

**NEW YORK STATE DEPARTMENT OF HEALTH**  
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**  
**PUBLIC HEALTH COMMITTEE MEETING**  
**June 23, 2026, 1:00 PM**  
**ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY**  
**TRANSCRIPT**

Dr. Boufford: [inaudible 00:00:00] here to remind everyone that the meeting is subject to the open meetings law and is being broadcast over the internet. Webcasts can be accessed at the Department of Health's website. The on-demand webcast will be available no later than seven days after the meeting for at least 30 days, and then a copy will be retained. Really reminding everyone, because there is synchronized captioning, please don't talk over each other. And the first time you speak, please introduce yourself and say whether you're a member of the council or staff. And again, the hot mics warning for side conversations.

And for those in the audience, there is a form out on the table outside which we've asked you to fill out before you come into the meeting. If you haven't got one, please get one. And this is required by the Joint Commission on Public Ethics, and the form is posted on the Department of Health's website for the future for those who wish to do it before they arrive.

So, I think that we'll do it for the preliminary remarks. We have a great agenda. A lot of staff have done a fantastic lot of work between our last meeting and this meeting, and this will be a busy analytics season coming up because of all the things that have been listed. But I want to thank Liza Whalen, especially her team and Mark Ansara who's online I think with us there, and Bella, who we'll talk to you later on.

Quick overview of the agenda. We have prevention agenda updates again to remind members that PHHPC has a statutory responsibility to help sort of create and oversee the implementation of the prevention agenda. So, we have that regular responsibility as an agenda item, and we're going to hear good updates, and I think very exciting report on the ad hoc committee meeting, which was held on May 6th. Very well attended. We can talk some more about that.

Bella Elogoodin? Okay. Elogoodin, who is in Doug Fischer's office, is going to report to us on community benefit, what the state has decided to do this cycle, and how that's going to play out because,

as you recall, this was one of the areas that the committee is tracking related to the prevention agendas, not specifically prevention agenda. And so, we'll be happy to have reports about that.

And then we had selected public health workforce as our sort of issue area, and we've been hearing a lot of reports lately, status reports. We have another good one today, I think about. And this first time there's been a sort of workforce analysis done in quite a while. So, we'll hear about that. And I think we're still, we have some candidate issues to work on collaboratively to try to address some of the problems that have been identified, but I think we still need to zero in on one or another. So, I think, with that, I will hand it over to Dr. Whalen for any opening comments.

Dr. Whalen:

Thank you so much, Dr. Boufford. I'm not going to go over the agenda. I think you just provided a wonderful overview of it. We're really happy to spend this time with you today. I think a particular focus today is going to be talking about the ad hoc work group, which as you know in this cycle of the prevention agenda, one of the things we were really excited about doing is developing an interagency task force.

And this first meeting was a great gathering of partners old and new. So, with the focus on the social determinants of health, we have really been able to expand the reach of the agencies and partners that we're working with to reflect the broader focus on the social determinants of health. And I really think that this is going to allow us to collaborate in a much more meaningful and impactful way to spread the work of the prevention agenda across the state, and really establish what the prevention agenda and state health improvement plan was meant to do in the first place, which is to create a collective impact, and to create this awareness across the state so that there is opportunity to collaborate.

The work and discussions at that meeting, Mark is going to be talking about, but I think there was a lot of very meaningful discussion and partnership opportunities. I just want to thank everybody that participated in that. And this is going to be kind of a living group. So, if there are those that haven't participated before that are interested in joining, please reach out to us.

I also want to just take a second to mention that we're very happy today on the latter part of the agenda to have our partners from the New York State Association of County Health officials who are very great collaborators in the Office of Public Health and across the

department on some of the work that we do with the local health departments. Cristina Dyer-Drobnack, hi Chrissy, is here today to present to us on that workforce enumeration survey, and we're very happy to have her. And with that, I am going to turn it over to Mark Waldenmaier to get to the meat of our agenda. Thanks everybody.

Mr. Waldenmaier: Thank you, Dr. Whalen and Dr. Boufford. So, my name is Mark Waldenmaier. I'm the director of the Office of Local Health Services, and glad to see a lot of my team in person here. So, a lot of the audience you see here is part of our prevention agenda team who have been working on all these projects that I'll be talking about, and Dr. Whalen and Dr. Boufford also referred to.

So, I wanted to start off just with a local partner update. So, one of the things I wanted to remind people of is we have the hospital community service plans already to us. They were due in December, but now we are getting the final plans from the local health departments as well. So, as we said, this is definitely going into analysis season. So, by June 30th, we're going to have all of the plans across all the main partners, the hospitals and the local health departments, and this will really be something that we'll be talking a lot about in all the future meetings in 2026 and 2027.

But along those lines, and the May 6th ad hoc meeting is going to kind of be a theme of all my updates. I wanted to point out one of the opportunities that in DOH we have been working towards. We have an RFA that's currently out. And one of the handouts that you have describes the basic scope of work of that RFA. We have a number of candidates that we're reviewing right now. But this project is really going to help us with doing more work amongst the different local partners, the local health departments and hospitals, but we really want to bring in community-based organizations as well through this project.

So, as you look through the deliverables, there are different activities that we're all going to report on the public health committee and the upcoming ad hoc committee. We have first delivery, which is statewide information needs assessment. So, the contractor will be able to do a report and recommendations based on that. Then they'll probably be working with us with the ad hoc committee or some other forum as a work group to kind of talk about that information needs assessment and next steps.

With the most important next step being something we heard a lot from the partners in the May 6th ad hoc committee, and we've heard actually from a lot of partners in a lot of different forums, is

we're actually going to have regionally based in-person summits across New York State in order to really focus on how did the prevention agenda planning go for the local partners in this current cycle, and then what are they moving towards implementation-wise? So, a real chance to hopefully bring all the partners together, discuss things. We know there's other forums like NYSACHO and HANYS and Greater New York that they also talk about this, but this will be another chance to bring that together as we move from planning to implementation. So those are going to be a couple of great activities and forums to kind of take what we're talking about on the ad hoc committee and provide that information more directly at the local level, which a lot of the ad hoc committee members pointed out as what we really should do.

The one other thing I'll talk about with this is we are partnering closely with our Office of Science within Department of Health. They're the ones who help us with the prevention agenda dashboard. And that dashboard is a keyway that we keep measuring the metrics and looking at changes over time with all the interventions that are identified within the prevention agenda. And so, we're hoping that it will also be an opportunity for the local health departments to connect and be able to understand kind of data systems and other resources we have in place for those measurements. Anyone have any questions on the local plan updates?

Dr. Boufford: Just to clarify, I think you will receive this by email, but in your place there are the notes from the ad hoc committee meeting, which I think Mark's going to get too next. Also, the item that was sent out, the questionnaire that was sent out to CEOs of hospitals relative to the Schedule H and community benefit is also here. They're both pretty thick, but they're there. So that's available. And then similarly, you didn't say anything about this, Mark. [inaudible 00:09:53].

Mr. Waldenmaier: I'm about to.

Dr. Boufford: Oh, you are? I didn't know when you were going to do it. But anyway, just so everybody knows the material that's at your place in supplementing the discussions we're going to have. Thanks.

Mr. Waldenmaier: So as Dr. Boufford just pointed out, we also have a very colorful fact sheet that we've talked about in a couple of previous meetings. And one of the things Dr. Boufford and Dr. Whalen has asked us to do is make sure we keep giving updates on kind of how we're working across different partners to socialize the prevention agenda.

So, this fact sheet's going to be a key part of this. And this was actually something identified in the planning of the state health assessment that we really wanted to connect more with the general public on what the prevention agenda is. It's a big tool that we use with all of our professional partners and professional organizations, but how do we get it to understanding, the plain language for more of the general public? And we've been working with our public affairs group to develop this fact sheet.

So, all of the language has already been approved within DOH. We are working a little bit more on the graphical structure for two main reasons. One, this is going to be translated into multiple different languages, and of course that translation then kind of moves things around. And the other reason is because we are going to develop it to allow the local health departments to do co-branding. So we do that with a lot of our information sheets and posters and things like that where they'll be able to add on the back of this with some of the other QR codes, maybe a QR code talking about their own community health assessment and community health improvement plan, and be able to use this fact sheet in their own ways for their own fairs and other activities, school fairs, school activities, anything like that.

So, we will also mainly be using this more in its electronic format and so we will be adding it to the DOH webpage. And again, as we set that up in the DOH webpage, one of the key things we want to do is kind of still help that public to connect with those local partners because we know those interactions are the most important for the prevention agenda.

The other outreach and collaboration activity I did want to mention is Dr. Whalen and I just last week did meet with the New York State Health Plan Association. They have their clinical directors committee. So, we met with them and gave them an overview and an update of the prevention agenda. That's the type of activity we really do keep on looking to provide to different partners. We are requesting the ad hoc committee to identify any opportunities for us to do that as we move forward as well. So again, we keep trying to spread the word and get real people to understand the prevention agenda and see how they can be partners with that. I don't know, Dr. Whalen, if you wanted to...

Dr. Whalen: Sure. So, I just think...

Ms. Soto: Nilda Soto, excuse me, member. You mentioned the different phases and processes of this flyer. So, what's the projected date?

How much more do you need to go through the different stages of it or approval and so forth?

Mr. Waldenmaier: So hopefully very near term. I'm looking to Gina, who's actually our communication lead in our office, working with Public Affairs Group for at least the English version. Our internal goal has always been the upcoming New York State Fair. DOH always has a booth at the state fair, so we wanted to include the prevention agenda as part of that. Oh August, thank you. August. So should be very short term. And then once the final version is done, I will send it out to Dr. Boufford and all the community members so you can have it as well. But we will have a distribution plan kind of in place, and we'll probably talk more about that at the next meeting.

Dr. Boufford: I think as always with this committee, you're welcome, this is to you in draft so that you can give comments back if you have any comments or feedback for Mark. I'm sure he'd welcome seeing them at this point.

Dr. Whalen: Absolutely. I just wanted to make a quick comment on the health plan director's meeting. I think it's important to recognize that when we usually speak about the prevention agenda, we're talking about the local health departments, the hospitals, and the community-based organizations that are working with them. The plans are really positioned well to be very important partners. I think that there has been a strong change of focus of most of the health plans over the past 15 years or so to understand the importance of prevention, understand the importance of putting some of their funding towards prevention, and of meaningful partnerships with the regional bodies that they work with.

So, there are some states that kind of have baked into their state health improvement plan that the health plans are a formal partner. New York State is not one of those states yet, but we do recognize the important contribution and the important possibilities that can exist when partnering with health plans. I had the opportunity to work as a health plan medical director for CDPHP here in Albany. And I know at the time, that was back in 2010, they were exploring utilizing community health workers. And so many of the metrics are trying to establish their HEDIS metrics and others involve making sure that their members have preventive services. So, it is a good fit, and it is something that we're interested in exploring going forward.

Dr. Boufford: If I can add on, I'm really glad that you brought attention to the health plans because, in effect, in the current financing system,

they are the only entity that has a win-win to keep people well, which is really what we're about. And I think you're right. A number of them are doing a lot of outreach, district health offices and others. So, they're very interested, and I think we've sort of overlooked them. I think in New York there is sort of a lot of conversation that is so dominated by the provider side of the world that we really haven't engaged some of the payers and the health plans in the way that we might go forward. So, we've had people from time to time on the council, but not very many. So, I think it's great.

Dr. Whalen: Yeah. I think historically the plans, and this is going back many years, were focused on initiatives that would create a return on investment in a short period of time. And what all of us know is that prevention takes longer. But given the preponderance of chronic disease, the costs that are escalating very rapidly, it really, I think, behooves, I think they all are realizing that it makes sense to make those long-term investments, and this is a great opportunity for us to collaborate, given the fact that they are also able to spend money a lot of times on these efforts.

Dr. Boufford: Dr. Eisenstein.

Dr. Eisenstein: Yeah. So, thank you for the presentation, Dr. Whalen and Mark. Question that I've had been simmering in my mind, but it was premature until now where you're getting ready to go live. By the way, Larry Eisenstein, council and committee member, this is somewhat new process, new version of the prevention agenda. And a lot of it sounds great, but as we know, and we know public health takes generations, a lot of it sounds great in public health, sometimes that proves to be true and then sometimes it doesn't. There are a lot of great ideas that actually didn't make an impact while others we didn't think about made a dramatic impact. So now I think it's a reasonable time to ask what evaluation you are planning and how you are going to determine if these changes worked and how we're going to move forward with that.

Dr. Boufford: Can I ask you to hold that question because we cut Mark off. He hasn't finished his presentation. I think I'm going to ask him to talk about the ad hoc committee meeting and then come back, Larry, to your question right after that because-

Dr. Eisenstein: I don't know if I can repeat it so eloquently the next time.

Dr. Boufford: I will remember what it was.

Dr. Eisenstein: All right. Thank you.

Dr. Boufford: I'll remember what it was. I'll remember it. Mark, please go ahead.

Mr. Waldenmaier: You'll won't have to repeat it, Larry. We'll be good. Okay. So final agenda point is one of the documents that you all have. This is still very draft. You'll notice it. Dr. Boufford, I, others, as we've looked through even this draft version, there's edits that need to be done. But we wanted to be able to at least provide to you the summary of really just the key information from all the partners that were on May 6th and hoc committee.

I know a number of you were there with the partners, but there was five breakout groups. You couldn't necessarily be in every single breakout group. And so, this is what's something we're really hoping to, not just share with you, but really be a tool of resources for our local partners. So, you'll see all of the attendees are listed in the first couple of pages, as well as then the rest of the summary report breaks down the five social determinant of health report outs from all the individuals into, if you remember, we had three questions. So, two of the questions are contained by social determinants of health, but the third question was one where basically as we worked with NYSTEC who helped us put this report together, we really saw there was enough commonality between all of the different work groups to just make it its own single section. And that was the question basically about what resources do you need from us and DOH to help basically promulgate the prevention agenda further?

So, this is a document that we got a lot of positive feedback from all of the ad hoc committee members during the meeting as well because it really is being able to provide the information of looking at all that we do as partners in order to help support and advance the social determinants of health. I think Dr. Whalen almost gave a summary of all of this already with talking about partners old and new and looking at prevention as a longer-term measure. Again, I was impressed with how many other partners are really focused on the social determinants of health with us, but they're identifying those same types of issues is how do we measure that longer term? How do we actually show that we're looking at impact?

There were a number of other key areas that a lot of the partners brought up during the meeting. Again, the sharing of information and resources, which I think in part is things like this fact sheet or things like our webpage, we're going to try to look at better ways to be sharing what's already on there. Because I think there are a

good number of resources that people were looking for, we do have connections too. But we also are going to be looking for, in our final version of this, adding a lot of links to what our partners shared.

Because part of those regional summits that I talked about in the fall, this is going to be one of these documents that we'll be providing to all of our local partners so they can see what all of the other statewide organizations and state agencies are also considering and thinking about with the prevention agenda and what resources and different services they may have so that those local partners either can connect with them in order to help with their identified interventions, or even possibly just start connecting now so that when they move towards their next round of planning for the prevention agenda, that they'll already have those partnerships established, and we'll help them plan that much more for the next round.

So, it is 24 pages. I would recommend, just like the state health improvement plan, that reading it from start to finish is a lot to digest. But again, it's broken up into those social determinants of health. So, it's really one of those things where, if you have a priority that you're really focused on and interested in, you go look for that priority within the specific social determinant of health in order to read the document, but it is something we want to share. If you have any comments, please feel free to email me about them. But it is just a draft version. We will be going through and finalizing it and then going through full approval because we've already had interest from the ad hoc committee members that, not only do they want to see this report, but they also want to distribute this to their own membership in order to really show the prevention agenda and the cross collaboration that is going on with the ad hoc committee.

So again, there are a lot of good positive out of this report. It will take us a few more months to get it finalized and through approval, but then I think it'll be a great tool for a lot of different people. So that was it.

Dr. Boufford:

Okay. I want to emphasize a couple things about this because I think it becomes relevant again when we get into the community benefit conversation. Liza mentioned the state agencies. And I think if you recall, there's like one sort of magical slide when we've had their prevention agenda presented where we have the so-called domains, which are the five social determinants. And under each domain, there are a set of objectives that are priority areas under those domains, and that's kind of the framework for this and also

similarly the framework I think for what we'll hear about from the questionnaire that Dr. Fisher's office has issued.

But I want to emphasize on the especially, I'm just trying to see it, page three, which is the agencies that were present, this is where the action is really on the domains, the five domains, because only the one really around access to healthcare is sort of, if you will, totally perhaps in the control of the health department. The others really depend on other agencies for action. And as Liza said, partnerships with other agencies.

So, for those of you that were there, there were two rounds in each of the domain areas. So, you had a chance to be in a couple of areas. I sat in on the ones that are sort of atypical ones, I guess, the economic development and the education one. And we had actually a very senior person from the Department of Education and a regent. And I don't think we've ever had anyone from education come over and be part of this. And I was praising them profusely and thanking them for coming, and they said, "Well, nobody asked us before." So anyway, that sort of tells you a little bit about that interagency challenge, I guess, that we all face.

If you look through the notes of Department of Transportation, which seems to have a good bit of authority, I mean, this is an interesting thing about state agencies. Some have a lot of statewide authority directly from the state, others don't because the local zoning rules or local rules sort of preempt that authority, but they were pretty active.

I also wanted to call out the Department of Ag and Markets, which is really a terrific agency. They've been working with the prevention agenda for a long time and Department of State, which has also really helped a lot in terms of funding technical assistance and others. But I think one of the things I'm going to ask Liza to talk about a little bit is the thinking on the follow-ups because there's, between now and the next ad hoc committee meeting, which is going to be September 3rd, we want to definitely have follow up with the agencies because they will eventually need to work with the department to deliver in the larger domain areas and kind of be able to answer part of Larry's question, which is what does success look like in the domains where the department has less authority.

But the other reminder is that this group is a sort of instrument of this committee of the PHHPC. It was created initially to be the public advisory committee for the voluntary accreditation of the state by the national accrediting body. So, it has a sort of standing,

many of you were there, but it is advisory, whereas this committee is sort of to the degree there are decisions that need to be made and recommended to the council, this group is that group. But maybe Liza, I could just ask you, because the interagency interaction, this is a great first step of bringing these folks to the table, what the thoughts are between now and the fall relative to that particular group of folks.

Dr. Whalen:

Thank you. And in particular, Dr. Boufford, I'd like to thank you for highlighting the tremendous cast of characters that we attended this meeting. It was, as we said, partners that were old and new, and certainly for some of the newer agencies, like Department of Education, I think there is great recognition that, when we work together, we work stronger and harder and in more meaningful capacity.

And so many of our partners that have been in collaboration with us will come to us and say, "Well, this is kind of our area of expertise." And our answer is always, "Yes, that's why we're asking you here." And it really is how we utilize the broad public health lens of public health as a convener, public health as a bridger, so that we can inform the local plans and the state plan as we continue to move forward.

We want this to be a very dynamic process. We want it to be meaningful for those that have given us the time to engage. So, it's going to be very important for us to reflect on what the discussions that occurred during this first meeting were, how we can utilize those discussions to further tailor our efforts, to focus them and to kind of filter things up and down. So, filtering things up is kind of creating these opportunities for collaboration that we can share between agencies at the state level. There are opportunities for state of the state. So, I mean, we're looking at opportunities for how we can expand nutrition as a focus across the state, for example. And this is a great way to make these relationships as meaningful as they are, a little bit more meaningful and a little bit more purposeful when they're focused on specific things.

So, there is going to be the kind of distilling down of what partners brought to the table, brought to share. And then when I talk about bringing it down, I mean, it's not down because it's the work of the prevention agenda is with the local health departments and their hospital partners. That's the boots on the ground stuff. How can these partnerships inform the work that's being done with boots on the ground? How can the larger agencies collaborate across the state with those that are working in localities? So, there's

tremendous opportunities here, and we are going to make sure that we follow up with the agencies that participated so that we can, as we said, kind of tailor and refine these things going forward.

In terms of measurement, I'll come back to Dr. Eisenstein's question about that, there's several ways that we are really looking at highlighting this iteration of the prevention agenda, which we want to, once we get the plans back, once the local health departments and the hospitals start on their work, it's not like we close the book and say, "Okay, we're good till 2030." It is going to be really important that we continue to look at the great work that's being done across the state and that we highlight the opportunities and the collaborations that are occurring.

We partner very often, as I said, with NYSACHO, so we want to hear about what the local health departments are doing. What's working for them and what can we highlight as best practices across the state going forward. In terms of formal measurement, we know that the prevention agenda dashboard-

Dr. Whalen: In terms of formal measurement, we know that the Prevention Agenda dashboard has been launched, and that is going to be kind of keeping track of where we are going as a state. That data dashboard will be updated at least twice a year. There is going to be opportunity as we go through this cycle to reflect work being done in real time and see changes that can be made. As I indicated last time with a lot of prevention efforts, you don't necessarily see immediate overall health changes, but we urge our partners as well to focus on intermediate measurements. I think that we all have an idea of what is beneficial from a public health perspective. So those process measures are important as well going forward, and we are going to be kind of working with our partners to hear more about that going forward and be able to share that with this group as we continue the work of this cycle.

Dr. Boufford: Okay. Let me ask for questions, and comments from members of the committee on this segment.

Dr. Soffel: Hi, Denise Soffel, committee member. I have been asked to make a small commercial for this group. I sit on the advisory panel of a project that's coming out of the Scholar Center on oral health access, and they have just launched a statewide initiative to enhance oral health access across the state. And one of their specific goals right now is to allow dental therapists to practice in New York, recognizing the incredible shortage of dental care providers, especially in more rural areas. And so, they've just

launched a statewide campaign, and the first push is going to be a bill that actually would allow dental therapists to practice in New York State. But they felt like because the Prevention Agenda specifically speaks to oral health access that I should bring their message to all of you. So, I am bringing my message to all of you. And I think that, I mean, oral health is such a critical piece of all kinds of healthcare that we don't even think about. And it's, I think, a really important and very under-looking area in prevention.

Dr. Whalen: I agree with you 100%. Having worked at Albany County on getting water fluoridated, which was a huge undertaking that was blocked for about 20, 30 years. We know oral health influences so much, particularly for children, it influences their education, it influences their socialization, it influences mental health. And in older adults, we know it affects many different areas of health. We have a tremendous shortage in particular of Medicaid dental providers across the state. And this is something that we're committed to working on. It is part of the Prevention Agenda. So that is a great effort. I've heard about that legislation and we're very willing to partner with this group going forward. Thank you.

Dr. Boufford: Yeah. I want to thank the New York State Dental Association for being a member of the ad hoc committee for the first time. They had not been there before, so this is terrific.

Dr. Soffel: Although dentists are not terribly keen on expanding

Dr. Boufford: Don't get started. Don't get started on the dentist's situation. Our planning committee went through about six months of conversation about emergency rooms and dental availability and stuff. So, it's a huge issue. I think everything that has been said is important, but at least they've come to be in the conversation, which Skylar ought to be on the ad hoc committee too, I would have thought.

Dr. Soffel: I believe that they are. [inaudible 00:33:28]

Dr. Boufford: Were not able to be at the meeting. That's great. Okay, good. The only other thing I was going to say, Mark and I were kibitzing ahead of time that some nice young person or student probably could claw on this and come up with some key themes, maybe some geographical issues, some other areas or some kind of qualitative analysis. So, we'll try to see what we can throw at it in terms of getting it down to digestible bits, especially relative to the point, which is to say what all the great ideas that came up, where the collaborations. And some of them repeat in different domains. And so, the key would be how do we connect the dots across these

folks because it was a very dynamic and exciting meeting, I think. Did your question get answered, Dr. Eisenstein?

Dr. Eisenstein: Good.

Dr. Boufford: Good. Okay. Anybody else want to make any comments on this point?

Dr. Watkins: Sure.

Dr. Boufford: Oh, I'm sorry, Dr. Watkins.

Dr. Watkins: No, thanks for the presentation. Excellent presentation. Kevin Watkins, member of the council and member of the committee. As the date for the plans are due June 30th for local health departments, I know that for the hospitals they were due December 2025. Do we have a percentage of how many plans are still outstanding by chance?

Mr. Waldenmaier: I don't know if Dr. Alaali, I know we're just in the last few and we haven't had any extension requests, which is good, but we did get a lot of the local health department plans in already. At the last meeting I reported out we do have about 31 joint plans, which is that having the hospitals and local health departments work so closely together that they agree on the singular plan, even though we know they do a lot of collaborative planning in a lot of other ways. I don't know. Dr. Alaali, do you have that number?

Dr. Alaali: Good afternoon. It will take me a few minutes to grab the numbers.

Mr. Waldenmaier: So, we can get back to you on that, Dr. Watkins. But we're very close to the end and we haven't had any indication from the local health departments of any issue meeting the deadline. So, we're pretty confident. We've just met recently with a lot of local health departments in NYSACHO's, CHA, CHIP work group as well. So usually, they flag things for us if there's something of concern upcoming. So, we think we're good to have that all set for June.

Dr. Boufford: I think the one thing to add is because we did lose the cycle. They had been a collaborative concurrent cycle, and we lost that through the last prep period. But I think you mentioned that maybe 40% thought you did the work together for the December deadline, and the others were given the extra six months and asked to actually to consult with what would have been their hospital partner in a joint effort to see to the degree to which they could be aligned. So that'll be really interesting to hear how that happened. This has been an

ongoing conversation around the Prevention Agenda because the collaboration and the sort of doing this work together has been collaborative, has been voluntary as opposed to thou shalt. So, it's been going on for about a decade now and I think we've maybe had 41% of folks doing it together, but I think a lot more may be happening together. It'll be interesting to see how that works out.

Ms. Farrell: I just want to note again-

Dr. Boufford: Ms. Farrell.

Ms. Farrell: Ms. Farrell on the committee, the aggregators of healthcare in the community are indeed health departments, hospitals, but there are others out there these days. And I understand that that's where you have your leverage, but the social care networks are happening and there's data. And again, all of that sorts of feeds into the Medicaid system so happy that the plans are involved. But I do think finally we've got these things off the ground. Finally, there's actual data points around community-based organizations, and they are the entities that are aggregating a lot of activity at the community level. I'm curious to know how we can sort of incorporate them because I think maybe you could do it with ease.

Dr. Boufford: One of the things we tried to do before or in this report that was coming in from the local health departments is, we always did a slide that said, "Who's at the table in your county?" And trying to be very specific, it was business, was CBOs, academia, advocacy groups, et cetera. And I think we want to be sure that's incorporated in the... It's not on the dashboard itself, but it was always in the sort of reporting part, because that really tell... I mean, one of the things that helps you figure out if there are counties or local health departments that aren't able to get or aren't reaching out properly to get CBOs involved. And we can certainly get the data from the social care net... From the waiver, although it's for there for very specific, as you know, for pretty narrow populations relative to the general need. But I think that issue is really important.

Ms. Farrell: The screening is robust and when the screening leads to the spending of Medicaid money, right? I think there's probably some very important lessons there that aren't historically captured in claims data or in hospital admissions and what have you. So, I just think it's probably a data source that should be evaluated.

Dr. Boufford: I noticed Amir Bassiri is presenting to the FIPIC tomorrow, so we should ask him that question when he's presented. I think that's really important. Any other comments, questions? Okay, great.

Thank you. So far, so good. This is really terrific. Very exciting. Okay. Our next agenda item is from Dr. Fish's office, Bella Elogoodin, who's our liaison on community benefit. Again, this is a longstanding sort of issue that we have... You'll remind everybody what community benefit is and what our focus within community benefit has been. This is a really important area.

And thanks to the governor's request I think a year ago on their budget message was really asking Doug's office to bring attention, charging the commissioner to bring attention to the reporting that hospital voluntary hospitals were doing on their community benefit contributions. And our issue has always been with community building, community health improvement segments to try to move towards, not that hospitals aren't doing a lot of things in that space to move more towards evidence-based interventions that are more aligned with the Prevention Agenda. So, Bella, do you want to start? I don't know what you are doing.

Ms. Elogoodin: Happy too. Absolutely. Can you guys hear me? Yeah. So, Bella Elogoodin here-

Dr. Boufford: You have a copy of the form that's being sent out at your places. Go ahead.

Ms. Elogoodin: Thank you, Dr. Boufford. Thank you everybody. Yes, the guidelines went out as of June 8th. I want to take a moment to thank each and everyone here in contributing to making sure that we have the guidelines that the letter went out as of June 8th and it's focused specifically on two specific components. So non-private hospitals will be uploading into the survey that we have developed with the Office of Science, which is the survey management and response tool. They created a specific space within that digital survey where hospitals that are nonprofit will be just uploading their Schedule H (form 990). There will be a question to Dr. Adelstein's point when you ask if there are certain things that are not reported in 990, how hospitals can actually go into describing what else they're doing. So as soon as the nonprofit hospitals are uploading that Schedule H form 990, questions will pop up asking them and they will have that opportunity.

I was actually impressed when the letter went out on June 8th, I started getting a lot of calls and emails, which was a good thing. It only shows the commitment from a lot of hospitals on how they are seriously focused on ensuring that we get the information so when we do analyze the report, we can actually see the contributions and the value that the hospitals are bringing. Now, when we look

specifically at public hospitals and there are about a total of, I want to say about 27. So, in that survey that we've developed, given that they do not file with IRS, there are some specific questions that are aligned with Schedule H (Form 990), and these hospitals can just go question by question responding. And because we aligned it with IRS form, there are some questions on IRS forms that are optional, and some are mandatory.

So, to this day, I've received a few questions from public hospitals as well. In terms of the number, given that we have a total, I want to say about 219 hospitals and 192, I believe nonprofit and the rest is public. We so far to this moment right before I came here, I wanted to see the actual numbers. So, we have a total of 72 surveys uploaded so far. But also, because we had some glitches in the system, a lot of hospitals sent me emails and called me saying, "Hey Bella, we're trying to upload the information we can't." I'm like, "Yes, very sorry for this inconvenience. We're experiencing some glitches and Office of Science is working diligently in making sure that they resolve the situation." My hope is finger crossed, that it's going to be resolved by end of day today, but I will obviously keep everyone posted and we'll make sure that all the hospitals are aware so to ensure that they know that they have a lot to worry about.

So, I want to give them peace of mind and they, I think at this point have our number at the speed dial. So that's the information. If we want to go into specifics to Dr. Boufford's point on what are those questions within the survey management and resource response tool that we put together, those are the questions. If you look at the IRS forms, there are some specifics from part one on question seven, financial assistance and other community benefits at cost. Some of the information here is mandatory, some are optional and then we'll look specifically at part two on community building activities, looking specifically at physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, workforce development and other. We also included some open box areas where people can go into narrative in describing what it is that they're doing in supporting local communities and how it is aligned eventually with the Prevention Agenda.

As I look more into it, and a lot of support that came from Mark's office and Zara, I definitely see a lot of collaboration, a lot of communication almost every day with Mark in making sure that as

we get closer and again, it's first year as we're going to learn a lot and put the report together going forward, we want to make sure that there is a little bit more closer alignment with Mark's office and specifically with the Prevention Agenda and that's the goal for us going forward. Obviously I want to see if you guys have any questions or comments, compliments? Negative, and then I'm [inaudible 00:44:56]-

Dr. Boufford: Let me just emphasize a couple, because I went through this. It's really helpful to get the whole printout. It's obviously dropdown menu. But I think just to really reemphasize the areas that we have been very interested in, one is, I think you didn't mention community health improvement services and community benefit operations, which is one of the headings and that's a really important area there. We're trying not to get... And then we're interested, as you mentioned, the other ones that you mentioned, Bella, the physical improvements in housing economic development. The other areas that are not specifically subsidized care, unreimbursed care, GME research, that's not what we're focusing on.

And the reason that this sub area, and I think we spent some time in the last public health committee meeting, a few, maybe not the last one, the one before that, sort of looking at the current draft of the Schedule H to look at that segment and try to see whether there might be tweaks to that segment that might have been implemented this round and decided that it wasn't feasible, and this is a good baseline for the next step because we want to be involved. But we do have good data thanks to one of our former health department employees who's just gotten his PhD at, well, not almost a year now at the University of Albany, who has records by hospital, by category of community benefit for the last nine years, 10 years, and is still keeping that database active.

So, this one category is a small part. It's been historically a rather small part of overall community benefit, which is quite significant. I think it's been 0.08% overall and that's kind of what we're looking at. It's just important because there are a lot of people here at community benefit and they think, wait a minute, we're dealing with all the people that can't pay. We're doing this for residents. We're not talking about that. We're talking about this other category to really make it more evidence-based and more directly aligned with consortia working in communities to fund that money. I think the last time I looked at those numbers, which was a while ago, but there's almost \$200 million in that one category, and that's not as

much money for healthcare delivery, but it's a lot of money for public health.

And if we could figure out how to steer that in the direction of collaborations and alignment with Prevention Agenda with health departments working with local CBOs and health centers and others and their hospitals, it would make a big difference because there's not a lot of other money, certainly not at that level floating around to fund public health. So that's the nature of the focus. And I just want to keep contextualizing that so people can really have those conversations, especially with hospital colleagues that are feeling the pinch around their budgets themselves. So, Dr. Eisenstein and then Dr. Soffel.

Dr. Eisenstein: Thank you, Larry Eisenstein, committee and council members. So, Bella, thank you. We've discussed the IRS responsibility multiple times. Certainly, their definitions are what they are, but I think it's really important you address this, and you did address this, Bella, that it doesn't always show the whole picture. And I think before, not that anybody here's vilifying anybody or the hospitals, but before we make a judgment, I do think we need to look at the whole picture beyond what the specific definitions are. Yes, we have a legal requirement with the IRS to fill out those forms. But again, if work is being done to help the most at risk or the neediest people and a hospital is able to partner with somebody who has the resources to do it, the hospital doesn't get to claim any benefit from that, yet there is a benefit to the community that the hospital is responsible for.

So, my point is, thank you for acknowledging that the picture needs to be a whole picture of everything that's happening and not just what falls into certain checkbox categories, even though legally we have to send them in the form of those checkbox categories. So, I think that's really important. The other thing you addressed, Dr. Boufford, I was going to raise, I recently saw HANYS study that said that 75% of the hospitals in New York State have lost money in the last calendar year. 75% of the hospitals in New York State lost money, yet we're looking at them to essentially invest in areas that are not always considered traditional hospital based.

We know that they're going to see patients, but you talked about housing and things like that. I agree. I'm a public health practitioner at heart, but when agencies are losing tens, hundreds of millions of dollars, which is what the reports say, I think we need a strategy to help those hospitals be able to make those investments because if you're running a hospital and you're under the gun and you're

losing a hundred million dollars, it's not going to be your first instinct to agree to lose \$110 million to check other boxes. That's just the reality of it. Even though nobody's denying these are great programs and the public health side of me thinks all the money should be on prevention, not all of it, but you know what I'm saying? So, I just wanted to... I don't want us to set an expectation that is just not practically achievable.

Dr. Boufford: Yeah. It's an important point. And I know you have raised this before and I think we're quite conscious of it. That's why I want to be clear that we're talking about the one small category and its basically money that the hospitals report they are spending. And I think the first goal here is to raise money they say they are spending to get it to make sure it's not a one-off screening program with no follow-up or it's not a green market on a once a month or something. I mean, not that they aren't all good things, but they're not the sort of evidence-based activities that we're hoping we'll begin to see.

I think part of the caution, and Doug may want to comment on this, but part of the idea of going slowly with this round rather than really changing the language dramatically is to exactly what you're saying, is kind of understand the lay of the land and then see whether different languages needed. I mean, states have a lot of response or authority to do what they wish to do. New York is pretty hands off in this space compared to some other states. So let me ask Doug and then maybe Denise will come back to your point. Well,

Dr. Fish: Thank you, Doug Fish, deputy commissioner in the Office of Healthcare Delivery. I mean, I really want to first thank this committee for your thoughtful input and ideas around this and Dr. Boufford, your leadership here in kind of helping to propel this forward. I know it's something that you've worked on and Amir for almost a decade. And I would just like to say also that we're not starting this work, this is a continuum. So, I would not see this as our first foray. The state pumped \$8 billion into the healthcare system between 2015 and 2020 in the Delivery System Reform and Incentive Payment program.

A lot of that went to hospitals and large healthcare organizations as well as into the Health Home program. So, I think we're going into a decade. There's more to be done to try to break down those walls between community and our brick structures, our rural health transformation programs and another kind of foray into that as we launch those initiatives. So, it's all good work and it's all been

supported by the public health committee, the Prevention Agenda, which also existed prior to DSRIP and the work of the Public Health Council. So, thank you for that.

Dr. Boufford: Dr. Soffel, do you want to comment?

Dr. Soffel: Yeah, hi. I think that the whole community benefit world is long overdue for a more transparent approach to how those dollars get spent and what we are getting as a result of those dollars. And I'm really interested that your office is called patient advocacy and I'm trying to put together the Prevention Agenda and a hospital community benefit versus patient advocacy. Because when I think about patient advocacy, I think about individual patients and their experiences, the challenges that they have in navigating the system, the lack of sympathy in terms of cultural and language competence and synergy, the challenge of putting together the social determinants with their healthcare experiences where I come from as a consumer advocate, that's what I define as patient advocacy. So, I'm curious how you envision bringing this community benefits Prevention Agenda, big brush view of public health together with the experience of individual patients on the ground who are having challenges navigating.

Ms. Elogoodin: Thank you so much for asking that. I will definitely defer to some extent to Dr. Fish, but one thing I want to mention is... Yeah. It is that patient advocacy is also focused specifically on hospital financial assistance law and working specifically looking into these complaints that come along from community health advocates and patients individually and that important work that hospitals do in allocating that financial assistance eligibility to each and everyone. And that in conjunction does touch a little bit more on that community benefit as well. But Dr. Fish, go ahead, please. Thank you.

Dr. Fish: No, no, totally. Thank you. And I was just going to add this. So patient advocacy director was the language in the statute, right? But we thought that this community benefit spending really went right along with that. So, it doesn't mean that these other issues and complaints and so on aren't getting addressed. And we try to do that, but we're trying to bring in house the kind of financial expertise too to those complaints. And Bella, you might just want to explain your background and what you did before you came to the department.

Ms. Elogoodin: Happy too. Yes. So, I worked for almost 25 years in a hospital private sector. I was responsible for language assistance. So,

language access I'm very passionate about given that I'm an immigrant from Ukraine, came here as a teenager. So, I was very responsible for looking into some possibilities in maintaining that language access, especially when Mark said that there would be this fact, it would be in many other languages, bringing a smile to my face. But in addition to that, I was also responsible for patient advocacy, patient experience, volunteer operations, and to the extent community benefits. So, I worked very closely with finance office as well as education. So, it's very familiar. And now it's interesting to be in state government and actually putting this work brick by brick. So, it is very exciting and to my extent is labor of love to me. So yeah.

Dr. Boufford: Other committee questions or... I want to get sort of next steps on this. I mean, obviously this is, I think things are due on July 1st, is that correct?

Ms. Elogoodin: Correct.

Dr. Boufford: More or less. And then one of the things we had talked about on this committee was the potential. Once you have that together and can analyze it and see what you're getting, it is to really maybe come back and kind of zero in over the next several months on as you're preparing for the next round, whether that... I think it's mentioned in the documents that maybe there'd be two cycles where there wasn't a lot of change, but I think the committee had wanted to really see based on what you get back on this, what are we learning, especially from the voluntary hospitals, which are, as you point out dominant, and I think the public hospitals are, it's their core activities, one you might say, whether there's an opportunity to refine language to focus in... Some questions may not be useful, some may be missing and maybe bring back the results of what you get analytically for the committee to discuss and maybe make suggestions about language at requests that might be made the next cycle of the ask from the hospitals.

Ms. Elogoodin: Absolutely. And we made it easier for public hospitals too. We created glossary terms given that they don't file with IRS, so they may not be as familiar. So, we do have glossary terms that are shared with different associations and also hospitals whenever they reach out. So hopefully they will appreciate that, but obviously they are welcome to reach out anytime to ensure they get all the responses from the department about how to fill out certain questions and become a little bit more familiar as we go along closer to that deadline. Thank you very much.

Dr. Boufford:

Yeah. As you point out though, the voluntary hospitals are numerically the dominant group in the state, and I think to the degree we can move beyond the... It's useful to move beyond the routine community Schedule H reporting in this category, which would be a really good discussion I think we're hoping to have with you with your office once we get the data back. Any other comments on this area? Okay. So, we're now ready. We're just reminding the committee we usually pick one issue we want to work on with our colleagues in the department so that we can use our, if you will, our bully pulpit or public panels or other discussion as a basis for bringing an issue to higher visibility. And we discussed the challenges of the public health workforce, which is one of the issues we wanted to work on during the course of this year.

And I've got, I can't see beyond this apparatus here. I think we have two folks here. One, Erin Knoerl, who's going to be reporting on sort of the thinking currently from the health department. The last conversation we had was I think some committee strategic ideas came from the committee relative to ways in which we could raise the visibility of public health as a career, public health workforce, people going into government in ways that they might not be so have not been going in recently and what some of the issues are, which I think are nicely laid out in our PowerPoint we're going to hear about. And then we'll hear from our local health department, Cristina Dyer-Drobnack. So, Erin, I think you're behind this machine somewhere. No, you're over here. Sorry.

Ms. Knoerl:

So, hi everyone. Erin Knoerl, associate director of Division of Public Health Infrastructure. So last month, Keshana Owens-Cody, our director for the Division of Public Health Infrastructure gave a pretty robust overview of some of the initiatives that we're working on, especially under the Public Health Infrastructure grant. So, I'm just going to highlight a few programs, a few updates, and then I'm hoping after Crissy's presentation, we can brainstorm a little bit some more concrete next steps of how we can work together and make sure that both Keshana and I know of what are some options that this committee can kind of help move our work forward. I wanted to highlight our pathways into public health internship programs. Keshana touched upon this last month.

It's an innovative public health career pathway program in the sense that it provides opportunities for students from trades, workforce development programs and colleges and universities to gain hands-on experience in governmental public health. A lot of times when we think about internships, we think, okay, schools of public health, which are great and a number of our interns are from

schools of public health, but it also has individuals from different degree programs, which I think we have to think about is that, especially when we're looking...

Ms. Knoerl:

... we have to think about is that especially when we're looking at some of the gaps that we have right now, like individuals with communications backgrounds, IT, a number of different things. So, for instance, one of the interns in our division is getting her doctorate in curriculum development and it's perfect because we're trying to develop a curriculum for K through 12 programming of how you get children to think about public health as a career. So, we had 13 full-time interns starting this summer on June 1st. And an interesting thing is I went to their orientation and there were a fair number of them not from New York State, that they were coming from Michigan, Kentucky, and they saw this opportunity and was like, "How cool is this? I'm going to pick up my life and move to Long Island or move to Albany." And so, it's kind of bringing I think the New York State Department of Health into their registers as a place to work.

One of the things we're doing with that is this coast-to-coast initiative. So, we've partnered with six other states to bring their interns together for virtual networking as well. And so again, there is a kind of increasing awareness of the New York State Department of Health. We're hoping to work with local health departments as well with their internship programs and again, provide support and opportunities for networking. And we anticipate about another 10 interns in the fall cohort as well. I wanted to highlight too some of our work on academic partnerships. So, I know Schools of Public Health and partnering with them came up at the last meeting. And so, our Office of Public Health along with the division is actually cataloging all memorandums of understanding and memorandums of agreement between the health department and colleges and universities in New York State and hopefully looking to formalize and more streamline the process.

So, like I know Dr. Boufford, NYU reached out kind of wanting to create more of an agreement or a formalized relationship. And so, Kali from our division's working on that. And our goal is to actually partner with all the colleges and universities, especially with the public health program. And so, we're trying to formalize that under the division as well and kind of manage those agreements. So hopefully at the next meeting or an upcoming one, or Mark can provide an update on how many agreements do we have. We actually don't know right now. So, we're undergoing that assessment and sharing that with you all. Our program's also

working on a report called Investing in Tomorrow's Public Health Workforce Starts Today, a catalog of public health workforce pipeline programs. Again, looking at the different types of opportunities that exist. We're entering into, hopefully soon, a contract with the New York State Public Health Association under the Public Health Infrastructure Grant to really strengthen connections, expand career pathways, support employee wellbeing, and create opportunities for lifelong engagement in public health.

So, this contract's going to have nine different kind of deliverables if you will, but I thought some of interest to this committee is we're going to be working with them on a career pathways and workforce mobility webinar series, which will develop educational programming focused on career development across all stages of public health careers. So those looking to enter into it, those in it right now, and those retiring. Doing a public health college and graduate student campus engagement activities where the association will partner with universities and public health programs to strengthen awareness of public health career opportunities and connect students to professionals. And then another one I thought this committee might be interested in is they're looking to organize a fall public health workforce workshop, which would convene a statewide workshop focused on workforce development and employee wellness, bringing professionals together for learning and connection, highlighting some workforce innovations out there, and creating action-oriented discussions.

I wanted to just briefly, I know Kishana mentioned it last month, the New York State Public Health Corps Fellowship program is ending on July 31st of this year. That team's working on publications right now, on the model, successes, lessons learned. I'm hoping we'll be able to share something with you all at the next meeting. They've got an impact report that's currently undergoing final approval, a promising approach document and some journal articles. I will say with fellowship programs, Kishana touched upon some of the data which is pretty robust. So, I'm excited for you to read the report. But the Department of Health does have some fellowship programs, but again, I don't think it fits the needs of everything that we're looking for right now. The governor has the Empire and Excelsior Fellowship programs, which are great, great benefit to the department, but those are policy based. The department also hosts fellows from the CDC Foundation and the Association of Public Health Laboratories, which is great, but there's concern that that funding on those may be ending soon. So, we're working with the Northeast Public Health Collaborative to take a look at their

fellowship and intern needs and then come up with a proposal on how we might be able to kind of move that forward. So again, that remains on our to-do list.

Sustainability-wise obviously is a big thing, right? Kishana emphasized that over a hundred individuals hired off of the Public Health Infrastructure Grant, local health departments, and over 150 people as well, and that funding ending November 30th, 2027. So, what do we do or how do we try to build succession planning and sustainability? Hopefully money's going to be made available as well, but again, that's a high number of individuals. So, we're doing an assessment called Mission Essential Functions, which is looking at all staff hired on the grant to determine their priority level, what's the session plannings in place should that position no longer exist, the burden on the health department if that position gets eliminated, and alternative funding. I did want to say we do have priority one is critical life-saving functions. We're still undergoing this assessment, but there are a fair number of individuals on that. Those are most essential functions that must continue without interruption to protect life, health, and safety. And priority two is functions that support level one and should be restored within hours to days if disrupted.

So, we're mid-active, but hopefully again, we'll be able to share that and especially when there are positions where there's no succession planning or alternative funding, how do we go about that? And Kishana mentioned too, kind of the different areas we're looking at. So, I've spoken a little bit about careers in public health, but what about our existing public health workforce? So, we're also polling staff internally into where those gaps are. So public health nurses, data analysts, engineers, sanitarians, IT, communications have all been identified, so strategizing about that. And Chrissy will actually highlight from the LHD side as well of where they're seeing gaps. So, kind of with all of that in mind, I'm hoping after Chrissy's presentation we can brainstorm again, what is the priority of this committee in terms of that? Are you interested in addressing the current workforce and gaps? Is it the pathways into public health? For us, a few things that we've identified raise awareness of public health jobs in general, especially hard to fill ones, and maybe advocating for additional state items, especially for those priority ones.

State investment for innovative workforce funding for public health. So, I think this was brought up last time. There's a lot of focus on the healthcare workforce, but what about the public health workforce? So, for instance, governor's initiative is this healthcare workforce innovation funding, but public health is not included in

that. So, is that something we want to investigate of how do we do innovative thinking or programming to address public health? And I will say under the healthcare workforce innovation funding, part of that is about schools and getting people involved. So, I think there is some alignment there if we wanted to take a look at that. And then lastly, championing integration of public health into like STEM and STEAM, loan forgiveness, or other workforce initiatives as well kind of on the governor's radar. So, I'm going to turn it over to Chrissy because I feel like maybe some of your questions might align with both of ours, both of our presentations.

Ms. Dyer-Drobnack: All right. There we go. All right. Thank you so much, Erin. And thank you to the committee. I'm Cristina Dyer-Drobnack. I'm the Public Policy and Program Director with the New York State Association of County Health Officials. I'm going to wave back to my colleague, Abby Han, who's here, who's our new program lead on our workforce enumeration study. I'm just going to go through, and there's slides and you have a handout, really a brief very high-level overview of what the study is and again, very high-level findings sort of discussing what trends tell us about the current state of New York's local public health workforce and where opportunities exist to strengthen capacity moving forward. So next slide please if you can.

So, a strong local public health workforce is fundamental to protecting community health. And prior to this effort, New York had not comprehensively enumerated its local public health workforce since 2006. And I've been with NYSACHO for 30 years. I remember that study, but really since then we have not seen any enumeration. We knew from our members anecdotally, especially during and following the Great Recession that they were losing staff, but we did not have the strong data to back that up. So, recognizing that gap, in 2021, we partnered with the Region 2 Public Health Training Center at Columbia University to develop a longitudinal study that would provide reliable and consistent information about workforce composition and trends. And we have since been partnering with Erin and Mark and the team at the State Health Department with public infrastructure grant funding support to inform those PHIG activities to support the local governmental public health workforce. This work builds on national efforts, but it provides us with New York State specific data that can support planning, policy development and workforce investments.

So next slide please. So again, we launched the survey in 2021. We modeled it using questions from NACCHO's 2019 national profile of local health department. We did that because those

questions were validated, and it would also give us the opportunity with some of that data to look back and do that look back in that period where we had a gap and it allows us that national comparison but also gave us the opportunity to do our own study to tailor for New York State. So, each year we collect core data on staffing and vacancies and broad title categories along with supplemental questions kind of depending on what we're looking at or what are issues. For example, when Article 6 was increased in the next year, we asked about base grant utilization, we've asked questions about PHIG hires, et cetera. And then every three years, and we started this in 2024, we're doing an expanded survey where we gather more detailed workforce and demographic information to track trends over time.

Next slide please. So, several themes have remained remarkably consistent since our 2021 survey. And I really want to kind of go with three main takeaways here. First, overall vacancies remain high, and they've remained high over this period. Generally, they are over 10% or more, a number over 20%. And in particular, the highest public health nursing continues to be the most impacted. That generally hovers around 30%. It's varied. It's been as high as 40% in some years. That's not a surprise to anyone here who has to hire nurses and we are particularly challenged in that area. It's not unusual to hear a local health department say that they have finally filled a position after three or four years of vacancy for a single public health nurse. And then post-pandemic workforce instability is ongoing and so overall those capacity challenges remain significant despite work and making some inroads in that.

Next slide please. So, when local health departments in the survey describe their challenges, they fall into three main categories. The first are what we would characterize as workforce pipeline issues. These are things like retirement. I think we're a little past that, but we definitely hit a period in the pandemic and then after where we had a significant number of staff that were retiring and taking a lot of institutional knowledge out the door. The other challenging pipeline issue is just limited candidates, just attracting the workforce and having them understand what local public health is and wanting to apply for those jobs and recognizing what that work is. The next area is structural barriers. These include things like just civil service processes and testing and compensation, which is set by the local government, not necessarily the local health department. They have to go to their budgets and fight for those positions, fight to be competitive with private sector and other sectors. And then challenges particularly attracting younger workers to governmental roles. This current generation coming into the workplace is looking

for more flexibility, more work from home options. They're looking for career advancement opportunities. And some of those things are harder to come by within a local government structure. So those are some of the challenges we're hearing.

So really to address that, next slide please, one of the strengths of this project is that these findings that we have been collecting annually are not sitting on a shelf. And this slide, and you can read it better on your handout probably, highlights some of the ways that the results have already been translated into action. We've disseminated the findings through publications and presentations to help share New York's experience with a broader audience. They have been informing us of our policy and advocacy efforts as an association. That includes things like discussions with the state health department about modernizing some of the qualifications in the Part 11 titles. And we're hoping that maybe in the next year or so we'll see some of those initial efforts come to fruition so that they're more in line with both meeting the needs and keeping the qualifications high but also recognizing that they need to recruit from a broader pool of candidates. And then also helping us communicate workforce implications of budget and policy proposals affecting local health department at both the state and federal level with legislative leaders.

The survey have helped shape workforce development activities. We have focused on leadership and supervisory development. Communications and de-escalation skills are an ongoing need we see in the field. And then technical areas such as data, AI use, public health law, grant management have all informed training priorities for NYSACHO for the public health infrastructure grant activities and with Region 2 Public Health Training Center as well. And then the findings have supported recruitment and retention efforts, including a campaign we developed called Not Just Work, Work That Matters that is focused on providing resources for local health departments where they can tailor the materials and brand them and use them locally. This includes things like flyers, billboards, and signage. We have videos with interviews from local health department staff talking about the work they're doing. And then just this year we did an outreach effort to students through the New York State Public High School Athletic Association where we ran public service announcements at their spring and winter championship events. And then we're also improving access to information itself through dashboards, fact sheets, and opportunities for our local health departments to learn from each other and share best practices. Because ultimately the value of the study lies not just in the data itself but in how we're using that data.

So next slide please. So, I really wanted to close here with what we thought when we talked about this as a team, how PHHPC and the public health committee can support and maybe utilize this work that we're doing. First, is there an opportunity to advocate? Can we use this data to build some momentum to advocate, for example, to identify private capacity dollars to continue a successful model like the Public Health Corps Fellowship program. Or as Erin mentioned, if there's funding that's being considered for the clinical workforce shortages, can we advocate making sure that that also includes the public health workforce as well? Share your expertise. You all come from different fields. You are all addressing your own workforce challenges. What can we learn from you? What are the best practices you're finding in recruiting and retaining talent? And where can we use those or look at new partnerships to increase capacity? And who are the partners that we're not thinking of that we should bring to the table? And then lastly, ask about workforce capacity. When policies come before you and you're making a policy decision, for example, something that expands or recreates a new public health responsibility for that local governmental workforce, ask for the data and learn about what the vacancy rate is on the ground and what the staffing challenges are that would be needed to implement that policy.

So just last slide. In closing, the study highlights our workforce challenges, ensuring our long-term workforce stability is critical to maintaining our public health capacity across the state. We would very much welcome the opportunity to return at some point and share findings from our 2025 survey once that analysis is complete. It's kind of in process right now. And don't click on this. Just you can exit out after this slide. But this slide does have a PSA from our workforce campaign that we did and you can view it. There's a link in your PDF electronically where you'll be able to view that PSA. Happy to answer any questions. I do have my colleague Abby here with our 2024 data if there's something more specific that you're interested in. Thank you so much.

Dr. Boufford: Thanks very much. This is really, really helpful. I have a couple of just informational questions maybe and then have colleague's comment. Has there been a national look at comparative salaries in the various public health titles nationally? So, we would know where New York stands relative to other state salaries, APHA or ASSPH or somebody?

Ms. Dyer-Drobnack: We have not looked at that and I don't know if the NACCHO, maybe someone who's done the NACCHO profile study can tell me if they have collected salary data, but we can certainly reach out

and find out. I know there's the Center for Public Health Workforce Studies out of Minneapolis and we could reach out to them and see if they've done any work on that.

Dr. Boufford: Because I think what I'm hearing a little bit is really trying to develop the argument for advocacy for more money, which is really the bottom line. And one thing to know, New York always likes to know where it stands relative to other states. And there must be somebody that's done that recently. I don't know. But anyway, that would be one.

Ms. Dyer-Drobnack: I do think the challenge with looking at other states is that when you think about at least the local governmental public health workforce it is that salaries have to be considered in the context of the whole county and their salaries for comparable titles and what their union negotiations are.

Dr. Boufford: I'm sure analytically they can control for some of that stuff, but I think you're absolutely right, it's important. Okay. Larry and then, sorry, then Ms. Soto.

Dr. Eisenstein: Yes, Larry Eisenstein again. I did look at that back when I was in Nassau County and the ratios change, the salaries are higher in New York, but one thing is the same and I've been making a whole bunch of notes to talk about during these last two presentations because I lived every side of this. Everywhere governmental public health salaries are less than what people can get in the private sector. So, we heard about engineers and nurses. Every county in America's public health department has less because a nurse can start at double the salary in the hospital versus in governmental public health. We don't need another study to show us that, to be honest. Great presentation, by the way, Chrissy. Chrissy and I advocated together on this for many years, so the irony of my comments that are about to come out are not lost on me. But we keep saying the same thing. It's not rocket science. Why are we short public health nurses? Because government pays them less than everybody else pays them, period. You could start them at three years old in nursing school telling them about public health nursing. When they graduate nursing school and have real bills and rent and kids to feed, they're going to take the job that pays double. That's just, I mean-

Dr. Boufford: It's true everywhere. I mean, it's not that unique public health. Absolutely.

Dr. Eisenstein: Right. So, until we have legitimate legislative policy change that requires public health departments to pay the going rate, you're not going to see this change, but I digress. Anyhow, so I did-

Dr. Whalen: Can I just add one little point to that, Larry, coming from my background in Albany County? And there's not a parody between looking at salaries from the state level and looking at salaries from the local level. So, for example, being commissioner in Albany County, we had our nurses that could walk up the street and make an extra \$20,000 a year. So that was a challenge as well.

Dr. Eisenstein: Yeah. Same.

Dr. Boufford: Hospital nurses make more money on contracts too than they would do working in hospitals. So, I didn't ask about... I was really asking about national public health related to New York, not the other stuff, which is absolutely true. Yeah.

Dr. Eisenstein: I did look. New York salaries tend to be higher than most, but in no state are they competing with outside of public health.

Dr. Boufford: No, no, I'm sure they won't, I'm sure they won't.

Dr. Eisenstein: A couple if I could. Really interesting, we can tie this whole day together. We talked about community benefits earlier. And if you really want hospitals to be able to do this preventive work job, they need to invest in public health people who know what they're doing and how to do it. So, we always talk about it, and I know I did this with you, Chrissy, I'm on the other side now, I understand the irony. The public health workforce is not only about local health departments. If we're going to be successful in community benefit, hospitals and the community partners that they have to have people trained in public health. This is a system-wide problem not only to local health departments. And the real study should be where is the gap in public health employment across the board? Because if there's just one segment of it that's fixed, we're still not solving the problem.

And we talked about educated people, nurses, engineers, et cetera. You know what the hottest job is in New York State right now in public health? It's not any of that. There's an all-out battle to get community health workers because the Medicaid waiver is paying community health workers. We're all competing with our own social care networks now to hire community health workers because that's how we're getting paid. So, one of the things I think we do too often in public health employment is look at the high degree positions

when in fact the thing we most lack is boots on the ground. And community health worker, there's no standard job description. I've done the research for every single job, because I wrote the job description for my system, every single system has a different job description for community health worker and a different education requirement.

My best, I want to say best, my most productive community health worker came to us at 18 years old after graduating high school. Now she's getting a degree now, but the point is you don't need an MPH to do good public health work all the time. So I'm just bringing these points up because I think we very often when we look at these challenges, we just look at how many people are graduating from our local public health schools and becoming public health nurses or engineers, when in fact if we're really going to solve this, true public health has to be an across the board multisystemic investment in employment and not everybody needs to be a nurse or an engineer or a public health doctor, and the real battle is won in the community with the community health workers. I'm done.

Dr. Boufford: I think it's an issue for sure. But anyway, Dr. Soto, Ms. Soto, sorry. And then Dr. Andrew Torres.

Ms. Soto: So, my question is more directed to PHHPC in that in terms of what PHHPC can do to support this, I'm curious about the advocacy for funding. What shape, manner, or form can we be engaged in because this is primarily with the governor and the legislature?

Dr. Boufford: Well, I think one of the issues, a reasonable thing that we can do is to help shine a light on some of the arguments, the analysis and the advocacy. And I think the point being that the advocacy for public health is not the same as having hospital systems advocating for clinical positions. I mean, there was huge amount of money invested a few years ago to top up salaries in the clinical space. There's no analog for public health. So, if nothing else, we could start a conversation there, I think, and sort of put a little bit of momentum into it. I did ask the commissioner directly at the last PHHPC meeting, were there plans to put in the next budget cycle, because I knew it was too late for this one, something to compensate for, if nothing else, the loss of the fellowship program, some of the money that had come in through the Feds. And he was not direct about it. He said it was a concern.

So, I think that an answer to one of the things we could do is to really have this argument made, bring these issues up, and hope to provide the support the commissioner needs to advocate for this in

a budget cycle. Because relative to the funding for clinical spaces, it's quite small and could make a huge difference, I think, really. So yeah, part of the bully pulpit, I guess, is kind of what we're about, we can be about here. It's what we did, I think, for maternal mortality now eight or 10 years ago was just really shining a light on the problem, getting the people across the department to talk about it with each other, solving some simple problems that were soluble, and then raising issues that might go to the commissioner, to the governor, to the legislature. Yeah.

Ms. Dyer-Drobnack: Yeah. I think sometimes advocacy is sometimes it's just effective to ask the question. You recognize the budget challenge, you recognize that it is not your role to go to the legislature, ask for money, but just asking the question of, do we have the personal, the people resources to do this? You want to do this policy, you want to make these broad policy changes. We're looking at this. What are the people's resources available to do that? And I think that's part of advocacy is putting the question in front of the people who do make those funding decisions.

Dr. Boufford: I mean, one of the issues in this space, and this has been many, many years in the global and other environment, when you say health, people think healthcare. And it can be decades to get people to not think only healthcare and to really ask the question, what are we talking about conditions in communities that make people sick in the first place? And how do you begin to tackle that? It has been a long conversation. I would say it's not taken up with as much energy in this country as it is in many other countries. And it's part of our system because the money is where it is. It's like following the money and you'll find out what's getting funded. So, I think that's the fact that you're developing this database, you're dealing with these issues I think is something that we can add value by bringing them to greater attention and then trying to position some kind of action steps. I don't think there's any question that budget for public health workforce is a critical issue.

Ms. Soto: I see in part what happened with the ad hoc committee and all the multiple areas and the individuals who were engaged in terms of once the report gets finalized. Because again, we are thinking of going to the doctor, the nurse, or what have you, and that is transportation, education, so forth and so on.

Dr. Boufford: It's all public health. And I think Larry's point is a good one. I mean, part of the health in all policies approach and part of what we're trying to do with the domains is to say there are decisions that people in the transportation department can make that will have a

difference on health in terms of cars and air pollution and road traffic accidents and active transport and all these areas. And that data is really, really solid now. It wasn't 10 or 20 years ago, but the evidence base is really solid for those actions. And I think a lot of talking to these other agencies is just anecdotally, having been through this a while, having talked to the state parks commissioner a number of years ago about the issue of physical activity and what's happening in the parks. And she said, "Oh, we have bike trails, and we have this, we have camping, and we have all this other stuff going on." She said, "But I don't control who sells the food at the vending machines in the parks." It's another-

Dr. Boufford: Who sells the food at the vending machines in the parks? It's another state department. She knew. And the same thing happened in the same conversation with criminal justice. They knew families were bringing healthy food to their family members that were incarcerated because the only food they could... I'm not talking about the food served. I'm talking about the food that they could buy from the vendors was junk, basically. So, part of identifying those issues in other sectors is... I mean, there is an article called Public Health 3.0, which really calls on public health to be the link across sectors and getting people organized around the evidence space to invest, which is what we're trying to do with the community benefit categories at least.

Ms. Knoerl: Yeah, I just wanted to add to Dr. Eisenstein's point. So that's one of the reasons why I think we're entering into a contract with the New York State Public Health Association, which is to try to look across sectors. And regarding your point about community health workers, we are looking at it. Dr. Whalen's looking at community health workers programs within the health department.

But I will also say externally, especially with local health departments, it's been brought up as we want to bring community health workers in. But when we look at the 1115 waiver and the Career Pathways Training program, where community health workers are included, where individuals can get funded to go to school for that and then they have to give three years in their community, local health departments are not eligible and school-based health centers are not eligible. And so, we've been trying to be strategic of can we look at apprenticeship programs or other places where people are getting trained and try to create those pathways into local health departments. We haven't quite figured it out yet, but it is on our radar.

Dr. Whalen, I don't know if there's anything you want to add with your work on community health workers.

Dr. Whalen: I'm a huge proponent for community health workers and have been for probably 20, well, 15 years anyways. And I think that when I was at Albany County, we had community health workers, they were very involved in our Maternal Child Health program. They would go out to homes, they would be boots on the ground, and they did a tremendous amount of very impactful, very important work.

The real hallmark of a community health worker is that they're representing the community that they serve and that they are a trusted voice. So, it is a little bit tricky to impart academic requirements. It is more about experiential and learning how to speak to people, meeting them where they are, learning about things like motivational interviewing, identifying things that people find impactful in their own health journey. Not necessarily to tell them what they should do with their health but to involve them and empower them so that they become the drivers of their own best health.

So, I think it's incredibly important as a workforce, and I think that there's a lot of work that can be done to continue to grow this workforce. I know the social care networks are doing this. I know the hospitals are doing this. The plans are doing this. It really has become a wave. And I think that there's opportunities here too, although we haven't got a specific pathway, to make sure that when we're bringing people from communities that are disadvantaged, that we create opportunities for them to continue to rise in their career pathways. That's incredibly important because everybody wants to come into a first-level job and say, "Well, here's where I'm going from here. Here's where I'm going from here." So, opportunities to create educational pathways or things like PHLOT that local health departments have been able to utilize their staff being able to train and get degrees, if that's what they want to do going forward, so that they can get higher-paying jobs.

I did want to make one other point a little bit divergent on what the PHIP can do and in terms of how we advocate for public health workforce. And I really do think it's important to say that in New York State, I think all of us are aware we have very strong support from the governor. We have strong support in terms of why public health is important, what public health does, and what public health can accomplish. That is not the case in every single county in New York, and local health departments are under their county

executives. And there is tremendous variability and a continued backlash from what happened during COVID of some counties finding it very difficult to work in environments that continue to politicize public health.

And that is a conversation that I think, at this committee's level, is very important to continue to toe the line on so that we're reflecting the values and importance of public health that New York State appreciates down to the county level, because it is incredibly impactful at the county level in our rural counties, in our urban counties. And to have that support is essential for them. A lot of those directors and commissioners who are operating smaller departments might not necessarily feel that support. So, to the extent that this committee can bring that support, I think it would be a great use of voice.

Dr. Boufford: Anybody else? Other comments? Yeah, I'm sorry, Dr. Torres.

Dr. Torres: Thank you for your words, Dr. Whalen. I feel that you were actually speaking to me personally and looking at my background and neighborhoods and so forth.

Some of the thoughts that came to my mind was, how do we home in locally? And you may want to consider reaching out to the advisory boards of some of these academic institutions that have access to these individuals, these students. And I was thinking, over 50 years ago, for some of you that may recall PAL, ASPIRA, Big Brother, Big Sister and so forth, and getting to a younger demographic so that they begin to reflect and think about the possibilities that lie before them, even if they take those higher-paying jobs elsewhere. But it's the introduction, because there's a deficit right now in our community. If you were to go into certain neighborhoods and talk about these opportunities, they will look at you and say, "What is that? And is that possible?"

So going back to a historical perspective, I think we don't need to reinvent the wheel. I think we need to reengage and recommit, and magic happens. And people are sponges and they're thirsty for this knowledge and this awareness, and that's how we can make possibly an impact. Some of the organizations have developed Workforce Wednesday and they've actually taken into their neighborhood. My agency, for example, took it to one of the senior centers. And in one evening, we customized the time, and we had over 110 people show up looking for jobs. And we put it on social media, grassroots, posters, putting it on the windows in the stores in the neighborhoods and so forth. And people took ownership of

that, and we were flexible enough to look at the time to accommodate, but it's reaching out in the traditional way.

Dr. Boufford: Yeah. Ms. Soto.

Ms. Soto: So, along your lines, because I'm Aspirante, because I knew the late Dr. Pantoja and she says, "You will always be an Aspirante." But I know that also some of the high schools have service commitments and service hours, because they had a high school program, and it was more the parochial schools, but they had to show every year X number of hours. And they got some compensation or award or certificate because they were different levels, how many hours. But there is probably a group of young people in particular that we can tap into who have this interest. And who knows how it would get them interested in various careers in terms of their awareness?

Ms. Dyer-Drobnack: And we do have resources. We have a Careers in Public Health webpage. It is targeted at the high school level. And I agree, I think we need to look younger than that to start getting kids to think about it. But that really focuses on both the videos that we have of people talking about their careers, what different titles and jobs are in public health, but then we also took that, and we said, "Are you interested in math?" And then you go in and then there's information on, "If you're interested in math, these are careers you can do in public health." And so, we really tried to take where their interest might lie and connect that back to them.

And the other piece I would say too is that thinking, going to what Erin said and Dr. Eisenstein, is after public health nurses, the next two areas where we see big vacancies are not licensed titles. They're actually in support and in business and fiscal. And so, I think that's an opportunity for us to reach out both to undergrad programs outside of public health and also to our Boards of Cooperative Educational Services and see about where we can make connections to get pipelines into those, because those also have very high vacancy rates.

Dr. Boufford: I think we have the Department of Education here looking at how to make schools healthy. That could be a message.

Ms. Dyer-Drobnack: Absolutely.

Dr. Boufford: I mean, just connecting up some of the ad hoc members and other agencies with this sort of message.

I was going to... There are a couple of other things to add to the conversation. I mean, I think one of the issues with community health workers is, what are they trained to do? I mean, again, dating myself, but we had community health workers at the Martin Luther King Health Center in 1970s, and they were high school graduates. They were helped to get their GRE. They lived in the community, they were helped to get their GRE, and then they were trained. But largely, the training... And this is one of the number one priorities the new New York City Health Commissioner is getting community health workers funded under Medicaid.

But again, it's still in the personal care space. There's nothing wrong with that. It's really important. But why not train them to do an environmental assessment of an indoor apartment? I mean, some of them, I think there are NGOs, Little Sisters of the Assumption, I'll give them a plug, in East Harlem, who have community health workers going in and doing departmental assessments for people with asthma and looking at how it has to be cleaned up. And that was funded by HUD. It wasn't funded by the health department.

So, I think it's really being creative about folks that are in these jobs to think about how they can deal with not only the individual's needs, but also the environment in which that individual is not being helped by that environment or maybe made sick by that environment. So, it's both/and in making that argument. But how did they train?

And I know the commissioner had tried to make an argument for scope-of-practice changes, fairly minor, actually, in the clinical spaces, but now that we have the DOE over here, maybe there's another conversation. I mean, this is scope of practice. We upskill so many people in this country to do things that are done in other countries where they don't have the money and they don't have the expertise that are... And there's clinical-trial-combined, double-blind clinical trials on mental health in India, using psychiatrists or using local individuals that are trained along the lines of what a lot of drug treatment programs have been doing for a long time. We have a lot of money, so we tend to say we can't do anything unless we can put money at it, or we have had up until now. So, I think we have to be... As have been called on being creative.

I want to raise one other issue. I'm writing some notes down on some things that we might do that we could talk about. One other quick... Because I know we're coming to the end of the meeting. One of the issues that was raised, and I think it's not irrelevant to

advocacy, is that there is not a network of public health, deans of schools of public health, across the state. There is of medicine, there is of dentistry, but not... And there had been of nursing. I don't know if it's still active. Is there a nursing? Good. But none of public health.

I was thinking also, the nursing dean, the nursing profession are the best advocates on the planet for whatever they put their minds to. So, I was also thinking about nursing deans, going to that meeting of nursing deans and talking about public health nursing as a phenomenon and really trying to deal with the academic support by mobilizing. There had been an effort, I think, two, three years ago before COVID, I think, to get the public health deans together. And it's a tough time because they're all under enormous pressure in terms of enrollment is down and because kids can't afford to go to school and stuff. But anyway, so that's another... I don't want to drop that or lose it.

And then the last thing I wanted to mention, I think, was... I'm trying to think of... I've lost the thread. But I think part of this, your point about the county execs and... I know what it was. One of the things about the Health in All Policies approach or the working with other agencies is... And I think maps are really important for getting elected officials to do things. And one of the anecdotal things that happened in a previous prevention agenda, local public health directors had identified in their county one of the big problems was food desert. And then we had somebody from Ag and Markets look at the programs in that county, which there were eight that were providing fresh fruits and vegetables free, and they didn't know each other, and they didn't know about the programs.

And so, I think one of the issues we may want to consider in the conversations with some of the agencies that have joined the Ad Hoc Committee is asking for them to give us a county report. Having been in city government, I can't believe that anybody, any agency head, doesn't report to the governor what's going on county by county in their programs. I mean, what programs are going on in each country? And could map that.

And so, some of the other... I noticed there were others here about other nonprofits, statewide nonprofits, that are doing this work. But I think the place-based analysis, the county-level analysis gets to Lindsay's point, is how do you get people around the table around issues that are identified? And how do you know what the local resources are? Because it's fair enough. People [inaudible 01:44:48].

Dr. Whalen: It's incredibly difficult, I'll say that. I'll say it's difficult.

Again, drawing on my experience at Albany County, we wanted to come up with a resource within the prevention agenda and all the community-based organizations within the county. And Albany County is a medium-to-large-sized county. What we found is that there's just such turnover. There is turnover of agencies, there's agencies that develop, and then they go. And so, it sounds like it might be an easier thing to do than it actually is.

Dr. Boufford: I don't think it's easy, but I think there's a starting point, I think, too really-

Dr. Whalen: I believe it's worthwhile. I agree with you.

Dr. Boufford: Because I really believe this place-based look, geographic by county, if that's the area we're looking at. And your point about county executives, I mean, with previous governors, there were a lot of tensions there. There may still be, but that may be something that can be addressed. I think it's an important issue. Absolutely.

Yeah, Denise and then...

Dr. Soffel: Not to put my colleague Q on the spot, but Rochester feels like a real outlier in terms of being able to convene both government, hospital, community-based organization. And I wonder partly if it's that they still have an HSA.

Mr. Thomas: We do.

Dr. Soffel: But there's something about Rochester that really stands out when you look across the state.

Mr. Thomas: It's a... Q Thomas, member of council. Not [inaudible 01:46:11].

Dr. Boufford: Speak into a mic, please. No, you're always invited.

Mr. Thomas: Q Thomas, member of council. Not on the committee, but I drop in occasionally.

Rochester and I have been deeply involved in all of that. I chaired the HSA. And it's unique, and it still is unique, in terms of community collaboration and coordination. We don't do it perfectly, but there's always been a table. And in fact, the HSA just merged with the PPS program that was very successful in Rochester. We had too many separate tables that were brought together. And

we're working hard to bring people together, make it more efficient, more coordinated, don't have people going this way and this way and this way.

And I have a theory. Now, there's a lot of people... I've been there a long time, but there's a lot of Rochesterians who may disagree with me about this, but I do think a significant piece of it was because of George Eastman and Eastman Kodak.

Dr. Boufford: Yeah. The companies, the businesses.

Mr. Thomas: And they just had that... They basically drove most policy around education and healthcare in the city for decades. Marcus and I were speaking earlier about MA. MA in Rochester, Medicare Advantage, probably has one of the highest penetration enrollment rates of all Medicare beneficiaries in the country, and that's because of Kodak, because Kodak put all of its retirees into that.

And so, you could see it's a unique set of circumstances not easily replicated in other places. And believe me, it's not perfect by any stretch, but it's been very fulfilling to be involved and try to do things properly and at a lower cost. And I think most people here know that costs tend to go down the farther west you go on Interstate 90. So, Buffalo to the west of us. Other than that, it's Rochester.

Dr. Boufford: But I think the Finger Lakes region, because of that coordination, has been able to get line items in the state budget for its work.

Mr. Thomas: That's correct.

Dr. Boufford: It's been able to advocate with foundations. I mean, I think it's really... They've gotten a lot of programs as pilots because of that community, the trust that something will happen that involves multiple sectors. It's a real marketing opportunity, I think, for sure.

Dr. Lopez, you wanted to...

Dr. Ortiz: This isn't a question. It's just a use of resources. So being the dean of a school of nursing and health sciences, I have over 1,500 students who... So, I have built in HR for you, so they can fill in healthcare gaps, resources, projects, quality assurance, all of that, as long as we're asked. And so, I think we're under-utilizing healthcare students because we keep sending them back to the same agencies all the time, as opposed to saying, "Your job for the next year is to work with the public health department or with Albany on these projects." And then those instructors now have

placements. The students are getting the hours. So, I think there could be a coordinated effort that could help ease some of this resource.

Dr. Boufford: That's a great idea. I think the nurse's target is a really great target, especially with you sitting here. Somebody was asking for what the resources are, what are the networks around the table. I think it's a really, really important one.

Dr. Whalen: I see Erin furiously taking notes.

Dr. Boufford: Well, I think the other issue, I mean, this other issue about Rochester is what are good practices? Where is it working? Which counties is this connection working with, and could we have them come? And they can come and tell us how they got it together, how it works, as opposed to an isolated program. How are the different stakeholders in that county and why do they think it happened? What made it happen? What's in the way?

Dr. Whalen: I also think it helps highlight the public-private partnerships if you look at a business sector having this large sphere of influence. And it makes good sense from a business perspective as well to have this sphere and to utilize it with... Especially if you're employing a large number of people and you want to keep your own costs down, it's good business practice.

Dr. Boufford: I know what the other thing was I was going to mention earlier in response to Dr. Torres's notion or thoughts. I mean, I think I mentioned this last time, but a number of the federalists... CDC has been funding the National Hispanic Health Foundation for the last three years and they've developed a lot of tools and a lot of activities to really recruit young Latinos to make them aware of the fact of public health careers existing, starting back in high schools and starting otherwise. So, I'm sure there's materials that are available, the Public Health Leadership group, I mean, I don't think all of them have gone away, relative to developing materials that could be adapted for the New York environment, rather than being so tough, especially when your bandwidth is then too really have to develop stuff from scratch.

So yeah, Ms. Soto.

Ms. Soto: Something went off in my head when you were talking about food deserts, and I think that... I know that we've developed this five-year plan and projection and all the effort and time and so forth, but we have to be adopted. We need to be flexible. Because how many

people in New York State are now losing their SNAP benefits? So, talk about food insecurity. How many of these food pantries and other places that people can get food, because they're no longer eligible, they didn't understand the process, what have you, are now going to inundate those processes?

In Manhattan sometimes when I'm traveling around, and some of these are communities and churches, and I see the lines and people with their shopping carts, waiting. And it's usually one day a week or whatever it is, whatever hours. But we're going to need to adapt. We've come up with this game plan, and this is one of the things that's a changer. And how are we going to address this? Are we flexible enough to adapt to that?

Dr. Boufford: Yeah, I don't think we're at the game plan stage yet. I mean, I think the idea is the target. And certainly, food insecurity is one of the areas, one of the domains. And to your point, I think the issue is being able to adapt to looking at the priorities because of the needs change in the situation. This is very dynamic... Prevention agenda has been dynamic. And I think every couple of years, I mean we're tracking it, but we're also asking local health departments and others, hospitals to... You've got to modify to be... That's why the stakeholder around the table is important. It's really recognizing the shifts in that environment that affect people.

Dr. Whalen: I think it's great to have these aspirational discussions. And I think when we look at food deserts, it's equally important to look at food swamps. And what food stamps are is areas where we really have high preponderance of just junk. And this is in lower socioeconomic neighborhoods. The food is cheap. The food is very bad for you. It contributes to all sorts of negative health outcomes. And it's something that we're not really looking closely at either. And when we look again at the role of the private sector and of big business to health, there has to be a turning point here, given the epidemic of chronic disease in the country.

Dr. Boufford: Commercial determinants of health is another area that's-

Dr. Whalen: Commercial determinants of health. Yes, that was just what I was going to say.

Dr. Boufford: No, it's a bit well-studied and acted on. So, trying to do it-

Dr. Whalen: Yep. That's exactly what it is.

Dr. Boufford: ... but it's an important issue. It's very lively.

Any other... This is great.

Dr. Whalen: Big food, big tobacco.

Dr. Boufford: Yeah. I mean, this is why it's really funny for me, I mean, just doing global health most of the time. Because there's something globally called the NCD Alliance, Non-Communicable Disease Alliance, and their target is the fact that big tobacco, the Tobacco Convention, which was the only legal framework that's ever been decided for the UN on a health issue, has not been working because of corruption in countries. And the tobacco industry has been, as one of them said, someone from the Philippines said, "Buying off elected officials." It hasn't been implemented. And they're going after tobacco again because it's been left on the side, even though the instruments are there to do something about it. And it's not going to be seen here. We barely signed it, I think, when I was on the WHO Executive Board back in the day.

There are a lot of lessons to be learned actually from other environments, and even people that are now at American institutions who've been elsewhere, doing things that are really creative in the space that we're... So, I think part of it is our bully pulpit is public access and deciding what makes sense, but I think part of it, the funding, has got to be the target. And how do we sneak up on it? Or how do we get broader thinking about public health? It's really, really important.

Okay. I don't think we have any members of the public. We have a few, looking at Lloyd, we have a few members of the public. Anybody have any comments they wish to make at all? Okay, good. We've done that, public comment. Any last words from you, Liza, I think?

Dr. Whalen: Nope.

Dr. Boufford: This has been a great discussion. I mean, we will keep a record of... We have now, thanks to Mark's great organization, something this committee's been asking for forever, which is have a calendar for your meetings for next year. They are on your calendar. And if we end up having to extend an hour or so to cover these things, we will do that. And then the next Ad Hoc Committee meeting is on the 3rd. And Mark suggested today, "Maybe we need to get a calendar for the Ad Hoc Committee as well." So, one of the issues has been the constraints on organizing technology and space availability, so we're working on that one.

But anyway, we'll come up with... Next time, maybe we'll lead next time on the workforce issue and lead with some of the takeaways we could consult offline before the next meeting to identify what some of the possibilities may be for planning an agenda. Our next meeting is the middle of September. So, I think September 16th is our next meeting of the Public Health Committee. So maybe we could have some options for collaborative work identified in time for that meeting in addition to updates on the other areas.

So, thank you all staff, really. You've done really a lot of hard work in the last while. Thank you for your leadership, Liza, as our point person on the prevention agenda. And we'll see you all tomorrow. Thanks, all of you who came.

Dr. Whalen: Thanks, everybody.