Ms. Edgar: Hi. Again, I'm Henrietta Edgar, the New York State Department of Health's accreditation coordinator. I just entered my position last year. Previously, the state had one member of staff dedicated to all the accreditation efforts. And now we're a team of two, but this is the sole work that we do for the department. We're looking at applying for re-accreditation in 2027. Right now, we're engaged with upwards of 100 staff to accomplish that effort. We're looking to submit our annual report in September of this year. So, I want to talk a little bit about the timeline. Right now, again, we're resubmitting the annual report in the fall. We're engaging teams through February of next year, and then we'll be looking at documents. We're looking at them as they come in, but we're looking to assemble a team of staff across the health department regionally and centrally to really look at those documents, policy documents, write-ups, documentation to make sure that we do meet the requirements for accreditation. And then we will be submitting our application in July of next year, and hopefully we get to the point of the site visit late in the year and actually be re-accredited.

So, some of the work we're doing additionally to our accreditation efforts is engaging with NYSACHO to support local health accreditation. Sarah will get into more of what that looks like, but right now, what the work looks like for us is providing technical assistance and guidance for locals that have reached out to us as they're considering accreditation or preliminary looking at their health department to see if they meet accreditation requirements. Some of our teams are engaged in the workforce development plan, so we're updating the plan and Laura talked about the strategic plan earlier. We're looking to implement some of the performance tools in that strategic plan to, again, meet the requirements for accreditation. We met with the ELT team last December.

Dr. Boufford: ELT is?

Ms. Edgar: The executive leadership team, and Dr. McDonald does support the work of accreditation. So, we're looking to keep them abreast of where we are and throughout the cycle of accreditation, which happens to be every five years. FAB expanded that to about six years, but we're still on course to re-accredit next year. We were initially looking at using version 2022 to submit our application. This year, they're coming out with version 2026, so we had to do a pivot. Right now, the work is somewhat paused till version 26 comes out on or about July 1st of this year. Then we'll look at what we have in terms of teams and experts in those different teams. We did receive a draft version of what FAB was proposing, and we still think that we can do it until we receive the final version to look at what's in place, we will gather the documents we need to. Any questions?

Dr. Boufford: Let me ask you a little bit. Since this is one of the first times we've heard about this, you mentioned there's a document that's issued by the accrediting body. Can you summarize the buckets that the information is in this? And I don't know if the term of art seems to be pillars these days, but what the categories of data are, just in general, so that we're aware of the things you're being asked to find out about for the central department.

Ms. Edgar: So, accreditation, just like the prevention agenda has domains, we have 10 domains with accreditation. And some of those domains are responsible for submitting documents in terms of does the health department engage with the public. Does the health department support the work of other health departments? Does the health department contribute to efforts with the public? Again, that could be different entities like hospitals. So, there's community health involved in this. Does the health department improve with innovation, with their policies? Do they have laws protecting the public's access to health and resources? So, there's a lot of work. There is 10 domains, but we've submitted in the past upwards of a thousand documents to show that we're doing the work. So, it's a lot of work, and

our teams that we've engaged in, they're really committed to doing that work. Does that-

Dr. Boufford: Yeah, that's really helpful. I just wanted to get a bigger picture for folks. Yeah, Kevin. Dr. Watkins?

Dr. Watkins: Thanks for your presentation. Excellent presentation. You mentioned that as part of one of your deliverables for moving forward for re-accreditation was encouraging NYSACHO to increase local health department participation. Is that what I'm hearing? With that being said, I believe at a previous meeting, we talked about state DOH and we talked about accreditation process and how they left out local health departments in this, I believe it was performance incentive number 14. And did not include them as a, I don't know, some type of special... What is it called?

Unknown: Incentive.

Dr. Watkins: Incentive for those who were previously accredited or those who were getting reaccreditation. Have you looked into any other form of an incentive for encouraging local health departments to become accredited besides just the performance incentive program that we have out there?

Ms. Edgar: Me, not specifically, but we have had that conversation and tried to brainstorm what that would look like. There isn't currently any funding to incentivize accreditation. Hopefully we're looking to FAB with some conversation around the requirements that the local health departments do have to meet and support that work. I don't know at this time where that funding would come from and what that would look like. My position sits under the public health infrastructure. We have talked about possibly looking at funding through that funding source, but I don't know yet what that would look like long-term.

Dr. Boufford: Kevin, your question made me realize I had made a mistake in the sense. I just want to hold off on questions and let Sarah present, because I think the idea of having Sarah here was too present. And then we can have discussion from both perspectives, if people don't mind holding off. Nilda, can you hold your question until Sarah has a chance to present? Okay, great. Sarah, please go ahead.

Ms. Ravenhall: Thank you, everyone. Thank you, Dr. Boufford and Laura Trolio, Mark Waldenmaier and everybody on the state and on this committee for having me present on local perspectives around FAB accreditation. I'm really excited to be here and share some real time perspectives from local health departments across the state of New York. These are local health departments that are either accredited in the process of being accredited, are interested in accreditation or are not pursuing it at this time for several

reasons. So, I'm happy to share those perspectives with you today. I also want to recognize Public Service Leadership Week. It's this week, it's always the first week in May. It recognizes the commitment and dedication of public servants working at all levels of government and all of the work that they do. So, thank you for your service if you fall into that category.

Okay, so let's get started. My slides are not advancing with this. So next slide. Okay. There we go. Thank you. May I just say next slide for you? Okay. And yes, you do have a color copy, so you can refer to that. So, while we get into this slide, I just wanted to give you a little bit of a perspective of the landscape of local health departments in New York State, because this plays into readiness for FAB accreditation. There are 38 full service local health departments and 20 partial service local health departments in New York state. You'll see those reflected on this map in front of you. The brown counties are full service, and the green counties are partial service. Partial service local health departments do not provide environmental health services. In those region, the state district office provides environmental health services. We're thinking about things like restaurant inspection, water quality testing, lead poisoning prevention activities. Those types of activities are covered by the district office. And those are primarily more of the rural counties within New York state.

But regardless, every local health department has statutory requirement in public health law that they have to provide six core public health services to be eligible to receive Article 6 state aid reimbursement from New York State. So that's an important context because the partial service local health departments do receive less funding than the full service, but they're not doing those environmental health responsibilities. Next slide. So NYSACHO collects information from our local health departments on an annual basis. It is a survey called the enumeration of public health workforce. And so primarily what we're looking at is vacancies in different positions and titles held by local health departments. One of the subsequent questions we also ask our local health departments is whether or not they're interested in pursuing FAB accreditation.

This slide gives you responses from that survey. It's a little bit mischaracterized. We actually need to go through and validate the data because this is from 2025 data that we just collected, but it does give you an idea of where local health departments are in the process of accreditation. But we have 19 local health departments out of 58 local health departments in New York State that are currently accredited. One has just applied for re-accreditation, so that's about 20 who are accredited in New York State. Also, there are 18 who are interested in pursuing FAB accreditation... Sorry, this is too small. Nine are interested in pursuing, but don't have any immediate plans to go through that process. So less than

half of the local health departments in New York State currently have accreditation through the Public Health Accreditation Board or FAB.

Next slide. So, when I heard I was going to give this presentation, I immediately reached out to some members and got some examples from accredited local health departments on how they approach this. So, this is accreditation timeline from Madison County who's currently accredited. They have a two-year timeline laid out in the slide, which is really, really wonderful, but it's really important to recognize that this is not a two-year process. They took years and years before they submitted their application to FAB to get foundational FAB accreditation requirements into place.

So, some of those other preliminary things they have to do is get local buy-in from their local county leadership or governance structure, whatever that looks like to pursue FAB accreditation. They have to set up and support their staff to get buy-in from their staff to all participate in the accreditation process and really set the tone in the county for pursuing this because as Henrietta mentioned, it is a lot of work at the state level. It's a great deal of work as well at the local level. So, after accreditation is done, there's also post-follow-up accreditation. So, you may receive an after-action report that you have to follow up on. So definitely not a two-year process, but this lays out very nicely like the key steps in your accreditation timeline.

Next slide. This is another example from our friend, Dr. Watkins, in Cattaraugus County, another accredited local health department. And this is a three-year accreditation schedule. Again, it doesn't take three years, you have to set up some foundational and preliminary steps, and I'll talk about those on the next slide. What we're learning from these two examples from actual local health departments is this is a long-term process. And I want to point out some of the foundational or big-ticket prerequisite pieces that local health departments must put in place is a community health assessment, a strategic plan, a quality improvement, performance management plans, and a workforce development plan. If you have all of those foundational pieces in place, that's wonderful. You may be going back to that as you go through the accreditation process and making updates to align yourself with FAB requirements, but having some structure in place before you get started is the best way to do it. I'm not saying you have to go in that way, but it's going to make your life much easier.

Next slide. So, what we can start to talk about now is the benefits of accreditation because our accredited local health departments do see a lot of value in this process. One of them is that it will significantly improve your documentation process. So many local health departments do the work that is required under FAB accreditation, but this process really puts

those policies and infrastructure into place so that you have a very strong structure that your staff can follow on day-to-day operational basis. The next is workforce engagement. The staff in the local health department really understand big picture what everybody else in their local health department is doing. And some of the bigger local health departments may have 100 or so staff or even more. And so, understanding what everybody's role is and how it accumulates into healthy outcomes in your community is really, really important. And it has been successful for those accredited local health departments to go through the process of that together. And then strategic clarity.

So, accreditation connects daily work to the 10 essential core public services, and it also strengthens community engagement and buy-in what your local health department does. So that was some of the feedback we got from local health departments on the benefits. Another benefit, next slide, is there's really value beyond the accreditation status. So even for local health departments who aren't pursuing accreditation formally, some of the structures and document templates that are available through the accreditation board have been valuable and can bring value to a local health department. So, they can be used as tools to help those agencies really formalize internal processes.

Now moving to the next slide, we're going to talk a little bit more about some of those challenges and barriers. And there are four major barriers that our local health departments did cite. Of course, the first is resource burden. This process requires significant staff time and buy-in. And there's really little direct financial return on investment. It's been really challenging for them to demonstrate the value add, which is something that local government leaders are looking to talk about. What does the value add to accreditation? Some of them have told me that when they first decided to pursue accreditation, the FAB organization would tell them, "You'll have more opportunity to earn more grant dollars. You'll have better reimbursement from billing." And that has not come to fruition yet. And this is a conversation we have with FAB, they're well aware of local health department's opinion on that. So, it's something that we're collectively thinking about.

In addition, cost. So, to give you a little bit of an example of cost, it costs about \$1,300 for local health departments to engage in readiness training. This requires FAB training that they have to participate in. The application to apply for accreditation is a population-based framework. So, depending on the population of your county, it could be between 10,000 to about \$50,000 depending on where you're located. And then there are also fees associated with the appeals process. Pathways recognition is another pathway that local health departments can opt into if they want to go in that direction. And then you also have to think about if you're doing a

strategic plan, there's consulting time. You may want to bring in somebody to help facilitate that process. And of course, staff time is also included in that.

And rural, smaller local health departments certainly have constrained budgets. And most importantly, you need people doing the work at the local health department. So, investing in staff resources sometimes will outweigh the cost of FAB accreditation costs, which could be prohibitive for them. So additionally, state dependency. So local health departments do need timely state documents and data to meet certain requirements. And as Henrietta mentioned, she has definitely a small team. And so, they're as helpful as they can be, but it can be very time intensive for all... Oh, stop?

Unknown Speaker: [inaudible 01:05:58].

Ms. Ravenhall: Okay. All right. Next slide. So, there are challenges-

PART 2 OF 10 ENDS [01:06:04]

Ms. Ravenhall: Okay. All right. Next slide. So, there are challenges.

Unknown Speaker: [inaudible 01:06:07].

Ms. Ravenhall: Yes. There are also policy and advocacy implications. So, we talked a bit about the performance incentive. I think there are more areas where local health departments can work with the state to identify where the state can help local health departments who are accredited.

Unknown Speaker: Sorry, Sarah. [inaudible 01:06:36]-

Ms. Ravenhall: Oh, okay. Well, I can keep talking. It's fine. I just want to point out those policy implications should not apply to grant eligibility requirements because we don't want rural local health departments to not be able to apply for grants. So, we don't want grant eligibility to be based around FAB accreditation. Next slide.

When asked local health departments about what type of support they value, really it came to the forefront that they want peer learning and sharing opportunities. NYSACHO is working with FAB and the New York State Department of Health to have a work group for local health departments who are at all levels of accreditation readiness. And so, we share a lot of information and best practices there. So that's a great opportunity.

The next slide goes over recommendations for stronger state local alignment with FAB accreditation requirements so that you can take a look at it. And then I share key takeaways as well. And I just want to reinforce that the most important point here is that every local health department is very unique in its readiness or interest in applying for PHAB accreditation. So, it's important for us not to assume that everybody's going to be at that point at some time. Building buy-in takes time. And so, if they decide to pursue that, they'll get there.

And then the final slide I thought was ... One more. Yeah. This is Dr. Watkins. And I thought it was a good slide to end on because it shows county leadership buy-in. That is his board of health chair, and he supports Dr. Watkins and his department in PHAB accreditation. So, thank you again. I am happy to answer any questions you have about local health department's prospects.

Dr. Boufford: Sarah, maybe we could put the key takeaway slide back up-

Ms. Ravenhall: Go right ahead.

Dr. Boufford: ... just to have it up for people to look at. I wanted to ask you, one of the items there, obviously this is sort of an alignment question, is the better alignment with the New York State Prevention Agenda. Can you elaborate a little bit on that? Because it's pretty timely if that's an issue we ought to talk about.

Ms. Ravenhall: Yeah, I completely agree. I think that's something we need to dig into a little bit more and I'd be happy to do that, Dr. Boufford. I'd want to get specific, maybe like a crosswalk between the PHAB accreditation framework as well as the priorities in the PHAB accreditation as well as the prevention agenda. And I don't know if that's something that, Mark, your office or Henrietta, you're planning to look at, but we're doing a little bit of work with a consultant as well around-

Dr. Boufford: That's important. We want to make sure people aren't doing one thing with the right hand, another thing with the left. Yeah, Henrietta. Or Ms. Edgar, sorry.

Ms. Edgar: I want to say that one of the problems that locals had was that they were having a problem meeting the five-year cycle for the CHA. And I was in a meeting with Zahra and PHAB and they extended it to six years. So, they are willing to work with us and understand the hurdles and the issues that locals have in meeting their requirements.

Dr. Boufford: Ms. Soto, you want to ... Can you remember your question? Sorry about that.

Ms. Soto: No, no. It was helpful to hear the presentation. On the chart that's very colorful. So next to the bottom, my question is regarding, "Not currently interested in pursuing the public health accreditation." And I think you may have mentioned that maybe it's around nine counties, but what are their reasons and are there any drawbacks to them? Well, just pointed out because I wrote my note before hearing the presentation, but what are the reasons that these areas are not interesting?

Ms. Ravenhall: Yeah, it's going to be those broad barriers that I mentioned, cost resource insensitivity. If they don't have buy-in from their local government, and I'm not talking about the local health department, I'm talking about the government entity that oversees their work at the local health department, whatever that structure looks like. So, it could be a variety of reasons.

It could also be that they're working on strategic planning and aren't ready to pursue that at this time. Their focus is on a different place. But I know from the enumeration survey that local health departments also have a high vacancy rate when it comes to nursing, environmental sanitarians, and other key positions. So that could be their focus right now, trying to fill those workforce gaps and accreditation is not the priority at this time because they need to serve the community and that's number one.

Dr. Boufford: Dr. Eisenstein (phonetic), sorry.

Dr. Eisenstein: Thank you. Sarah, always represent your departments well. Amazing job. But I let my county health department through the accreditation process the same year as Kevin did, 2017. It's a decade later. We started to work probably around 2013, 2014. At the time that I made the decision to do it was, I think at multiple meetings we heard from the state and CDC that grant applications would be considered you would get better positioning if you were accredited, that there would be tangible reasons to be accredited. It's a decade later, and we're talking about how this is good and maybe we can align it with that. A decade later, nobody can give us tangible benefits for local health departments to do this.

Now, I'm not saying I was opposed to it. I thought it was good as a health department to look at our internal processes. And if you ask me my formal recommendation, it would be this is a nice thing to do if a health department had extra time and money to spend. But where does that exist in a government agency? Could we go to the Kevin Watkins slide at the end, please? It's really important for the point that I'm going to make. It's a little sarcastic, but the truth is, you know what you get when you become accredited? Come on, guys, this is a joke. You got to get the slide up. For the love of God. You're killing me here. Yours

Dr. Boufford: Going to say a plaque, right?

Dr. Eisenstein: Literally. That's what you get. You get a plaque and there's something on page 27 of your local newspaper that says your health department achieved public health accreditation. But I'm not opposed to the process. I think conceptually there could be something good about it.

But here's the point for the state health department, for PHAB, for everybody. Unless you create tangible incentives and reasons for health departments to fund this and spend the time. At the time in Nassau County, the costs were \$50,000. The professional costs were probably hundreds of thousands of dollars to do this. And we have a plaque on the wall somewhere in that department, which I don't run anymore. And again, I don't think it hurt us. It took time, it took money, and it wasn't bad to look at our processes. But there we didn't get preferential grant treatment, we didn't get any new funding streams. It cost a lot of money and time to do an internal look at us, which again, if I had time and money would be great. What government agency has that?

Dr. Boufford: Okay. Thank you. Dr. Watkins, would you like to have an equal time?

Dr. Watkins: No. I don't know if I need equal time. But you also get a certificate, Larry. And I got a letter from CDC.

With that being said, excellent presentation, Sarah. As usual, you do represent local health departments very, very well.

With that said, I also looked at North Carolina as an example. Now, North Carolina requires all local health departments to have state accreditation. So, I'm not sure how that works or where we are with that potential plan. Although they may not all have national accreditation, there is a requirement to have the state accreditation. And I'm not sure what is entailed in that state accreditation, strategic plan, CHA, workforce development, those requirements for local health departments. But it's part of the ... I think we have this Article Six requirements that we have to ... There are some deliverables. I don't know if that's something that could be incorporated so that everyone is on the same page. And that if they were to pursue national accreditation with PHAB, then they would have to just take that extra step. I'm sure it would not be as detailed, or a lot of work involved in getting that national accreditation.

Ms. Ravenhall: Thank you for sharing that. And I have a colleague in North Carolina who does what I do, so I'm going to be talking to him later about it. I know that Ohio State does require local health departments to be accredited, and that has been a significant challenge.

Dr. Boufford: That's important and good input. Yeah. I think we have time for maybe one more comment we need to wrap up because we've got to have time for our workforce presentation.

Ms. Edgar: I don't know if that conversation is being looked at the executive level. Maybe Laura can speak to me whether it's not. But Ohio is a centralized state. I don't know about North Carolina and because we're not, there is no mandate currently for local health departments to become accredited.

Dr. Boufford: You want to say anything about that?

Ms. Trolio: Thanks, Henrietta. This is actually really great conversation that I will plan to bring back to the executive leadership team at the department. It's important to be able to factor in the benefits and the costs for accreditation for the local health department and ensure that it makes sense. Obviously, accreditation requires the entity to look at their processes and ensure that it meets certain standards, which of course we all want to achieve a certain standard of excellence, but at what cost? And how can we partner to ensure that we're doing this thoughtfully?

Ms. Ravenhall: And for the record, we celebrate and recognize our accredited local health departments, but we do not support any kind of mandate for local health departments to have accreditation as a requirement.

Dr. Boufford: Okay. I understand Zahra Alaali has a comment and then we're going to have to wrap up and move on. Zahra?

Dr. Alaali: Yes. Hi. I don't know if everyone can hear me or not. I'm having some issues with Webex. But I wanted to mention that the Prevention Agenda guidance is actually aligned with PHABEC rotation domains and measures. So basically, local health departments when they seek accreditation, they're required to submit a challenge about community health assessment and community health improvement plan and a strategic plan. So, the guidance cover those two plans, the community health assessment and community health improvement plan, and all the required elements are aligned with FHAB accreditation measures and standards.

So, this is really the part of alignment between prevention agenda in terms of what is required, it is covered in the guidance, but also the timeline is aligned. Those documents has to be updated every five years for accredited local health department, and this is the requirement of the state as well.

Ms. Ravenhall: And I would point to ... Thank you for that, Zahra. That's very helpful. I would point to slide 13. I didn't have time to dig in on that, but those were some specific examples where local health departments have had

challenges in the past with alignment, not necessarily prevention agenda, but it could be an emergency preparedness grant funding they receive. So, it could be a CDC requirement or a state ... I'm not sure. Anyway, that could be some good information to look at.

Dr. Boufford: That's really helpful. I think this is probably worth another discussion here over the next few months in one of our meetings, I think the other point I wanted to raise, we don't have time, is the issue of whether its local health department is accredited or not? And is that something that could be useful going forward? But I'm going to leave that just hanging and maybe we'll raise it the next time around.

Ms. Ravenhall: We need to think about the value add for accreditation and how to communicate that.

Dr. Boufford: Politically, how could they take advantage of that? How would it be a win-win for them? Okay. So, we'll put this on. To continue that conversation, this is super helpful. Thank you.

We want to move on now to the public health workforce and infrastructure. This is the priority issue that we selected. Before Doug leaves, I just want to mention one thing that I didn't mention before. Sorry. Apropos of your office. I think one of the other sister activities relative to the prevention agenda and committee benefit is in fact this revising the CON language that links certificate of need for the acute care facilities. And there had been a notion in the FIPC that it would go beyond acute care with the prevention agenda. And I think it needs to be revised. We've talked about it a while, especially with the new incarnation of the prevention agenda. So, I just want to leave that as a reminder.

Dr. Fish: Yes. Got it. And I talk to Shelly regularly, so we'll take that and continue to work on it. Thank you.

Dr. Boufford: Okay. Thank you so much. I really appreciate you coming. Thank you. Also, Bella's staying, but thank you, Bella, for being with us now in that role.

All right. Keshana, over to you. And Keshana has done some great presentations. I think she's been caught in the middle of a reorganization's hiring staff and now probably reductions in funding going forward. But we did ask her especially to focus today on what she has done since the last time she presented, but what she'd like us to do to be of help to her agenda on this public health workforce advancement. So over to you, Keshana.

Ms. Owens-Cody: Thank you. Thank you all for having me. I'm excited to actually give you lots of updates on public health workforce and some of the

recommendations that you all have provided me during these meetings. I want to share with you how I've been able to implement some of those recommendations into some of our programming.

So, in the division, we do manage the Strengthening Public Health Infrastructure grant, which is charged with supporting and strengthening our public health workforce, increasing the size and diversity. Another portion of it is to strengthen our public health foundational capabilities as well as data modernization. For this meeting, I'm just going to focus completely on the workforce domain. The department so far, and actually we are I want to say capped at this right now, is the department has hired 133 staff on the public health infrastructure grant.

When Laura and both Henrietta reiterated and they were talking about public health being across the department, I would say that some of the roles that we have hired on the grant have actually expanded beyond just the Office of Public Health. We've also included our public affairs team, our Office of Health, Equity and Human Rights, just really recognizing where we have gaps in terms of public health programming and public health infrastructure. So, we have staffed in other areas besides the centers that are inside of the Office of Public Health.

Our local health departments have hired 159 staff. This does include New York City because we also are inclusive and engaged with their public health infrastructure grant implementation. In terms of workforce development, we have trained, we have seen 5,000 public health professionals participate in training across the state, which is really exciting. Whether it's in person, webinars, there's a lot of different training that our workforce development team continues to put out to our public health professionals across the state.

We are aligning better with our accreditation. We are supporting some of the workforce development planning that's underway. And as you mentioned, we are starting to look at succession planning. So, we are looking at all of the roles that are on the public health infrastructure grants, and we're going through a succession planning exercise as we speak and then being able to share that with our local health departments, our lessons learned with the local health departments.

So, in terms of career pipelines, that's what I wanted to focus on, our call to action today. So, we have a variety of different career pipeline programs to strengthen our public health infrastructure. One of those programs is the New York State Public Health Fellowship Program that all of us are very familiar with. I wanted to acknowledge this program, acknowledge the intensive efforts to help us with our COVID-19 response, but also strengthening our public health infrastructure. The impact was felt within

our local health departments, our community-based organizations, and our state health departments. Many of you may know that this program was funded under COVID-related funding from the federal government, and it will end on July 31st, 2026.

We continue to look for additional funding sources to bring in a fellowship program. We were able to mobilize 834 fellows. If anybody was at the conference last week, we actually just graduated 50 more. And this program really helped to bring in an excited, dynamic, innovative workforce, and we want to continue to produce programs like that. It's not funded through public health infrastructure, but I wanted to make sure that I brought the fellowship program up in our discussion.

Another pipeline program that we have within division is also the Pathways to Public Health Internship program. This program has, we have been facilitating interns fall, winter, spring, and summer semesters. We've had 44 students participate. These students are across the entire state. So, they're not just like here in the capital region. We've also located in our regional offices. We've excited, I would say, empowered a lot of departments or a lot of regional offices and bureaus and units to bring on interns.

It's a two-prong program. Our emerging supervisors are also getting supervisor and leadership training at the same time as the interns are also building a network with each other as well. So, we bring them together. We have community service projects. There's a lot of excitement around that program here and nationally. Our team has actually presented on ASHTO, or Association for State Territorial Health Officials, and there's just been a lot of kind of publicity around that program. Tuition assistance, we've talked about that in this group before.

We do have the ... Many of us are familiar with the Public Health Leaders of Tomorrow program we've expanded. We've added additional funding to support ... I think one of the things we talked about in this group is that DRPH is ... Not that it's not prioritized, but because it's for FLOT is for first time employees that do not have an MPH or a public health degree. And a lot of times maybe a DRPH is like someone may already have an MPH degree. So, we've expanded looking at the degree requirements, the graduate certificates that were under the initial FLOT program, and we've expanded. So DRPH is prioritized. UAlbany has also brought on graduate certificates like in health disparities and epidemiology. Those were in the initial MOU or the initial FLOT program, so those are being paid for local and state government staff to participate in as well. So, there is additional investments that have been put into FLOT.

Another area that we've been really focused on is our academic engagement and definitely got a lot of recommendations in this space for that. We've started to facilitate a work group internally to understand how DOH engage with our colleges and universities across the state that have public health programs, not only from a recruitment standpoint, academic career fairs and things like that, but also being in the classroom. How are we showcasing how does what you're learning in the classroom translate to going into the workforce? So, we've been very active in that space. We've organized a reference catalog that will be shared across DOH so that ... Like a toolkit for more to be able to connect with colleges and universities.

Another area that we're really strengthening is our K-12. We recognize that there's lots of opportunities in the K-12 space to also engage those students in knowing about public health and seeing themselves in public health careers. All of this, again, that we're building, we're sharing with our local health departments. So, we're very actively engaged. Sarah and I talk a lot. We're engaged a lot in our team, and we participate in their different conferences where they bring different things to their leadership team as well. So, our hope is to bring all these different initiatives, especially as it relates to building internships, fellowship programs, and bringing those resources into our local health departments as well.

So, my call to action is that all of these initiatives are on, I want to say, unstable funding. And I don't want to see all these efforts and this excitement that's around public health fall to the wayside because of funding. There's some problems that we have or some issues that we have ahead in engaging with our academic institutions. I don't know if any of you are recognizing there's a dip in enrollment right now. May 1st was the application deadline for fall. Some of our schools have seen a decline in just applications coming through. We're also seeing just a decline overall in students enrolling in public health. We're very data driven in our division, and we're also watching our public health workforce survey data that says we're anticipating 22% of the public health workforce will leave on their current positions as well.

Before the public health infrastructure grant, we already had challenges, as many of you probably could all attest to, is that we've had challenges filling public health nurses, data analysts, engineers, sanitarians, our backend infrastructure that includes fiscal, IT, human resources, and communications. So, with those challenges, we've talked about it in this group before that how do we continue to elevate public health careers, public health work as an opportunity for students to come into the field? We have launched a new public health works website so that students can see how to ... I mean, because there's lots of different ways to apply to get into public health. So, we feature the local health departments. We have

NYSACHO's information, and you can see how to apply for local health department positions, we have Health Research Inc called out, we have New York State Department of Health. We have videos too that also showcase ... And actually, I'm sorry, Sarah, to keep calling you out, but we have featured different videos so that students can see what different careers that are available to them in public health.

We also connect with a lot of other jurisdictions, and there's a lot of different campaigns that other states have done, like North Carolina has a great campaign about, "We are public health." But not only are they educating the public on what public health is, they're also talking about those careers. So, they're able to model both or dispel mistrust too at the same time as that they're also educating students on opportunities in public health.

There's some other states too that I could share, but I wanted to ... I know we've had this discussion in the past of how we continue to bring elevation to public health, public health careers. So, I was hoping that we could have a call to action or conversation on how we continue to sustain the momentum around empowering more students too, more students and more people to come into public health. We are seeing more people also fall into public health that we're in other careers and recognizing those non-traditional public health career folks that we need to, as I mentioned, communications, fiscal.

So that was my call to action to see if we can have continued conversations around how do we continue to just elevate the need for pipeline programs, the need for just awareness of public health in our state?

Dr. Boufford:

Yeah. I just want to make a couple of comments and then actually open it to the committee. I mean, one of the areas, a couple of areas of opportunity, I think we've talked about this but not landed on anything yet in relation to the call to action. There is no statewide organization of public health deans of schools of public health or directors of public health programs in New York. There was an incipient effort under the prevention agenda maybe four or five years ago, and it met a few times and didn't continue. And I think this issue is an opportunity. I was just thinking in terms of perhaps us having some public sessions in our meetings where we sort of bring in deans and directors talk about the issues they're facing, what some of the issues are in this sort of formal training.

I think the other issue is the last time I saw national statistics, only about less than 30% of people that are in the public health workforce actually have formal public health training, academic public health training. I don't think that's a lot better now. I'm not sure. So, it speaks about what you're

talking about. And being in a school of public health, the overall national applications are down 23% nationally to schools of public health for the MPH degree. And a lot of it has, along with schools of public administration, social work, master's programs and teaching, I'm just speaking about the NYU situation that people are hanging on by their fingernails.

And some of the issues, most of these students cannot afford the tuition because they're working and they can't afford the tuition of certainly of private universities or public universities. The DRPH program, which I've been advocating for is completely at the expense of the student, whereas PhD students and universities are fully funded with a tuition remission and a stipend. And this is a national problem.

So, the valuing thing, it strikes me that we could be helpful perhaps in trying to promote at least a network on the academic deans and directors within New York, because they have a national organization, but there isn't a statewide one and trying to give them some time to present their issues, have people understand it more widely. I would get my vote there in one of the areas.

And I guess the other area I want to raise is, as we know, and I'm not an expert on the governor's budget, but two years ago, last year, not this year, there was several of tens of millions of dollars were put in the budget to top up the salaries of healthcare delivery employees, of people in the healthcare delivery system. I don't believe there's been anything comparable in the public health space. So, I just want to throw those out there for discussion and ask my colleagues to jump in with comments. Yeah, go ahead. Ms. Soto, and then ... Anybody else?

Ms. Soto: Have you been able to track the students who have completed the fellowship? And have the majority of them or ... Where have they stayed? In New York or have they gone elsewhere?

Ms. Owens-Cody: Actually, I have those data points. 60% of our fellows have secured positions in public health and healthcare. Oh, I'm sorry. Is it on? Okay. 60% of our fellows have secured permanent positions in public health and healthcare. In terms of staying in our state, I would have to review ...

Ms. Ravenhall: Yes. I don't have a percentage, but the majority of fellows have stayed within New York State post-fellowship.

Dr. Boufford: And I would say relative to the cost of healthcare delivery system, nothing wrong with that either, but this is a rounding error relative to that in terms of potentially supporting the public health fellows, if nothing else, which provides additional staffing cash commitment, at least for more of a

contract commitment as opposed to an ongoing spending rate commitment for the state, yeah.

Yeah. Dr. Lim and then Dr. Eisenstein.

Dr. Lim: I don't have an answer to your question or to Dr. Boufford's question, but I also want to emphasize that I think in addition to what's already happened in terms of the decrease in the public health workforce applications and the schools, as people may know, there have been federal changes to the loan limits for graduate programs and professional students. And I think there may be an opportunity not only to talk about what the state can do about the public health workforce, but actually the healthcare workforce in general. I mean, this will be rolling over time, but I think that's like a developing snowball. So, I'm sorry to add on an additional complication, but I think it highlights the increasing urgency of coming up with practical solutions potentially at the state level.

Dr. Boufford: Dr. Eisenstein?

Dr. Eisenstein: Yeah. And great presentation. And you touched on so many important things. I love that you touched on the fact that very often academia and the real world disconnect. And having taught public health for a long time, that's always something tried to turn it into a real-life experience. But this is a dangerous and tragic number that you're talking about and a trend. And I think a lot of it has to do ... It was hard to recruit public health people into jobs like nursing to begin with when public health departments, especially local health departments, I remember when I was a commissioner, nurses were getting paid half what they were at hospitals or outside.

Who's going to do that? Very few unique people who either it's their mission, or they wanted health benefits, or there is an ulterior motive. But for young people coming out of school, I can make half and work at the health department or double and work somewhere else. I mean, this isn't rocket science to understand what the problem is. So, if we don't find a way to subsidize these roles, make them more appealing, the national sentiment coming out of the pandemic the first few months, we were the heroes in public health. Coming out of it the dark side of the story took over and I remember I was accused, "You're pushing the vaccine. You must be on Pfizer's payroll." I wish. I wish. But the fact is that misunderstanding has pushed, I think, fear into people.

And even in my own daughter who's graduating school, some of her friends are going into public health, they say they want to go into public health, but I'm not really sure they connect that to where we want them to

get. They know what public health is, they think they'll be doing good. But if we could find a way, I think this is so important.

And the other thing that's happening is the business world, in the way business has taken over healthcare, 10 or 15 years ago, you didn't see every hospital executive or insurance executive in healthcare or whatever going and getting an MBA. I think a lot of business has shifted away from public health to the business side of things. And we've been talking about the value proposition. The value proposition right now for getting a degree in public health, it's harder to define and to describe. And I think as a whole, we need to do a better job of that.

There's a lot of public health programs just on Long Island, I can name six or seven of them that I've lectured for or teach at. They're all competing with each other. The costs to get a degree. Some hospitals have deals where they'll pay for you to get that degree. But how's somebody who's graduating college supposed to spend \$1,000 or \$1,500 on credit to get a master's degree for a job that if they go to it is going to start them at 30 or 40 or \$50,000 a year? That's the reality. It really isn't complicated. The math doesn't work out in our favor right now, and I think we need to do something to fix that.

Another thing, one of my colleagues, I'm not sure of the details, so correct me if I'm wrong, but there's a public health leadership program that's only available through University of Albany. I love University of Albany. I have great respect for it. But out on Long Island or in Buffalo region, there are great public health schools. And I think the message if you live on Long Island is that this is an Albany-based program, you feel excluded. And I'm sure in the Western country, they feel that way too. And I'm sure in New York City, I'm sure there's a public school. Maybe this becomes not out of this wonderful capital ...

#### PART 3 OF 10 ENDS [01:39:04]

Dr. Eisenstein: ... This becomes not out of this wonderful capital city that we have here that I love visiting, especially when the weather is nice, but that we do this something that's statewide initiative and we tie in the, if it has to be the state-funded schools, I get it. If we can include all the public health programs, even better.

Dr. Boufford: It has to be. It has to be. I think it has to be beyond, because otherwise you've got CUNY and Albany and we understand why that happens, because the money is like a neo-state agency. Same with CUNY for City Agency. It's much easier to collaborate financially than it is with some of the other areas. But you're correct.

Dr. Eisenstein: I think we can do this. I think we have to do this. So, you've got my support.

Dr. Boufford: Yeah, that's great. No, I think we're... Let me get some other ideas or thoughts. Dr. Watkins?

Dr. Watkins: I don't know if I have any other ideas, but I just want to say your report was just excellent reporting. And to hear the stats that you had 60% of your fellows return to public health, that was a very good return on investment, especially when there's a shortage in public health workers. And so, to know that your fellows were able to fill some of those gaps really shows the need to continue and find resources in order to continue these programs going forward. I don't know where these resources will come from. I think if you do a very good report, maybe CDC... Oh, I shouldn't say. Well, maybe in the future, the feds may support this program going forward. You may look at other foundations that may want to invest in this going forward for good return on investments. And any other grant opportunities that might be available to continue to really look at the workforce for public health, would be ideal to look into going forward.

Dr. Boufford: It's another notion of bringing together potential donors and sort of awareness raising, et cetera. Marcus, do you want to say something? No, nothing? Okay. Denise? No. Okay. A number of ideas, maybe we can talk and follow up. I mean, I do think there is a real opportunity. I mean, let's just say something very simple, and a budgetary title might be just sort of as many public health fellows as would be useful to fill in that gap. And otherwise, I think when you get some of the other gaps you mentioned of environmentalists and nurses and other things, it gets more complicated. But a fellowship program that really provides infrastructure workforce and successful, that ought to be a selling point.

You mentioned a campaign. I think maybe hearing more about that in the public venue would be really helpful. And I don't know, I would love to see us try to do something with deans and directors statewide, because they do... I mean, as I said, there is a national organization and people scheme to that meeting every year because it is the only gathering place. So, I would think given in New York, we might think about figuring out how that might happen if the commissioner would be interested in it. I think it could be a very powerful sort of voice there. And we have a new health commissioner in New York City who might also be interested. He comes from an academic environment more directly, so I think that might be an interesting thing to worry about. I'm just trying to think of us being able to give, with our bullying pulpit, if you will, giving kind of public attention to these issues and how important they are.

The other thing I'd mention, you mentioned even in this environment, CDC is in fact funding a significant grant to the National Hispanic Health Foundation to make K-12 and community college, high school, community college Latino students aware of the fact that there is something called a public health profession. And I've been on an advisory committee with a few people there, it's been really interesting to the degree, they don't even know that the career exists. I mean, they know about nursing and being doctors and other things, but it's just the knowledge base about that as an alternative career is just not out there in the culture. And so, they have a four-year grant. NHF has a four-year grant to really work on that. So, we might look at some of those materials that might be used, I think, that are being developed in CDC or others for those programs that are continuing. See how they might be adapted to the New York environment, Keshana, by your colleagues. Yeah.

Ms. Farrell: Dr. Boufford?

Dr. Boufford: Yeah, please.

Ms. Farrell: I think we need a white paper on innovation in public health. Public health is kind of old and stodgy and not well-compensated, but if you look at what's happening in Washington DC, it's all about innovation and AI. And we can't get enough of it and it's all we talk about all day long. And so, maybe Michael Bloomberg, who's well-known for his interest in public health, if there was a white paper that talked about how we might do things differently in the future, maybe that's an angle worth pursuing to get some attention. All I know is there's a ship off of, I don't know, Cape Verde that has people with hantavirus, and apparently the death rate when you have hantavirus is like 35%. So, whenever there's some sort of epidemic or public health-

Dr. Boufford: Infectious disease always is a call to action. Anything else is pretty hard.

Ms. Farrell: Yep. Yep. And so, we have to capitalize on those moments when we're in the news, because we will be back in the news. There will be another epidemic, pandemic, that we'll get a lot of attention and we should harness that.

Dr. Boufford: No, I think your point is well-taken. As somebody who works mostly in global health over the last 10 years or so, the big killers in the world are chronic diseases, cardiovascular disease, cancers, and certain chronic pulmonary diseases. And we were sort of turning the corner on even paying attention to the role of public health and upstream prevention in that area when COVID happened. And so, we're back to appropriately focusing on infectious diseases, because politically people don't want to catch stuff and people don't want it to come into their space. You're right. I

mean, we don't talk about the other ways in which public health professionals can be really critical and can be important in terms of preventive programs saving money in the healthcare system, et cetera. So, I like that idea of broadening the presentation. Yeah. Ms. Soto?

Ms. Soto: So, there is also the interdepartmental collaboration. The New York State Department of Education have science technology entry programs. And they run, the step programs run from K-12 and there's the collegiate. And between those two funding sources, there's over 80 programs. And as Dr. Boufford pointed out, a lot of times students are interested in health, and what do they know? They know doctor, nurse, and maybe dentists, and there may be real interest or exposure to public health, the individual may say, "Oh, I want to go in that direction as to being maybe a direct provider," because those are the ones who are a direct provider. But I think it's a lack of awareness. And so, there are already programs that are state-funded, and those are five-year grants, by the way, that could be a source for outreach that you can do.

Dr. Boufford: Last comment, you get the last word, Keshana.

Ms. Owens-Cody: I was just going to ask a question back, but I'm curious, I guess something else to raise potentially too is also making sure public health is one of the identified degree programs or areas to go into, because sometimes those programs, even though it says... I'll do my research, and I'll reach out actually to that team, but sometimes public health isn't called out in some of those STEM, STEP areas.

Dr. Boufford: Usually it isn't at all, actually.

Ms. Owens-Cody: Yeah. So, I think that's another-

Dr. Boufford: Sometimes medicine in STEM education doesn't... The M is not for medicine. So, the sort of health professions in that STEM initiative is a really important opportunity, I think, is sort of inserting it in. Okay, we're running out of time. I do want to open the floor for any comments from the public. Anybody there? We have two or three people in the room. No? Okay. So, I think we're done with that. And thank you for a really rich meeting. Again, Mark, thank you for organizing this, the materials and everyone. Keshana, I think we can follow up on some comments and float some ideas around among our colleagues and see if we can get something going for our June meeting maybe. I mean, it's not too late to think about some panels or some further discussion in some of the areas that you think might be really helpful to you.

And we know we're going to hear more from Bella going forward. We have some commitments from that office. And Mark will keep us posted

on the work on the prevention agenda progress. The ad hoc committee is this afternoon. You have a very short lunch break. We're supposed to start at 1:00. The plan for the meeting is an initial sort of presentation of the prevention agenda to this group, many of whom will not have been involved in this process from before. And then we're going to have two rounds of breakouts, where the rooms, hopefully we'll have signs here on the tables where they can go to one of five domains twice to find out, as Mark said, what the questions are going forward. So, you'll hear that again at the beginning, but it's going to be a very interactive meeting.

And when we get the report out at the end, there will be people with each of the breakouts keeping notes on the kinds of ideas, the thoughts, the issues that are coming up, and we'll have a written report of that sort of at the end of the meeting for this. We'll have that to consider when we get together again. And welcome, Dr. Wilcox, who was sitting here before, but I want to just acknowledge your presence. So, thanks, Wendy, for coming. Thank you for being involved. Okay, so I think I can declare this meeting adjourned and grab some food and see you shortly.